COMMITTEE B

FIRST MEETING

Thursday, 19 May 2005, at 09:15

Chairman: Dr J. WALCOTT (Barbados)

1. OPENING OF THE COMMITTEE: Item 14 of the Agenda (Document A58/48)

The CHAIRMAN, welcoming participants, reminded the Committee that representatives of the Executive Board voiced the Board's views and explained the rationale behind recommendations for the Health Assembly's consideration. He drew the Committee's attention to the third report of the Committee on Nominations,[1] which contained proposals for the offices of Vice-Chairmen and Rapporteur.

Decision: Committee B elected Professor J. Pereira Miguel (Portugal) and Dr M.A. Rahman Khan (Bangladesh) as Vice-Chairmen and Mr Yee Ping Yi (Singapore) as Rapporteur.[2]

2. ORGANIZATION OF WORK

The CHAIRMAN drew attention to document EB115/2005/REC/1, which contained the resolutions and decisions adopted by the Board in January 2005 and to which frequent reference would be made. He suggested that the Committee should meet from 09:00 until 12:30 and from 15:00 until 18:00, and urged speakers to restrict the length of their contributions to no more than three minutes.

It was so agreed.

He recalled that at its meeting on 16 May 2005 the General Committee had decided that the following subitems under agenda item 13 would be transferred from Committee A: 13.12 (Cancer prevention and control); 13.13 (Disability, including prevention, management and rehabilitation); 13.14 (Public health problems caused by harmful use of alcohol); and 13.15 (International Plan of Action on Ageing: report on implementation). He suggested that agenda item 17.3 (Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution) should be considered after agenda item 16 to enable the Health Assembly to reach an early decision on the restoration of voting privileges for those Member States that had submitted requests for special arrangements to settle arrears in the payment of their contributions.

It was so agreed.

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[1] See page 351.

[2] Decision WHA58(4).

The CHAIRMAN said that, pending approval of the Proposed programme budget 2006-2007, which was currently being discussed by Committee A, it might be premature for the Committee to consider the draft resolution on the Real Estate Fund contained in document A58/44 Corr.1. He suggested postponing consideration of agenda item 18 until after completion of agenda item 17 (Financial matters).

It was so agreed.

3. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 15 of the Agenda (Documents A58/24, A58/INF.DOC./2, A58/INF.DOC./4 and A58/INF.DOC./5)

The CHAIRMAN drew the Committee's attention to a draft resolution entitled Health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan, proposed by the delegations of Bahrain, Egypt, Jordan, Kuwait, Oman, Qatar, Tunisia and United Arab Emirates, which read:

The Fifty-eighth World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Expressing appreciation for the report of the Director-General on the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine;[1]

Expressing its concern at the deterioration of the economic and health conditions as well as the humanitarian crises resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

Affirming the right of Palestinian patients and medical staff to the health facilities available at the Palestinian health institutions in occupied East Jerusalem;

Deploring the impact on the Palestinian environment and in particular on Palestinian water resources of the disposal of Israeli waste in the West Bank;

Concerned about the possible health effects on the Palestinian people of the "enhanced X-ray machine" used by Israel at Palestinian border-crossing points,

1. CALLS UPON Israel, the occupying power, to halt immediately all its practices, policies and plans which seriously affect the health conditions of civilians under occupation;

2. DEMANDS THAT Israel reverse and stop its practice of dumping waste in the occupied Palestinian territory;

3. EXTENDS its gratitude to Member States, and to intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people;

4. EXPRESSES its deep appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people, the rest of the Arab population in the occupied Arab territories, and other peoples of the region;

[1] Document A58/24.

5. REQUESTS the Director-General:

(1) to dispatch a fact-finding mission on the deterioration of the health and economic situation in the occupied Palestinian territory;

(2) to undertake without delay an independent health-impact assessment of the "enhanced X-ray machine" used by Israel at Palestinian border-crossing points;

(3) to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties and to help it during and after the announced Israeli withdrawal from the Gaza Strip and parts of the West Bank, in particular so as to guarantee the free movement of all health personnel and patients within and out of the occupied Palestinian territory including East Jerusalem, and the normal provision of medical supplies to the Palestinian medical premises;

(4) to provide health-related technical assistance to the Arab population in the occupied Syrian Golan;

(5) to continue providing necessary technical assistance to meet the health needs of the Palestinian people, including the handicapped and injured;

(6) to support the development of the health system in Palestine including development of human resources;

(7) to report on implementation of this resolution to the Fifty-ninth World Health Assembly.

Mr MELEKA (Egypt), introducing the draft resolution, said that it reflected the deteriorating health conditions of the people in the occupied Palestinian territory including East Jerusalem and the occupied Syrian Golan as a result of the continued Israeli occupation. The current situation made it incumbent on WHO, with the support of the international community, to reaffirm that the health of all peoples was fundamental to the attainment of peace and security. Demolishing homes and constructing blockades that prevented humanitarian assistance reaching those who needed it not only amounted to a violation of the basic human rights of the Palestinian people, but also showed a flagrant disregard for the many relevant international conventions and resolutions, including several adopted by the Health Assembly. He called on the Organization to remind Israel of its obligations in that connection, and requested the Director-General to dispatch a fact-finding mission to investigate the deterioration of the health and economic situations in the occupied Palestinian territory. In addition, Israel had to stop and reverse its practice of dumping waste in the occupied territory, and take steps to prevent the Palestinian people being subjected to the harmful effects of the "enhanced X-ray machine" used at Palestinian border-crossing points. The Arab countries called on WHO to continue to provide support to the Palestinian people despite the many obstacles and problems, and urged the Government of Israel to reconsider its practices and take the necessary steps to improve conditions. He hoped that the draft resolution would be approved by consensus.

Mr MOKHTARI (Islamic Republic of Iran) said that the reports of the Director-General and of the Director of Health, UNRWA[1] painted a grim picture of the situation in the occupied Palestinian territory: many thousands of killed and injured; severe economic recession, with a sharp increase in unemployment and poverty; and many children suffering severe psychological problems. People with medical emergencies were often subjected to delays as they attempted to obtain much-needed treatment, delays which sometimes resulted in death. Despite the efforts of the international community, the enjoyment of good health would remain beyond the reach of the Palestinian people until the occupation came to an end.

Dr AL-WUHAIDI (Palestine) said that Palestine was looking to WHO as a non-political organization to provide continued support to the Palestinian Ministry of Health. The wall/fence

[1] Documents A58/24 and A58/INF.DOC./2, respectively.

constituted an additional obstacle in the daily lives of the people, separating thousands of Palestinians from their families and work, depriving them of their right to education, health and political participation. As a result of the deteriorating economic situation and growing unemployment, there had been a sharp rise in the number of people suffering from anaemia, especially pregnant women and children. He was also concerned about the possible harmful effect on people's health and morale of the "enhanced X-ray machine" used by Israel at border-crossing points. Israel showed its further disregard for the health of local populations by continuing to dump toxic waste on Palestinian land and to build settlements that had an adverse impact on both water supplies and the environment.

He drew attention to the large number of people killed or seriously injured during the recent intifada, and called on Israel to withdraw from all the Palestinian territory it had occupied since 1967, including East Jerusalem and all border checkpoints. Despite Israel's claims that it was offering training and other facilities to the Palestinian people, the price they had to pay for such facilities far exceeded what they would have had to pay elsewhere.

He thanked Member States and intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people.

Dr TSHABALALA-MSIMANG (South Africa) expressed her condolences to the Government and people of Palestine on the loss of their leader, President Yasser Arafat. It was to be hoped that the peace process would soon reach a successful conclusion, but, in the meantime, the health status of the Palestinian people was being severely compromised. She had noted with particular concern reports relating to interrupted water supplies, flagrant inequities in water distribution and use, and what appeared to be deliberate acts of pollution in the occupied Arab territories, including Palestine. The current situation impeded the free movement of the Palestinian people, and thus restricted their access to health services. A unified, fully functional health infrastructure was essential for the delivery of health services.

The wall/fence, still being constructed even though it constituted a violation of international law, seriously disrupted the provision of health services by isolating clinics and hampering the distribution of medical supplies. Any breakdown in the health infrastructure disproportionately affected the health of women, mothers and children by undermining maternal health care, disrupting vaccination programmes and reducing the likelihood of delivery in optimum conditions. Any interference with health-care workers and ambulance services was a serious cause for concern; reports of health-care workers being injured or killed while performing their duties were shocking. She supported the draft resolution.

Mr BERNS (Luxembourg), speaking on behalf of the Member States of the European Union, commended the focus by the resolution's sponsors on the health aspects of the situation, and said that he would be proposing several amendments at the appropriate time.

Mr MARTABIT (Chile) expressed concern over the current situation in the occupied Palestinian territories, and urged Israel to lift the restrictions that were preventing the people from receiving proper medical attention. Improving the health of the people in the occupied Arab territories was closely linked to effective implementation of the peace process. The Palestinian people had a right to live in an independent State and to co-exist peacefully with Israel in accordance with relevant United Nations Security Council resolutions. Therefore, it was to be hoped that both Palestine and Israel would do their utmost to reach a just and lasting peace based on mutual respect in the best interests of their citizens and of future generations. Chile supported the draft resolution.

Dr SENAN (Malaysia) urged all Member States to support the draft resolution. The situation in the occupied Palestinian territory continued to be a cause of grave concern to his country, in particular the deterioration in the health conditions of the Palestinian people as a result of the construction of the wall/fence by Israel. He called on WHO to take urgent measures to address the various problems highlighted in the reports of the Director-General and the Director of Health of UNRWA, in particular

the health and nutritional needs of pregnant women and children, the continued decline in immunization coverage and the restrictions on the movement of medical personnel. He strongly supported the call for the Director-General to dispatch a fact-finding mission to the occupied Palestinian territory. As the occupying power, Israel must immediately cease all policies and practices that were having a damaging effect on health, and must allow the Palestinian health system to function properly again.

Mr M.N. KHAN (Pakistan) also expressed grave concern at the health situation in the occupied Palestinian territory, including East Jerusalem and the Syrian Golan. The highest attainable standard of physical and mental health was a vital human right that was being violated by Israeli policies and practices. The Organization, as the world's leading health body, should provide a proper diagnosis and a prescription in the form of an independent and comprehensive health-impact assessment. He was alarmed at Israel's dangerous practice of dumping waste in the West Bank, damaging the environment and the water resources of the Palestinian people and adversely affecting health. The Health Assembly should call for that practice to be halted immediately. The deterioration in conditions was largely due to the economic siege imposed by Israel, and WHO could help to ease the situation by coordinating its activities with other specialized agencies in the occupied territories and by providing financial and technical support. The provision of medical supplies and the free movement of health workers and patients were paramount, particularly during and after the declared Israeli withdrawal from the Gaza Strip and other parts of the West Bank.

He fully supported the draft resolution and called on Member States to endorse it. The international community should express its solidarity with the Palestinian people and should work towards a just, comprehensive and lasting solution of the Middle East problem.

Mr WANG Chuan (China) said that the international community must take into account the humanitarian needs of Arab populations in the occupied territories and take measures to promote and protect their health; he expressed appreciation for the efforts of WHO and other organizations in that regard. The peace process in the Middle East had entered a new phase in which Palestine and Israel had an opportunity to achieve success; for that, it was crucial that both sides persist with political negotiations based on relevant United Nations resolutions. China, like all peace-loving countries, wished to promote peace and stability. Resolution of the conflict in the Middle East would require not just determination and effort on both sides, but also the assistance and support of the international community. For those reasons, he supported the draft resolution.

Dr ESTÉVEZ TORRES (Cuba) said that health conditions in the occupied Palestinian territory were an important issue for the Health Assembly, given the negative effects of the Israeli occupation on its population and on the environment. The violation of the human rights of the Palestinian people was the most flagrant, massive and systematic of its kind, and the numbers of dead and injured, mostly civilians and including many children, continued to increase. He condemned the building by the Israeli Government of the wall around the West Bank and Jerusalem and the expansion of Israeli settlements. Health conditions had continued to deteriorate as a result of that and the restrictions on freedom of movement imposed by Israel, which particularly affected ambulances, health workers and the sick and injured. Patients and medical staff were being denied access to health centres and hospitals, leading to a reduction in the number of immunized children. The Palestinian Ministry of Health had suffered unprecedented damage, which put its very survival in jeopardy. As a result of the continued existence of blockades, curfews and road closures, the multiplication of checkpoints and denial of access to their places of work, tens of thousands of Palestinian families had been cut off from their sources of income and were on the verge of collapse. The great majority of Palestinians suffered or were at risk of suffering from food insecurity, while the supply of international financial resources was declining.

At the same time the environment in the occupied Palestinian territory continued to deteriorate as a result of Israel's dumping of solid nuclear and chemical waste, which contaminated underground water supplies, adversely affecting health. International humanitarian efforts, including those

undertaken by the United Nations, had failed owing to lack of cooperation by the Israeli authorities and their total contempt for the increasing number of resolutions adopted by the United Nations on the subject. He fully endorsed the request to the Director-General in the draft resolution to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health in its efforts to overcome the current difficulties, and to provide health-related technical assistance to the Arab population in the occupied Syrian Golan.

Member States of WHO needed to join forces, notably by calling for full implementation of the successive demands made by the overwhelming majority of members of the international community, through relevant United Nations bodies and the Health Assembly, for the immediate cessation of aggression by Israel against the Arab and Palestinian populations in the occupied territories. He expressed support for the draft resolution.

Dr ELSAYID (Sudan) acknowledged health workers in the occupied Palestinian territories, who had been providing services to Palestinian citizens despite the obstacles imposed by the occupying authorities. Israel's policy of collective punishment, which resulted in women, children and elderly people being killed and housing and environmental structures damaged, was universally condemned. The Director-General should send a fact-finding mission and present a report to the Health Assembly. The refusal of the occupying authorities to permit such a mission violated United Nations resolutions.

Dr JA'AFARI (Syrian Arab Republic), endorsing the draft resolution, said that the Israeli occupation of the Palestinian and Syrian territories had been of significant concern to the international community for decades. It was frequently included on the agenda of international forums and was given non-stop coverage by the media. Israel's response, however, was to escalate its activities.

The poor health status of the Palestinian people in the occupied territory could not be denied. For example, a pregnant woman had been forced to give birth at a checkpoint, after being prevented by Israeli soldiers from reaching hospital; 286 Palestinian children had been killed in the last four years, most of them shot in the head; and Palestinian ambulances bearing the emblem of the International Red Crescent had been bombarded by Israeli tanks, killing health workers. Israel had prevented the building of hospitals and schools in the occupied Golan, forcing Syrian populations there to seek medical care at Israeli hospitals. The Israeli authorities used Palestinian wells to supply their settlements, dumped nuclear waste in the occupied territory, and made use of enhanced X-ray machines, which caused cancer and sterility, at border-crossing points. In view of that situation, the least WHO could do was to adopt the draft resolution. Israel was not only occupying Arab territories in Palestine and Golan but was destroying the environment of those territories in the long term. The path to peace was clear, and was based on justice and international legitimacy. Israel should accept that the international community was right, and heed the 1000 or more international resolutions adopted since 1948 calling for it to end its occupation.

Mr FERGUSON (Canada) expressed his continued concern at the declining living standards and impaired access to basic health facilities and services in the West Bank and Gaza, which had been exacerbated by barrier construction. Canada was a longstanding provider of humanitarian assistance to the Palestinian people, including through contributions designed to meet urgent health needs.

However, with regard to the draft resolution, he regretted the focus on a specific geographical area, the singling out of Palestinians for special attention and, in particular, the request for an independent assessment of X-ray equipment, which in his view served no technical or health purpose and would be a misuse of resources. WHO should focus primarily on achieving the highest possible level of health for all peoples by advancing global health strategies. For those reasons, while commending the sponsors of the resolution for their constructive efforts, he would abstain from the vote.

Mr LEVANON (Israel) said that, although he had been encouraged by statements made in plenary to the effect that WHO was free from politicization, that did not appear to be the case. He had

the impression that the Health Assembly, in singling out one country for attention, was operating a system of double standards, which detracted from the Organization's image and prestige.

The draft resolution, which was basically political, fell outside the scope of the Health Assembly's remit; it did not improve the health of those living in the territories; nor did it call for Israeli-Palestinian cooperation or mention the positive developments that had occurred since the Sharm el-Sheikh summit. He pointed out that medical care for Palestinians was the responsibility of the Palestinian Health Authority, which had been independently managing its health services for over 10 years, whereas the 40 emergency health situations currently existing around the globe were the responsibility of WHO, which should be dealing with those crises, not a political issue.

Two specific allegations in the draft resolution were clearly designed to mislead the Health Assembly. The first was the pollution of water supplies through the disposal of waste in the West Bank. Israel would not pollute water that was used by Israelis as well as Palestinians. The second concerned supposedly harmful X-ray equipment. In fact the equipment in question was a commercial product that did not use ionizing radiation, only radio waves, the intensity of which was in accordance with international standards and did not endanger human health. It was used in several European Union countries and as far as he knew had not been considered to pose any health risks.

He mentioned some of the positive aspects of the situation, including Israel's humanitarian policies, unchanged despite several acts of terrorism by Palestinians. Israel continued to admit Palestinian patients to hospital, provide ambulatory medical care, public health and laboratory services, and training programmes and postgraduate studies for health professionals, and facilitate the transfer of medical donations and medical equipment to centres in Palestinian territories. In the past year more than 35 000 patients from the West Bank and Gaza had been treated in Israeli hospitals. Despite the fact that the Palestinian Authority had halted payments for those services, Israel continued to admit Palestinian patients without delays or restrictions. Under Israeli cooperation with the Palestinian health sector, in the past year, 53 Palestinians had participated in training programmes in Israel, consultative meetings on crucial public health and infectious disease issues had been held, public-health laboratories continued to provide assistance, and a joint initiative to improve the nutritional status of children from both sides had been launched.

Past experience had shown that resolutions did not help to improve the health of Palestinians. He called on his Palestinian partners, instead of tabling political resolutions, to declare publicly their willingness to resume the work of the six joint committees established by mutual accord in the field of health for the benefit of both peoples. He called on Member States to reject the draft resolution, and to steer the Health Assembly away from further politicization to enable it to focus on crucial health issues, which would be of much greater benefit to the welfare of the Palestinian people.

Dr SHANGULA (Namibia) joined in expressing grave concern at the deteriorating health situation in the occupied Palestinian territory. He had particular misgivings about the use of the "enhanced X-ray machine" at border-crossing points, since it was universally accepted that it was morally and ethically wrong to subject individuals to radiation except for diagnostic purposes; it was not allowed for pregnant women, for example, even in low doses. By implication, an enhanced X-ray machine would subject individuals to higher doses of radiation than normal: that was unacceptable and WHO, in view of the clear health implications, should demand that the practice be stopped. The draft resolution addressed health issues – the prime mandate of the Health Assembly – and he therefore supported it.

Dr AMMAR (Lebanon) expressed his concern at the health conditions in the occupied territories, including Palestine, especially given the lack of any restraints at international level on Israeli aggression. He endorsed the observations relating to the negative economic and health effects of restrictions on the movement of goods and people, and of other obstacles that hindered access to health services, particularly for women and children. The construction of a partition wall would exacerbate those effects. Israeli practices breached international law and violated human rights. With regard to the question of the dumping of waste and the pollution of water resources, which would

affect present and future generations, he called on the international community to ascertain the nature of the waste dumped and to condemn the practice. WHO should assess the "enhanced X-ray machine" and its effects and submit a report.

All the issues that had been raised were related to health, and the Organization had a duty to take them into account. He therefore supported the draft resolution, and in particular the request to the Director-General to send a fact-finding mission to the occupied territories.

Mr MOLEY (United States of America) said that his country deeply regretted that the draft resolution was introducing largely political considerations into the debate of the global health body. The United States shared the concern about the situation in the region and the terrible toll that the violence was taking on both the Palestinians and Israelis. It had worked intensively with both sides to find a way forward. However, the question of the final status of the occupied Arab territories was clearly outside the mandate of the Health Assembly. The resolution would neither help to further the search for peace in the Middle East nor improve the health of those living in the occupied territories.

The draft resolution should confine itself to the health of the Palestinian people. The United States was committed to providing assistance to the Palestinian people for primary health care, child survival, maternal health, nutrition and other humanitarian programmes, and was the largest donor to UNRWA. As much of the language in the draft resolution was biased and political in focus, he opposed its adoption and requested that it should be put to a roll-call vote.

Ms SOLTANI (Algeria) expressed concern at the health situation in the occupied Arab territories. She supported the draft resolution, and wished her country to be a sponsor.

Mr SUMIRAT (Indonesia) said that his Government remained deeply concerned about the economic deterioration of the occupied Arab territories and the continued security restrictions imposed by the Israeli forces, which had caused Palestinians much suffering, not only by restricting freedom of movement within the territories but also by restricting their access to medical treatment and health facilities. The construction of the separation wall in the West Bank had added to that suffering, particularly for sick and wounded Palestinians needing immediate health relief. Moreover, the deep psychological trauma experienced by 50% of Palestinian children owing to conflict-related violence was giving rise to aggressive behaviour and the need for mental-health treatment.

Although he appreciated WHO's efforts, in cooperation with UNRWA and other organizations, to support the Palestinian Ministry of Health in improving the health capacities in the occupied Palestinian territories, he recognized that Palestinian health services could not be improved effectively while the strict security measures remained in place. He therefore reiterated his support for the Palestinian people in their struggle to achieve their basic right to health and freedom and urged delegates to approve the draft resolution.

Dr OTTO (Palau) expressed sadness at the suffering that the peoples of Palestine and Israel continued to experience and expressed the hope that a peaceful resolution to the conflict in the region would be found. Although he commended the more positive direction of the draft resolution, compared to similar past resolutions, he was concerned about two of its provisions. First, hard facts were needed to prove that the deterioration in the economic and health conditions as well as the humanitarian crisis resulted solely from the actions of Israel, as was stated in the fourth preambular paragraph. Secondly, with reference to paragraph 1, it was not clear what were the "practices, policies and plans" that Israel was being called upon to halt; that wording might refer to the political situation. He was therefore unable to support the resolution as drafted.

Dr EL ISMAILI ALAOUI (Morocco) recalled that the deteriorating health situation of people in occupied Palestine and Syrian Golan had been discussed for decades, but that the situation had worsened since the wall had been erected. All reports of visits to the region corroborated the evidence

of its impact on health conditions. He supported the draft resolution and urged WHO to intervene to end the health crisis.

Dr AL-RABI (Yemen) noted with concern the deteriorating conditions of the Palestinians. He supported the draft resolution and wished to be added to the list of its sponsors.

Dr JA'AFARI (Syrian Arab Republic) observed that foreign occupation was rejected by the international community at large; indeed that the United Nations had been established to protect humanity from aggression and occupation. The veracity of his previous statement was confirmed by the fact that the delegate of Israel had ignored the occupation by Israel of the Syrian Golan. The Palestinians, Lebanese and Syrians who had been living under Israeli occupation for decades did not need Israeli clinics and doctors; they wanted to end the occupation and be able to live in dignity.

The claim made by the delegate of Israel that the "enhanced X-ray machine" was in normal use in other parts of the world was false, since similar equipment used in a European airport had been dismantled immediately after public protest.

The disposal of waste in the occupied Arab territories should be investigated by a WHO fact-finding committee, which would put to the test the statement by the delegate of Israel that it would not pollute water supplies.

Dr ALI MOHAMMED (Iraq) expressed deep concern about the deteriorating health conditions in the occupied territories, and the hope that WHO would fulfil its humanitarian mission in the occupied Palestinian territories without politicizing it. He strongly supported the draft resolution.

Dr OULD MOHAMED VALL (Mauritania) asked for his country to be added to the list of sponsors.

The CHAIRMAN announced that Mali had also requested that its name be added to the list of sponsors.

Ms BASSO (UNRWA), speaking on behalf of the Director of Health, UNRWA, reported that five years of severe humanitarian crisis in the occupied Palestinian territories had taken a heavy toll in terms of casualties, large-scale destruction of the infrastructure and generalized poverty. The obstacles to humanitarian access had constrained Palestinian development, affected the delivery and quality of services and jeopardized relief assistance. Income per capita had dropped by over half, and the proportion of the population living in poverty had risen from 20% to 60% since 2000; food insecurity was common.

The year 2005 had brought hopes of a breakthrough in the cycle of violence. However, the international community should not lose sight of the continuing and future challenges. All projections suggested that, if the Gaza Strip were to be sealed and isolated from the outside world, the economy would suffocate and the humanitarian conditions would deteriorate further. The residual problems of decades of occupation and conflict would require years of well planned and adequately coordinated efforts to facilitate transition from conflict to recovery and development during the post-disengagement era. In the West Bank, where the roots of the crisis lay in the lack of mobility and access, the separation barrier would worsen rather than improve humanitarian access. According to the Israeli Government, about 14.5% of the West Bank land (excluding East Jerusalem) would lie between the separation barrier and the internationally-recognized Green Line. That land, some of the most fertile in the West Bank, was home to 274 000 people. More than 400 000 Palestinians living to the east of the barrier would need to cross it to get to their farms, jobs and services. About 30% of the Palestinian population in the West Bank would be directly affected by the barrier. In addition, there were currently 220 000 settlers (not including those in East Jerusalem) who controlled 42% of the West Bank territory.

The transition from conflict to recovery and development was greatly hindered by the conditions of land confiscation, a depressed economy and stunted civil institutions, systems and services. Any improvements in the political and security situation owing to implementation of the disengagement plan would not immediately ease the humanitarian crisis or reduce the need for sustaining international assistance. Meeting the basic development needs of the population would be more complex than the current emergency interventions.

Since 2000, UNRWA had requested some US$ 1000 million to support its programme of emergency humanitarian assistance, in addition to the support it received for maintaining its regular programme activities and to that provided by the international community to the Palestinian Authority. As a major provider of services to about half the population of the occupied Palestinian territories, UNRWA required additional support not only to sustain its much-needed regular activities, but also in order to contribute to the process of rehabilitation and development. UNRWA was keen to maintain close cooperation with local and international partners within the framework of internationally coordinated and supported efforts. WHO's support for the medium-term development plans of UNRWA and the Palestinian Authority would be crucial to the success of that difficult mission, and its technical support for the rehabilitation and development of the Palestinian health-care system would be needed more than ever before.

Dr AL-HUSSEIN (Saudi Arabia) said that the reported health conditions in the occupied Palestinian territories were shameful and were the result of the occupation of that area. He supported the draft resolution.

Mr ALFARARGI (League of Arab States) maintained that the draft resolution was moderate and balanced in both content and form, aiming to present to the Health Assembly the true situation in the occupied Arab territories in Palestine, East Jerusalem and the Syrian Golan. If Israel's version of the facts were true, the Israeli Government should support the resolution so that WHO could produce a report absolving Israel. As it was not known whether the claims made by the delegate of Israel were true, the Committee should not accept them.

Mr BERNS (Luxembourg), speaking on behalf of the Member States of the European Union, welcomed the focus of the draft resolution on the health conditions in the occupied Palestinian territories. Resolutions submitted to the Health Assembly and to other technical agencies of the United Nations, however, should not be political in nature. He therefore proposed that in paragraph 2 of the draft resolution the words "and stop" should be deleted and in subparagraph 5(1) "dispatch" should be replaced by "submit", "mission" should be replaced by "report" and "the deterioration of" should be deleted. Subject to those changes, the European Union and the countries that aligned themselves with it would be able to vote in favour of the draft resolution.

Dr MOSTOFA NUAJE (Libyan Arab Jamahiriya) expressed alarm at the situation facing the people in the occupied Arab territories and strongly supported the draft resolution. He hoped that the United Nations organizations, including UNRWA, would continue their support, as the occupation of Arab territories must be brought to an end, especially in view of the daily suffering of residents in those areas.

Dr JA'AFARI (Syrian Arab Republic) said that the two amendments proposed by the European Union were not in keeping with the requests made by his country and many other Member States, but he agreed to them in order to reach a consensus.

Mr MELEKA (Egypt), speaking on behalf of the sponsors of the resolution, said that he agreed with the amendments proposed by the delegate of Luxembourg.

Dr YOUNES (Secretary) read out the proposed amendments to the draft resolution.

The CHAIRMAN recalled that there had been a proposal to proceed to a roll-call vote.

Mr BURCI (Legal Counsel) set out the protocol for such a process. The Member States whose right to vote had been suspended by a Health Assembly resolution, or which had not submitted credentials, and would therefore be unable to participate in the vote were: Afghanistan, Antigua and Barbuda, Argentina, Armenia, Central African Republic, Comoros, Dominica, Dominican Republic, Georgia, Grenada, Guinea-Bissau, Iraq, Kyrgyzstan, Liberia, Nauru, Niger, Niue, Republic of Moldova, Saint Lucia, Somalia, Suriname, Tajikistan, Trinidad and Tobago, Turkmenistan.

A vote was taken by roll-call, the names of the Member States being called in the English alphabetical order, starting with Jamaica, the letter J having been determined by lot.

The result of the vote was as follows:

In favour: Algeria, Andorra, Austria, Bahrain, Bangladesh, Barbados, Belgium, Bhutan, Bolivarian Republic of Venezuela, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Cameroon, Chad, Chile, China, Congo, Croatia, Cuba, Cyprus, Czech Republic, Denmark, Ecuador, Egypt, Estonia, Finland, France, Germany, Greece, Hungary, India, Indonesia, Islamic Republic of Iran, Ireland, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mauritius, Mexico, Monaco, Morocco, Mozambique, Namibia, Netherlands, New Zealand, Nigeria, Norway, Oman, Pakistan, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Romania, Russian Federation, San Marino, Saudi Arabia, Senegal, Serbia and Montenegro, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Tunisia, Turkey, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, Uruguay, Viet Nam, Yemen, Zimbabwe.

Against: Australia, Fiji, Israel, Marshall Islands, Federated States of Micronesia, Palau, Solomon Islands, United States of America.

Abstaining: Canada, Costa Rica, El Salvador, Guatemala, Honduras, Iceland, Nicaragua, Paraguay, Singapore, Thailand, Togo.

Absent: Albania, Angola, Azerbaijan, Bahamas, Belarus, Belize, Benin, Bolivia, Burundi, Cambodia, Cape Verde, Colombia, Cook Islands, Côte d'Ivoire, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guyana, Haiti, Kazakhstan, Kenya, Kiribati, Lao People's Democratic Republic, Madagascar, Malawi, Mongolia, Myanmar, Nepal, Panama, Papua New Guinea, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Tonga, Tuvalu, Uganda, United Republic of Tanzania, Uzbekistan, Vanuatu, Zambia.

The draft resolution was therefore approved by 95 votes to 8, with 11 abstentions.[1]

Ms HALTON (Australia), speaking in explanation of vote, opposed the continuing consideration of the resolution by the Health Assembly, and expressed concern that the maintenance of the item on its agenda not only introduced inappropriate political issues into that forum but also distracted the Health Assembly from issues that should take a higher priority. Furthermore, the consideration of such political issues by WHO was out of step with the need to streamline and

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.6.

rationalize the work of the United Nations and did not contribute effectively to the Middle East peace process.

Dr SADASIVAN (Singapore), speaking in explanation of vote, said that while his country had always supported the peace process in the Middle East, it did not believe that the Health Assembly was an appropriate forum in which to raise political issues.

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

4. REPORT OF THE INTERNAL AUDITOR: Item 16 of the Agenda (Documents A58/25 and A58/45)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking as Chairman of the Programme, Budget and Administration Committee, said that the report of the Internal Auditor provided a review of audit results from 2004. The Committee had welcomed the information on the status of audit reports, but requested timely and effective follow-up by the Secretariat, in particular to tackle delays in implementing audit recommendations in the Regional Office for Africa. It had reviewed the schedule[1] and acknowledged that all audit recommendations had been monitored until closure of the audit. The Committee had acknowledged the efforts to identify means to improve efficiency and cost-effectiveness in some areas, and those aimed at strengthening the Office of Internal Oversight Services.

Mr JAYATHILAKE (Sri Lanka), referring to paragraph 22 of document A58/25, said that, according to the constitution of his country, the Ministry of Health was responsible for monitoring provincial health activities and the national health policy. WHO's direct involvement with provinces and districts would cause problems of financial accountability and administration by creating two parallel administrative structures. All technical agencies in the health sector were under the ministry's authority and WHO's direct involvement with those agencies at a district level would create confusion. His Government therefore urged WHO to cooperate with the Ministry of Health, according to its mandate and current practice. Under existing arrangements, more than 90% of funds were allocated at provincial and district levels. WHO would be welcome to monitor closely the use of those resources jointly with the ministry.

Ms BLACKWOOD (United States of America) commended the work undertaken by the Office of Internal Oversight Services, which provided value-added, and effective monitoring, evaluation and accountability services. She was concerned, however, that the Internal Auditor had noted weaknesses in some internal controls for accountability and safeguarding resources, and she called for those controls to be strengthened. The effectiveness of the Organization was diminished when audit recommendations remained open, and the reported "growing backlog of audit recommendations" for which there was no reported implementation was a cause for concern. She recommended that Member States should request their regional committees to follow up recommendations so that corrective actions were taken to improve WHO's operations at all levels, as her country planned to do in relation to the audits undertaken in the Region of the Americas. As WHO moved towards decentralization, its operations at country level became increasingly important, and the need for effective, efficient and accountable structures was imperative.

She welcomed the evaluation of the WHO fellowship programme, and urged that the programme should be changed to ensure objectivity in the selection of candidates and a clear purpose

[1] Document A58/25, Annex.

in their assignments, so that when they returned to their home nations the fellows could contribute to sustainable national capacities in the area of health and human resources. She supported the recommendation that WHO should undertake a systematic review at each level, and better integrate fellowships into overall health and human resources policies.

Mr MACPHEE (Canada) welcomed the Internal Auditor's report, particularly its annex, and the strengthening of the Office of Internal Oversight Services, which he considered an essential part of results-based management. He also welcomed the identification of areas where improvements made would lead to greater efficiency and hence to cost savings, which would make additional funds available for particular programme areas of the budget.

Referring to paragraph 3 of document A58/45, he shared the concern expressed regarding delayed implementation of audit recommendations in the Regional Office for Africa, and noted the commitment of the Internal Auditor to make more provision for tracking the issues identified. A checklist of areas where backlogs had occurred should help to solve the problem.

Dr ACHARYA (Nepal) expressed satisfaction with a timely and informative report. The irregularities identified should be addressed promptly, so that they could be corrected in good time and would not recur. There was a need to evaluate the outcome of expenditure under various programmes at country level, and he asked the Internal Auditor to look into the matter and report back, so that Member States could know whether the Organization's resources were being properly used.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) endorsed the statements made by the delegates of the United States of America and Canada, particularly on the need for tracking the follow-up to audit recommendations. She would like to see a more structured response to those recommendations in future reports.

Referring to paragraph 45 of the Internal Auditor's report, she noted that the implementation of recommendations for improvement in the Regional Office for Africa was currently stalled, and asked for an explanation and a timetable for the resolution of that long-standing problem.

Dr QI Qingdong (China), commending the work done by the Office of Internal Oversight Services, said that he was concerned as to how follow-up was to be done. He stressed the need to strengthen internal oversight services in order to ensure that the same problems did not recur. To facilitate follow-up, a performance indicator should be created, and regular reports should be submitted to the Executive Board.

Mr MCKERNAN (New Zealand) said that he too was concerned to note that some audit recommendations remained open and that no action had been taken on others. In view of the fact that under the Proposed programme budget 2006-2007 a significant increase in total revenue and project expenditure was planned, strong financial discipline was crucial. The Director-General should be requested to provide a report on proposed action on all outstanding audit items.

Mr VAN DER HOEVEN (Netherlands) welcomed the generally positive picture given by the Internal Auditor, but was concerned at the stalled implementation of recommendations in the Regional Office for Africa, which might entail financial risks for WHO.

Mr LANGFORD (Office of Internal Oversight Services), in reply to the delegate of Sri Lanka, said that the report in question was an internal audit addressed to the WHO Representative in Sri Lanka, which dealt with increasing the effectiveness of WHO's work at all levels in countries. He was confident that proper consultation with stakeholders would take place.

Concerning follow-up and implementation, more specific information would be provided in the next report. Since publication of the current report progress had been made, and he expected that by the following year there would be considerable improvement.

As to the evaluation of outcomes at country level, a technical evaluation and performance audit programme was in place to cover both programmatic and administrative issues. Concerning the situation in the Regional Office for Africa, it should be noted that in the past year both the Regional Director and the Director, Administration and Finance had changed, which had affected implementation of the recommendations. An audit was in progress that would give a better picture of the current situation.

The Committee noted the reports.

5. FINANCIAL MATTERS: Item 17 of the Agenda

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 17.3 of the Agenda (Documents A58/31, A58/31 Corr.1 and A58/43 Rev.1)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking as Chairman of the Programme, Budget and Administration Committee, said that the Committee had noted the reduction in the total amount due for prior years to US$ 85 million, excluding amounts due under special arrangements which had increased to US$ 46 million from US$ 14 million in 2004. The Committee had requested greater clarity in the reporting of payments made under special arrangements, and that future reports should provide up-to-date information on the amount owed by the former Yugoslavia. It had also noted that the voting privileges of 20 Member States remained suspended, but, since Chad had subsequently made payment of all arrears and current contributions, its voting privileges were restored. The Committee had considered the four Member States with arrears at 31 March 2005 to an extent that would justify adoption of a resolution under Article 7. Since sufficient payments had been received from Guinea, Paraguay and Peru, they would no longer be covered by such a resolution. For the remaining Member, Uruguay, the Committee had decided to draft a resolution whereby its voting rights would be suspended from the opening of the Fifty-ninth World Health Assembly unless sufficient payments were received before then. Finally, the Committee had agreed to recommend the proposals made by Georgia, Iraq, Republic of Moldova and Tajikistan. It recommended the five resolutions contained in document A58/43 Rev.1 for consideration by the Health Assembly.

Ms WILD (Comptroller) said that, since the Committee's report, payment had been made in full by Gabon of all its arrears and assessments due for 2005. Payment of arrears had also been made by Antigua and Barbuda, but unfortunately the amount had not been sufficient to remove it from the provisions of Article 7. Discussions had been held with representatives of the Dominican Republic and Liberia concerning their situation, and they intended to present proposals for special arrangements to the Fifty-ninth World Health Assembly. There had also been discussions with Armenia, which intended to present a revised proposal in 2006.

Mr MACPHEE (Canada) urged all Member States to pay their assessed contributions in full and on time. He noted with concern from the report than an even larger number of Member States appeared to have made no payment for the current year, and that a substantial number of assessed contributions remained outstanding. He commended the Secretariat's continuing efforts to resolve that situation, particularly the introduction of special arrangements for the settlement of arrears.

The CHAIRMAN invited the Committee to consider the draft resolution recommended in paragraph 8 of document A58/43 Rev.1.

The draft resolution was approved.[1]

The CHAIRMAN invited the Committee to consider the draft resolutions in respect of requests for special arrangements by Georgia, Iraq, Republic of Moldova and Tajikistan set out in paragraph 9 of document A58/43 Rev.1.

The draft resolutions were approved.[2]

6. STAFFING MATTERS: Item 19 of the Agenda

Human resources: annual report: Item 19.1 of the Agenda (Document A58/34)

Recruitment strategy integrating gender and geographical balance: progress report: Item 19.2 of the Agenda (Document A58/35)

Dr OSMAN (Representative of the Executive Board) noted that the sixth annual report provided complete data on the WHO staffing profile as at 31 December 2004, including information on overall numbers, gender and geographical balance, age and length of service, temporary staff, the distribution of the workforce by occupational group, internal and external recruitment, and national professional officers.

Mr MACPHEE (Canada) noted with pleasure the progress made in some areas, and particularly that five previously unrepresented or underrepresented countries were within their desirable range of representation and that, in 2004 32 appointments to the professional category had involved nationals of such countries. Although the percentage of women in the professional category had increased since the last report, it was still short of the goal of gender balance, and he encouraged continued efforts in that direction, bearing in mind that merit should always be the primary criterion in the selection of personnel.

He voiced concern that nurses accounted for only a small percentage of professional medical staff, and that that figure had declined since 2001. Some 630 staff members were due to retire in the next five years. That situation should be monitored closely, as it offered potential for the development of a human resource strategy.

A summary of any efforts made by the Organization not covered by the largely statistical presentation given in the report would be welcome.

Dr QI Qingdong (China) welcomed the efforts made to increase diversity among staff. However, he noted that the total number of staff at P.4 level and above had been increasing year by year, and far exceeded the number of staff at lower levels. Would that situation have financial repercussions? Furthermore, only 16.7% of appointments to the professional category had been from unrepresented or underrepresented countries, which was a long way from the goal set by the Health Assembly. What action would be taken to remedy that situation? Was there any long-term strategy to achieve a balance between permanent and temporary staff?

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.7.

[2] Transmitted to the Health Assembly in the Committee's first report and adopted as resolutions WHA58.8, WHA58.9, WHA58.10 and WHA58.11, respectively.

Dr ENAMI (Japan) said that the annual report showed that many countries were still unrepresented or underrepresented. He strongly urged that steps be taken to improve that situation.

Mr HENNING (Human Resources Services) thanked the delegate of Canada for his advice. In reply to the delegate for China, he said that there had been an increase in the number of fixed-term appointments during 2003-2004 and in the number of staff at P.4 level and above, pursuant to an earlier Health Assembly decision on regularization of staff positions through contract reform. Some additional increases were expected before the completion of the regularization exercise due by the end of the year.

Concerning geographical distribution, the report showed that improvements had been made. Increases in the number of institutions, both governmental and nongovernmental, in which WHO vacancies were circulated should start showing results in late 2005 and 2006. In addition, the Director-General had given precise instructions on how the various offices should increase representation of unrepresented and underrepresented countries and attain 60% of recruitment from developing countries, as well as reaching gender targets.

On the point raised by Japan, he said that the recruitment strategy noted by the Board the previous year, and which aimed at increasing diversity, should soon start to show results.

Mr STRØMMEN (Norway) said that, to fulfil its role as the global community's centre of excellence for health, WHO depended on having the highest calibre of staff. Like other United Nations organizations, however, the Organization needed to take into account gender and regional balance. The report in document A58/35 showed that WHO was taking seriously the request by the Health Assembly in resolutions WHA56.17 and WHA56.35 on gender balance and representation of developing countries. Progress had been made, but the results did not appear to match the efforts undertaken. The annual report on human resources (document A58/34) indicated that 32 of 192 new appointments to the professional category in 2004 were nationals from underrepresented countries: how many were filled through nominations and how many through vacancy announcements? Nominations generally favoured recruitment by managers of persons they had already worked with, thus reinforcing the tendency to recruit from countries already represented. In addition to the negative impact on regional balance, that tendency contributed to a lack of diversity. WHO should in general recruit professional-category staff through vacancy announcements, and look at the practice in other United Nations organizations with regard to new appointments, particularly at D.1 level and above. He sought more transparency, and encouraged the Secretariat to publish and update regularly its organizational chart, as the current lack of information hindered representation of Member States on WHO's staff, albeit unintentionally.

The Committee noted the reports.

The meeting rose at 12:20.

SECOND MEETING

Thursday, 19 May 2005, at 15:00

Chairman: Dr J. WALCOTT (Barbados)

1. STAFFING MATTERS: Item 19 of the Agenda (continued)

Amendments to the Staff Regulations and Staff Rules: Item 19.3 of the Agenda (Resolution EB115.R17)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that at its 115th session the Executive Board had confirmed amendments to the Staff Regulations and Staff Rules made by the Director-General, including an increase of 1.88% in the base/floor salary scale for the professional and higher categories based on the recommendation of the International Civil Service Commission to the fifty-ninth session of the United Nations General Assembly (September 2004). The adjustment implied similar adjustments to the salaries of staff in ungraded posts and of the Director-General. In accordance with Article 3.1 of the Staff Regulations, the Board recommended that the Health Assembly adopt the draft resolution on salaries of staff in ungraded posts and of the Director-General contained in resolution EB115.R17.

Mr HOHMAN (United States of America) said that at the 115th session of the Executive Board his delegation had requested WHO to harmonize its practice on education grants for internationally recruited staff living and working outside their home countries with that of other United Nations bodies. Contrary to his expectation, however, the issue had not been addressed, and he therefore asked for updated information to be provided at the 117th session of the Executive Board in January 2006.

Mr HENNING (Human Resources Services) said that, in the course of the review carried out in response to that request, it had been discovered that the criteria used by the United Nations to determine entitlement to education grants would be equally applicable to other expatriate entitlements. The work involved in the review was therefore considerably wider in scope than had been expected. A start had been made, however, and a proposal on education grants and other related entitlements would be submitted to the Board at its 117th session.

The draft resolution was approved.[1]

Report of the United Nations Joint Staff Pension Board: Item 19.4 of the Agenda (Documents A58/36 and A58/36 Corr.1)

The Committee noted the report.

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.12.

Appointment of representatives to the WHO Staff Pension Committee: Item 19.5 of the Agenda (Document A58/37)

The CHAIRMAN invited the Committee to appoint one member and one alternate member to the WHO Staff Pension Committee, in accordance with the rotational schedule explained in the report. In the absence of objections he took it that the Committee wished to convey the following draft decision to the plenary:

> **Decision:** The Fifty-eighth World Health Assembly nominated Mrs R. Veerapen of the delegation of Mauritius as a member, and Mrs C. Patterson of the delegation of Australia as an alternate member, of the WHO Staff Pension Committee for a three-year term until May 2008.
>
> **The draft decision was approved.**[1]

2. PROPOSAL FOR ESTABLISHMENT OF WORLD BLOOD DONOR DAY: Item 20 of the Agenda (Resolution EB115.R15; Document A58/38)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that the Board considered universal access to safe blood to be an essential part of health-care systems and an effective strategy in HIV prevention. At its 115th session, it had expressed strong support for the establishment of an annual World Blood Donor Day as part of a global strategy to promote voluntary blood donation, which was crucial in ensuring the safety, quality and availability of blood and blood products. The goal of eliminating paid blood donation should be pursued, especially as few countries had achieved that goal more than 25 years after resolution WHA28.72 had urged Member States to work towards it. The Board had recommended that the Health Assembly adopt the draft resolution contained in resolution EB115.R15.

Dr SANGALA (Malawi) said that the first global world blood donor day had been celebrated in his country on 14 June 2004. The event had been attended by more than 500 blood donors and its theme had been the formation of Malawi's "Club 25", a WHO initiative undertaken with European Union funding. The project, which was designed to mobilize young people between the ages of 16 and 25 to become safe and committed regular blood donors, was well established. The initiative had been welcomed enthusiastically by young people in Malawi, who were responsible for at least 40% of the donated safe blood. He supported the draft resolution.

Dr KONATE (Côte d'Ivoire) commended WHO's efforts to establish adequate blood transfusion services worldwide. To ensure wide coverage with safe and tested blood and blood products his country had set up a national and three regional blood transfusion centres and 64 blood banks. All blood donations were voluntary, and the strategy for recruitment was based on education of the population to encourage and motivate donors.

He proposed that in subparagraph 3(7)(a) of the draft resolution the words "quality-control systems" should be replaced by "quality-management systems". The resolution should also urge the inclusion of the subject of the clinical uses of blood in the curriculum of medical schools, and the education of children in the concept of voluntary blood donation. He thanked WHO for its support to Côte d'Ivoire in the area of blood transfusion and fully supported the draft resolution.

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[1] Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA58(9).

Dr SHANGULA (Namibia) commended the proposal to establish World Blood Donor Day. Blood transfusion constituted an integral part of the clinical management of patients, but donors were becoming increasingly scarce. Celebrating the event would ensure that more people were sensitized and encouraged to become donors. He therefore supported the draft resolution.

Dr LEPAKHIN (Assistant Director-General) thanked delegates for their support for the establishment of World Blood Donor Day as an annual event. It was important to reduce the percentage of family replacement and paid donations, as they were often unsafe. World Blood Donor Day should increase the number of countries achieving a 100% rate of voluntary, unpaid donations.

In response to a request by Mr HOHMAN (United States of America) for clarification, Dr KONATE (Côte d'Ivoire) explained that the term "quality-control systems" would cover only laboratory analysis, whereas "quality-management systems" would cover both quality control and quality guarantees. He would not press for an amendment in regard to his other suggestion.

The draft resolution, as amended, was approved.[1]

The meeting rose at 16:00.

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA58.13.

THIRD MEETING

Friday, 20 May 2005, at 10:00

Chairman: Dr J. WALCOTT (Barbados)

1. DRAFT FIRST REPORT OF COMMITTEE B (Document A58/53)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft first report of Committee B.

Dr SHANGULA (Namibia) expressed disappointment that the External Auditor would not be submitting his interim report to the Health Assembly until the following week, by which time many ministers would have been obliged to leave Geneva. The External Auditor had known for a year that he was required to report to the Health Assembly, and it was reasonable to expect him to have adjusted his schedule accordingly. Ministers were accountable to their constituencies on the use of funds, including those paid to WHO. By depriving them of the opportunity to discuss the report, the External Auditor was showing an unacceptable lack of respect, and he asked the Director-General to bring the matter to his attention. He wished his comments to be placed on record and to be recalled during consideration of the appointment of the next External Auditor.

Dr KEAN (Governance), in reply, said that, in both the preliminary daily timetable for the Health Assembly agreed by the General Committee and that presented to the Executive Board at its 115th session, agenda item 17 had been scheduled for Monday, 23 May. The External Auditor had, accordingly, made plans to travel from his home country for that date. That was the reason why he could not be present if the item were to be brought forward.

The report was adopted.[1]

2. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 15 of the Agenda (Documents A58/24, A58/INF.DOC./2, A58/INF.DOC./4 and A58/INF.DOC./5) (continued from the first meeting, section 3)

Mr SUMIRAT (Indonesia), making a point of clarification, said that in the previous discussion on the draft resolution on health conditions in the occupied Palestinian territory including East Jerusalem and in the occupied Syrian Golan, in expressing support for the draft resolution he had omitted to ask for Indonesia to be added to the list of sponsors.

[1] See page 355.

3. IMPLEMENTATION OF MULTILINGUALISM IN WHO: Item 21 of the Agenda (Document A58/39)

Dr YOOSUF (Maldives, Representative of the Executive Board), introducing the item, said that the Executive Board had been presented at its 115th session with the clarifications requested at its 114th session, informed of the progress made in improving multilingualism in WHO and shown the recently launched new version of WHO's multilingual web site. The Board had welcomed progress made but said that more needed to be done, such as the translation of *The world health report* in all official languages, providing simultaneous interpretation in meetings of regional groups, and drawing up a plan for longer-term measures on multilingualism, which would include cost implications. A plan of action with quantifiable targets had been requested.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Latin American and Caribbean Group, attached great importance to multilingualism in the Organization, given the multilingual nature of the region, in which three of the official United Nations and WHO languages were spoken. His Group defended and promoted the equal use of those languages, without discrimination, within the Organization. Although he welcomed the progress made on multilingualism, further improvements were necessary, particularly with regard to the availability of simultaneous interpretation services for the consultation and coordination meetings of the regional groups, the meetings of the governing bodies, and the meetings of expert groups; the Group had experienced problems with meetings during the Health Assembly for that reason. Acknowledging that promoting multilingualism was a long-term endeavour that required the allocation of resources, he said that the task force on multilingualism should take into account his Group's concerns relating to interpretation in the medium-term measures it would be proposing.

Ms LANTERI (Monaco), endorsing the importance of multilingualism and the need to ensure its implementation, said that interpretation in meetings, both formal and informal, and the translation of documents into WHO's six official languages were essential not only for the full participation of Member States in the Organization's work but also to ensure general access to knowledge and information, particularly by health workers. At the 114th session of the Executive Board, the Director-General had undertaken to increase the volume of documents translated and make provision for the training of WHO staff in the official languages. She welcomed the progress made – although it was still not enough – and the establishment of a task force to draw up a strategic plan. Its proposals should be submitted at the latest at the next Health Assembly for consideration.

Dr QI Qingdong (China) commended WHO's progress in the area of multilingualism – particularly in promoting the use of the six official languages – and suggested three possible improvements. First, the promotion of the six official languages, which had been successful at headquarters, should be extended to regional and country offices. Secondly, the timeliness of translations needed to be improved; there had been a lag of several months, for example, between publication of the English version of *The world health report 2005*[1] and the Chinese version, thereby reducing its effectiveness. Other important news, such as that concerning disease outbreaks, also needed to be rapidly translated. Thirdly, it was necessary to allocate funds to translation in order to ensure a balance between the six official languages. Referring to paragraph 8 of the report, he asked why there was no provision for the Chinese language in relation to the Health InterNetwork Access to Research Initiative (HINARI), and whether there was a plan to introduce it, since that would facilitate access to health information for one quarter of the world's population.

[1] *The world health report 2005: Make every mother and child count.* Geneva, World Health Organization, 2005.

Mr KOCHETKOV (Russian Federation), commending the Director-General's strengthening of multilingualism, observed that the report did not provide a strategy for reaching that goal but merely commented on projects under way. Like other delegates, he requested the establishment of a valid strategy on multilingualism in WHO, not just translation of the web site or publications, incorporating the experience of other United Nations organizations. ITU had adopted a resolution on funding all languages on an equal basis. Such an example could be useful to WHO.

Mrs LE GUEVEL (France) also endorsed the importance of multilingualism and commended WHO's work in translating the documents on its web site. However, further progress was required since only top-level content was available in the six official languages and many information documents were only translated at the last minute, if at all. She expressed regret that some meetings were still held without interpretation, including some presentations of the programme budget, which was unacceptable in view of their importance and technical content. She maintained that improving multilingualism must remain a priority for WHO, including at regional level. That was in the interest of both Member States and the Secretariat, given that multilingualism was the best way to reach a broad audience and thus contribute to improving health for all.

Dr EL ISMAILI ALAOUI (Morocco) welcomed the efforts made to improve multilingualism in order to optimize the Organization's work. Regrettably, the lack of interpretation for certain meetings handicapped some countries in following that work. Also, delays occurred in the translation of documents that were of the utmost importance for improving health conditions in certain countries. He therefore asked for further efforts to be made in the translation of documents in the six official languages.

Dr ABDULLA (Sudan) commended the important report, which reflected WHO's desire for dialogue with all peoples of the world. Improving multilingualism would ultimately improve the health of the populations at large, which was the Organization's main concern. He encouraged the use of the six official languages for communication and translation, and regretted that many documents were still not translated. Targets had not been met in that area, and he asked WHO for more financial support to that end. He also called for documents to be translated not only into the six official languages but also into all local languages, especially in those areas where health conditions could be improved, and asked for his request to be conveyed to WHO's regional and local offices.

Mr MOLCHAN (Belarus) welcomed WHO's efforts on multilingualism, but joined other delegates in expressing concern that the speed, coverage and quality of translation – including that of information and methodological materials – into all six official languages and their distribution in print still needed to be improved.

Dr STEIGER (United States of America), speaking in Spanish, commended the report with regard to improving interpretation and translation services and the extension of multilingual services to all of the Organization's work. He regretted, however, that interpretation services had not been extended to informal groups or to negotiating groups during the Health Assembly, as all countries should have the right to participate in those groups in their national language or in the official languages of the United Nations system.

Dr AL-HUSSEIN (Saudi Arabia) acknowledged the Secretariat's work in the area of multilingualism. He endorsed the suggestion of other delegates that a clear action plan should be drawn up for the broader use of languages and the translation of documents into all languages in order to attain WHO's objectives.

Mr MACPHEE (Canada) commended WHO's progress, particularly the improvements made to the web site, and he hoped that would continue. As a bilingual country, Canada had always been

strongly in favour of increased multilingualism and respect for the official working languages within WHO, especially the use of the French language.

Dr BEHBEHANI (Assistant Director-General), responding to comments, said that in 2005 *The world health report* had been translated into all six official languages for the first time. With regard to the delay mentioned by the delegate of China, he would try to improve the timeliness of publication the following year. In response to the observation that Chinese was not included as a language for training in the use of the HINARI system, he recalled that HINARI had been made available to more than 70 countries free of charge. He would consider making such training material available in Chinese, if so requested. Responding more generally to other issues raised, he said that following the concerns expressed by the Executive Board at its 114th session a task force had been established under a special coordinator to review multilingualism in WHO and to identify problems and obstacles in its implementation. The task force would make its recommendations and suggest medium- and long-term measures, together with the appropriate budget, to the Board at its 117th session. He would take into account all the other observations made regarding the further progress that needed to be made.

The Committee noted the report.

4. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (referred from Committee A)[1]

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16)

Dr OSMAN (Representative of the Executive Board) said that at its 114th session the Executive Board had examined a report on the prevention and control of cancer and had supported the need to develop and integrate adequate national programmes into existing health systems.[2] It had also stressed the importance of dealing with all the components of cancer control – prevention, early detection, treatment and palliative care – in a balanced way. The need to explore appropriate mechanisms for adequate funding of cancer prevention and control programmes, especially in developing countries, had also been raised. Emphasis had been placed on the need to establish innovative partnerships and appropriate networks to reduce the cancer burden. The Board had adopted resolution EB114.R2 on cancer prevention and control which recommended a draft resolution to the Health Assembly for adoption.

Dr MIZUSHIMA (Japan) said that his country was greatly concerned at the rapid increase in cancer cases, in view of its ageing society, and had therefore prioritized the strengthening of cancer control and research. In 2004, Japan had launched its third 10-year strategy plan for cancer control and in 2005 had established a task force for cancer prevention and control within its Ministry of Health to promote cancer-control measures. The quality of medical care should be improved through ensuring access to information on cancer and information-sharing among medical institutions. Japan was currently developing a fibre-optic network between its national cancer centre and local cancer centres to facilitate case-study meetings. His country had developed effective measures to prevent and control cancer, which included a mass screening programme, particularly for gastric and colon cancer. Japan

[1] See summary record of the first meeting of Committee A, section 1.

[2] Document EB114/3.

wished to contribute to such efforts internationally, in cooperation with WHO and IARC, and to learn about successful measures that other Member States had implemented.

The draft resolution rightly emphasized the need for health system infrastructures to be strengthened for the effective implementation of cancer prevention and control programmes. He supported its general thrust, but considered it ambitious. He asked to be informed of its cost implications, bearing in mind Financial Regulation XV on resolutions involving expenditures.

Ms OLLILA (Finland), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that, with increasing life expectancy and less healthy lifestyles, chronic diseases, including cancer, posed a major threat to health in developing countries. Although much could be done through effective treatment and rehabilitation, WHO should prioritize disease prevention and health promotion, and reallocate resources accordingly. Prevention was far more effective and economical and reduced avoidable suffering. It required collaboration among all sectors of society, with primary health care, including health education and screening, playing a key role.

More research into etiology and pathogenesis was needed, but there was firm evidence of the success of prevention measures. Current evidence on the etiological role of tobacco use, diet, physical inactivity and harmful use of alcohol supported the concept of prevention of noncommunicable diseases and the need for integrated (rather than disease-specific) prevention programmes that aimed to reduce social inequity and emphasize primary health care, health promotion and national intersectoral policies. Certain carcinogenic infectious agents and occupational hazards, such as asbestos, should be appropriately controlled. Globally, prevention depended on successful implementation of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health, and cancer organizations should therefore actively support their aims. All Member States had to have access to information on the high-quality international research that was coordinated by IARC.

Ms VALDEZ (United States of America) recalled that, at the 114th session of the Executive Board, all members had urged the Secretariat to help them to make cancer prevention, detection and treatment a higher priority. Members had also spoken of the need for a strong political movement. Cancer was the second leading cause of death in the United States, responsible for one in four deaths. In 2001, the Government had set a goal of eliminating the suffering and death caused by cancer by 2015. Although research was crucial to cancer-control programmes, prevention should not be underestimated: the adoption of healthier lifestyles could significantly reduce a person's risk for cancer.

WHO had recognized the essential role of sustained partnerships in reducing cancer mortality and morbidity. Examples included IAEA's work with WHO on radiation treatment for cancer, and IARC's leadership and focus on screening. Reducing cancer morbidity and mortality required early detection, diagnosis and treatment methods to be tailored to available resources. Breast cancer was the leading global cause of cancer deaths among women; the Breast Health Global Initiative brought together international health-care organizations, nongovernmental organizations and the private sector to establish best practice guidelines for care in limited-resource settings. The International Tobacco and Health Research and Capacity Building Program, sponsored by WHO and the United States National Institutes of Health, provided research and training grants to combat the growing incidence of tobacco-caused illnesses and death in the developing world, including those related to cancer. The Secretariat's report highlighted the growing need to expand palliative care for cancer patients and for support mechanisms for their families. The Secretariat and the International Narcotics Control Board might consider joint sponsorship of workshops to review the unmet need for opioids.

In view of the threat posed by cancer, particularly in ageing societies, and the expected future rise in cancer mortality rates in many countries, she supported the draft resolution but proposed that the preambular paragraph beginning "Recognizing the importance" and subparagraphs 1(9) and 2(13) should be amended by the addition of "and palliative care" after "control". In subparagraph 1(8), "and palliative care" should be added after "options". To reflect the progress made since the 114th session

of the Executive Board, the words "a programme of action for cancer therapy" in the last preambular paragraph should be changed to read "the Programme of Action for Cancer Therapy".

Dr SOMBIE (Burkina Faso) welcomed the draft resolution. Prevention was the best strategy, particularly in developing countries. Once people were taken ill, most of them did not have access to adequate treatment; the minority of people who did then faced difficulties in obtaining follow-up treatment, which led to relapses. Burkina Faso was in the process of setting up a system of cancer prevention.

Dr SOLOMON (Kenya) reported that Kenya had seen rapidly rising incidence rates of cancer among groups 10 to 15 years younger than in other developing countries; the five major cancers were cancer of the cervix, breast, oesophagus and prostate and Kaposi sarcoma. Colorectal and hepatocellular carcinomas were linked to consumption of alcohol and exposure to aflatoxins, and non-small cell lung cancer was associated with tobacco smoke. Non-Hodgkin lymphoma, squamous cell carcinoma and Kaposi sarcoma were related to HIV infection.

Owing to lack of knowledge, of political will and of national capacity in policy development and programme implementation, primary prevention, early detection and palliative care were too often neglected in favour of treatment-oriented approaches, regardless of whether the latter were cost-effective or improved the patient's quality of life. Strategies had been established to raise community awareness of cancers, expand cancer screening, early detection, treatment and palliative care, and establish hospices. A noncommunicable disease division in the Ministry of Health to deal with cancers and a cancer technical working group had been set up. The Ministry had developed a cervical cancer prevention programme and produced guidelines on the prevention of breast cancer with the support of WHO, and cervical cancer screening was being provided in several districts. Hospice centres had been set up in several cities.

Kenya had to deal with low awareness of cancer, inadequate screening facilities and funding, and a paucity of radiotherapy and chemotherapy units. It intended to strengthen health-care delivery services to improve screening coverage and early detection; establish a cancer-control programme, including a cancer registry; and emphasize cancer prevention, care seeking, early detection, treatment options and palliative care in community health care. He supported the draft resolution.

Ms TEZEL AYDIN (Turkey) said that most cancer cases were preventable or curable, and that the population could be protected from one third of new cancer cases through tobacco control and another one third through changes in nutritional behaviour; early detection strategies for some cancers were also successful. The number of new cancer cases was expected to treble over the next 20 years and the developing countries would account for 70% of that increase. She supported the draft resolution.

Dr YAN Jun (China) said that, faced with the severe challenges posed by noncommunicable diseases such as cancer, China had had to adapt its health strategies and focus on prevention, with an emphasis on early detection, primary prevention and palliative care. Developing countries, in which health resources were often limited, needed to adopt comprehensive prevention strategies, and the experience gained by his country in cancer prevention could provide a valuable example for others.

He proposed that the draft resolution should be amended by the insertion, after the existing paragraph 1(11), of a new subparagraph that would read, "to spread and popularize the appropriate technologies for the diagnosis and treatment of cancer, in order to promote its early diagnosis and treatment, especially in developing countries;".

Mrs WAUTERS (Belgium) said that in Belgium cancer was the second leading cause of death and a common cause of morbidity, with significant implications for quality of life. Many cancers were preventable, but primary prevention activities were still often insufficient. She therefore welcomed the emphasis on integrated strategies for disease prevention and health promotion in the draft resolution,

following up on earlier Health Assembly resolutions such as those on the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. She also commended WHO's normative work in cancer prevention and screening, and IARC's research.

In subparagraph 1(6) of the draft resolution, she proposed that the words "traditional and herbal medicine" be amended to read "traditional medicines and therapies, including for palliative care", and that subparagraph 1(14) be amended to read, "to ensure, where appropriate, the evidence-based safety and efficacy of the available traditional medicines and therapies".

Ms WILSON (Canada) strongly supported the draft resolution. She commended WHO's cooperation with IARC in the publication of the IARC handbooks on cancer prevention and the *World cancer report*.[1] Canada was currently implementing a national strategy for cancer control by means of a partnership between government, nongovernmental organizations and research and community-based institutions, as well as an integrated chronic disease-prevention strategy. It wished to encourage technology transfer and sharing of best practices between countries suffering cancer epidemics, and to that end was hosting the first International Cancer Control Congress (Vancouver, British Columbia, 25-28 October 2005).

Professor IVANOV (Bulgaria) said that programmes had been launched in his country for control of breast, uterine and cervical cancers and prevention of prostate and lung cancers, and a national programme for colon and rectal cancers was in preparation. Those programmes emphasized prevention, with particular regard to lifestyle and environmental factors, and a ban on smoking in public places had been introduced. For the past three years, cancer diagnostics and treatment had been carried out on the basis of evidence-based medicine. National standards for surgery and general and clinical pathology had been formulated and enforced, and standards for radiation treatment and oncology were in process of adoption. Guidelines for the diagnostics, treatment and tracing of patients with stomach cancer had been in force since 1991. All cancer patients, irrespective of the stage of the disease, the cost of the treatment, and their economic status, received free medication. A national cancer registry had been established in 1960 and was included in the International Association of Cancer Registries. There was active cooperation between Parliament, the Government, professional associations and nongovernmental organizations in cancer prevention and control.

He strongly supported the draft resolution.

Dr BLOOMFIELD (New Zealand) said that in his country a cancer-control strategy and accompanying action plan had been developed over the past three years. The strategy included primary prevention, screening, early detection, treatment, support, rehabilitation, palliative care and research. It aimed to reduce cancer morbidity and mortality and reduce inequalities in outcomes, and had been formulated in partnership with the Ministry of Health, nongovernmental organizations, the health sector and consumer organizations. It had enabled cancer control to be considered holistically, so that adequate emphasis could be given to preventive measures, in particular tobacco control, improved nutrition, and research and evaluation. He supported the draft resolution.

Dr YOT TEERAWATTANANON (Thailand) said that the draft resolution was asking too much of Member States; the actions called for should be prioritized, especially when resources were limited. He proposed addition of a new subparagraph 1(1), reading "to set priorities based on national burdens of cancer, resource availability and health system capacity for cancer prevention and control programmes;".

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, in Cuba, cancer was the second leading cause of death for all age groups, representing 23.9% of all deaths. However, according to WHO, 43% of

[1] Stewart BW & Kleiheus P, Eds. *World cancer report,* Lyon, France, IARC *Press,* 2003.

cases would be preventable by lifestyle change, at least a third would be curable if diagnosed early and treated using current methods, and a further third would at least have a greater chance of survival and an improved quality of life through effective and appropriate treatment.

There was an imbalance between the resources allocated to basic research and those allocated to prevention and control, treatment-based approaches being favoured in some cases to the detriment of primary prevention and early detection. If two thirds of cases could be prevented or treated, research into etiology and the evaluation of prevention, treatment and control strategies should be intensified. A system of monitoring, which would include cancer registries, was crucial both for research and for the planning and evaluation of control programmes. He supported the draft resolution.

Dr SHANGULA (Namibia), expressing support for the draft resolution, urged an integrated approach to cancer prevention and control in order to maximize the impact of interventions. It was good that the draft resolution recognized the involvement of IAEA in cancer control, treatment and research, and he proposed that some reference should be made in the operative part to the need for close collaboration between the Secretariat, IAEA and Member States. He would submit his amendment in writing.

Mrs VEERAPEN (Mauritius) said that cancer was a significant public health problem in Mauritius, where about 1500 new cases were diagnosed and 900 deaths from the disease occurred each year. With assistance from WHO, a national cancer registry had been established in the 1990s, which had shown that cancer was the second most common cause of death. A study in 1989-1996 had shown a marked predominance of breast, uterine and cervical cancers, and accordingly mammary and cervical screening had been included in noncommunicable disease screening services from 2001. A report on cancer incidence and mortality for the period 1997-2000 had been published, and a report on data from 2001 to 2003 was being produced using customized IARC software.

To deal with the current alarming incidence rate of cancer, legislation prohibiting smoking in, inter alia, public buildings, hospitals and health-care centres had been introduced; higher excise duties had been levied on tobacco products; health education on the dangers of tobacco use had been undertaken through the mass media and in primary and secondary schools; balanced diet and physical exercise were being promoted; and mass screening was being carried out for cervical and breast cancer. She supported the draft resolution as amended.

Mr SOLANO ORTIZ (Costa Rica) said that in his country cancer was a public health priority; it was the second leading cause of death, the most frequent forms being cervical and breast cancer in women and prostate and lung cancer in men, although lung cancer was increasingly affecting women, mainly owing to tobacco consumption. It was important for WHO to give cancer a prominent place on its agenda. His country had adopted many national strategies, relating to disease prevention, promotion of healthy lifestyles, diagnostics, treatment, cancer registries, research, strengthening of health services and the development of palliative care; a national cancer institute had also been established.

He proposed that subparagraph 1(12) of the draft resolution should be amended by the addition of the words “taking into consideration the recommendations made by the Second Global Summit of National Hospice and Palliative Care Associations, held in Seoul, Republic of Korea, in March 2005;”.

Mr WANGCHUK (Bhutan) welcomed the emphasis given in the draft resolution to prevention, early detection and treatment, healthy lifestyles, risk factors, human resources and infrastructure development. He commented that cancer incidence in Bhutan was increasing rapidly, and that a focus on the Millennium Development Goals might cause cancer management and prevention issues to be neglected. He therefore fully supported the draft resolution.

Dr SANGALA (Malawi) said that cancer was a serious problem in Malawi, in particular cervical cancer among women, Burkitt lymphoma among children, and Kaposi sarcoma in people with HIV infection. Aside from surgery, no other intervention was available to such patients, and when

funds were available they were referred to neighbouring countries for treatment. Because of the increasing number of cases, an oncology centre, including a radiotherapy unit, was being established, and in that connection Malawi had applied for membership of IAEA, which had shown willingness to assist. Technical assistance would also be sought from WHO. He supported the draft resolution.

Mr BELOT (South Africa), supporting the draft resolution, said that primary health-care facilities should be the first point of contact with the health system for people with cancers, and the provision of information and education for patients and their families at that stage should reduce late presentation of cancers. In South Africa patient compliance was problematic in chronic disease management, and following the identification of some of its causes a Therapeutic Patient Education programme had been set up; a training manual for behavioural change in both health professionals and patients was being developed. Appropriate information and education would help patients to understand and manage their condition in partnership with health professionals.

The issues of primary prevention and reducing exposure to risk factors had been tackled by introducing tobacco legislation and by formulating appropriate guidelines for identifying modifiable risk factors. Guidelines for cervical cancer screening and prostate cancer testing and information documents on breast and testicular cancers had also been prepared, and a healthy lifestyle strategy and generic risk assessment tool were being developed.

Tertiary-level cancer-treatment centres had been identified. Palliative-care guidelines had been developed for adults and children, covering pain management, drug and other therapy, referral and legal and ethical issues. Partnerships between individuals, the community, government, not-for-profit and community-based organizations and the private sector were essential. The most important issues remaining were availability of opioids at community level, reliable information, models to enhance health-seeking behaviour and the minimum resources needed to implement a successful programme.

Mr CROITOR (Republic of Moldova), speaking on behalf of the GUAM countries (Georgia, Ukraine, Azerbaijan and the Republic of Moldova), said that the increasing incidence rates of oncological illness and death in those countries reflected a global trend. The cancer epidemic was also characterized by the neglect of a significant number of patients diagnosed with the disease, a large number of whom died within a year of diagnosis. High treatment costs placed a heavy burden on national health budgets in the four countries, and the governments understood the need to integrate preventive measures into national programmes. Health professionals were indispensable to cancer control; family doctors had a significant role in explaining risk factors.

Breast cancer, the main cause of cancer-related deaths among women in the GUAM countries, was given high priority in national reproductive-health agendas. As treatment was more effective in the early stages of the disease, breast cancer was being targeted by means of a complex set of primary and secondary preventive measures, tackling such risk factors as alcohol use, physical inactivity, obesity and poor nutrition. Programmes were being developed to improve knowledge among health professionals regarding early cancer detection, and greater emphasis was being placed on improving public awareness of the role of healthy lifestyles in preventing cancer.

He thanked the Regional Office for Europe for its work on the European strategy on noncommunicable diseases, and urged the countries involved in its further development to ensure that it contained adequate measures for cancer prevention. Given the importance of partnerships at national, regional and global levels in cancer prevention, he welcomed the efforts to establish links with other organizations working in the field. The GUAM countries supported the draft resolution.

Mr DELVALLEE (France) commended the report on basic intervention strategies that took into account risk factors related to the environment, socioeconomic conditions and infectious agents. He welcomed the focus on primary prevention, screening and health education, three areas which formed the basis of France's new cancer plan. The development of partnerships was undoubtedly the best way of making progress, and France was pursuing that objective by actively participating in the excellent

work of IARC. He encouraged those countries that had expressed an interest in that work to join its Governing Council.

He fully supported the draft resolution, and proposed that a new subparagraph 2(14) should be added, to read as follows: "to examine jointly with the International Narcotics Control Board the feasibility of a possible mechanism to aid effective pain control via opioid analgesics". That amendment would take account of the fact that in March 2005 the Control Board had invited WHO to participate in a feasibility study on the subject.

Dr ELSAYID (Sudan) expressed strong support for the draft resolution. Cancer prevention and control was a fundamental area that needed support both technically and financially, since incidence of the disease had significantly increased in all countries. According to *The world health report 2002,*[1] cancer was one of the 10 leading causes of death; the situation was worsening and the case-load based on risk had increased 20-fold in the previous 30 years. Dealing with the burden of cancer was beyond the capacities of the health facilities and personnel in Sudan, and its treatment was one of the most costly for patients and families.

Cancer screening and early detection were challenges that had still to be overcome, and newly established cancer centres were suffering from shortages of medical supplies for radiotherapy and chemotherapy and financial resources for training. Human resource development in areas such as cancer epidemiology, radiation and medical oncology, clinical haematology and medical surgery was necessary to support cancer control, and further priorities included a cancer registry, palliative care and pain relief.

Mr RYAZANTSEV (Russian Federation) said that the disease was the third most common cause of death after cardiovascular diseases and accidents, poisoning and trauma in the Russian Federation which accordingly placed strong emphasis on prevention and early detection. Legislation aimed to reduce risk factors, and to that end several federal laws governing treatment and prevention had been adopted. He welcomed the efforts being made by the international community to determine optimum ways of reducing cancer morbidity and mortality. A national cancer programme, developed on the basis of WHO and IARC recommendations, would be one such means, and the Russian Federation had collaborated successfully with WHO in that connection. It would also be useful to establish a specific mechanism whereby scientific advances could be incorporated into working practices, accumulated experience evaluated, and recommendations on primary prevention developed. He supported the draft resolution.

Dr SEALEY-THOMAS (Antigua and Barbuda), speaking on behalf of the Member States of the Caribbean Community, said that cancer was among the 10 leading causes of death in many countries in the region. The most common cancer sites were the colon and prostate among men and the breast and cervix among women; the estimated incidence of cervical cancer in the Caribbean was among the four highest subregional rates in the world. Previous attempts to establish cancer-control programmes in the region had not been sustained. Currently many countries were working with PAHO and the Caribbean Epidemiology Centre to develop a Caribbean cervical-cancer prevention and control programme, and many had also developed national strategic plans and guidelines for cervical cancer control.

She supported the draft resolution, which would not only strengthen current efforts for cervical-cancer prevention and control, but support countries in developing plans for other cancers seen in the region.

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

Dr AL-HUSSEIN (Saudi Arabia) supported the draft resolution, but proposed that the words "to give technical support to countries for treatment programmes and methods" should be added after "control" in subparagraph 2(7).

Dr CHAOUKI (Morocco) said that in recent years Morocco had undergone an epidemiological transition. In addition to having to deal with communicable diseases, it was also facing the growing problems posed by noncommunicable diseases, in particular cancer. Several chronic diseases had common but avoidable lifestyle-related risk factors. Prevention was linked to the promotion and adoption of healthier lifestyles. One core element of the strategy for control of noncommunicable diseases, and cancer in particular, should be implementation of the WHO Framework Convention on Tobacco Control at national, regional and global levels. Cancer registries, which were the principal tool for epidemiological surveillance, should be established in all countries to enable them to assess the magnitude of the cancer burden, and WHO should redouble its efforts to assist them.

He fully supported the draft resolution as amended by the delegate of France, and stressed the need for it to include a reference to palliative care.

Mr AL-LAWATI (Oman) said that Oman was demonstrating its determination to combat cancer by making the necessary preparations for implementation of the WHO Framework Convention on Tobacco Control. In 1976, Oman, with the cooperation of WHO and IARC, had established a cancer registry, and cancer patients were able to receive appropriate treatment.

He supported the draft resolution and proposed the following amendments: the inclusion in the eighth preambular paragraph of wording relating to palliative care; the inclusion in subparagraph 1(4) of a reference to the negative effects of tobacco use; the inclusion in subparagraph 1(13) of wording advocating the provision of opioid analgesics to patients in clinical treatment; and the inclusion in subparagraph 2(8) of a reference to guiding principles on palliative care for cancer patients, including ethical aspects.

Dr KAMUGISHA (Uganda) said that, with an estimated 20 000 cases annually, cancer was becoming an increasing cause of morbidity and mortality in Uganda. As a resource-poor country, Uganda was unable to offer adequate access to treatment. HIV/AIDS had exacerbated the situation; among some 1.2 million people living with HIV/AIDS, about 200 000 were at risk of developing cancers, such as Kaposi sarcoma, Burkitt lymphoma and other opportunistic tumours. The Government recognized the serious threat of cancer, and the health ministry had undertaken to reduce the burden it represented by a multisectoral approach focusing on palliative care and primary prevention (including vaccination against hepatitis B under the Expanded Programme on Immunization), legislation on tobacco control, health education, risk-factor surveillance, and alcohol- and substance-abuse programmes. The Uganda Cancer Institute had long experience of cancer management through its research on Burkitt lymphoma and other tropical cancers. Plans were being prepared to expand and improve radiotherapy centres, establish chemotherapy centres at selected regional referral hospitals and increase the number of trained cancer-management and palliative-care personnel.

He supported the draft resolution, and proposed the addition in the operative part of the following wording: "Given the close association between cancers and HIV/AIDS and the fact that some of them respond to chemotherapy, and given that the drugs concerned are very expensive, WHO is requested to negotiate with the pharmaceutical companies with a view to reducing the price of anti-cancer drugs and to consider placing those drugs on the WHO Model List of Essential Medicines, as is the case for other drugs used in the treatment of opportunistic conditions".

Dr SINGH (India) expressed his support for the draft resolution. He proposed the following amendments: the inclusion in subparagraph 1(5) of "and oral" between "cervical" and "cancer"; the insertion after subparagraph 2(5) of an additional subparagraph to read "to support research on cost-effectiveness studies on different strategies for prevention and management of various cancers";

and the insertion after subparagraph 2(6) of an additional subparagraph to read "to support research on development of an effective vaccine against cervical cancer".

In resource-constrained developing and least developed countries with large populations, mass population screening might not be feasible but screening for at-risk populations might be explored. There was also a need for appropriate legislation and policies to ensure that morphine was readily available for palliative care.

Dr AZIZ (Pakistan) said that, like many other countries, Pakistan was facing a double burden of disease, and cancer, an increasing cause of morbidity and mortality, represented a significant portion of the noncommunicable disease burden. Sufficient insight existed into cancer etiology, prevention, early detection, treatment and palliative care; the extensive research by IARC over the past 40 years had revealed that tobacco use, unhealthy diet, alcohol consumption, inactive lifestyles and infections were responsible for most cancers. Pakistan appreciated WHO's efforts to create a framework for an integrated mechanism for control and prevention of noncommunicable diseases, including cancers, and acknowledged the adoption of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health as landmarks. In establishing its national cancer prevention and control programme, Pakistan was following WHO's recommendation that it should be outcome oriented. He supported the draft resolution.

Mr SZTWIERTNIA (Poland) said that cancer prevention and control were among WHO's most important activities. Poland had introduced a national programme for cancer control, whose main aim was to reduce the incidence of cancer among middle-aged people, and a new research programme on applications of new molecular technologies in oncological diagnosis and treatment. The latter programme was funded by the Government with additional support from nongovernmental organizations and the private sector and, if successfully implemented, it should result in a 5% reduction in cancer cases within 10 years.

Dr ZAHER (Egypt) said that the Egyptian health ministry regarded combating cancer as a priority, and had established a cancer-control project that involved awareness-raising, measures to facilitate the provision of appropriate treatment, and performance evaluation. In Egypt, breast cancer accounted for 33% of all cancer cases and affected 48% of women; 65% of cases reached the third or fourth stage before they were detected, which underscored the need for much earlier diagnosis. The project should have a positive impact and enable the desired objectives to be achieved.

Professor GHODSE (International Narcotics Control Board), speaking at the invitation of the Chairman, said that WHO and the Control Board had collaborated closely to ensure adequate provision of drugs for medical purposes while preventing their diversion into illicit channels. The Board had also been working towards attaining the targets for increased access to affordable essential medicines in developing countries in relevant Millennium Development Goals. The consumption of narcotic drugs had increased significantly, but the benefits often did not accrue to populations in developing countries. Opioid analgesics, for example, were still in short supply, particularly in developing countries, which accounted for only about 6% of the global morphine consumption despite representing about 80% of the world's population. The shortage prevented governments from providing adequate care to thousands of cancer and AIDS patients. If availability did not improve, lack of access to opioid analgesics would cause much unnecessary pain and suffering. The situation became even more grave during crises. Essential medicines should be available when needed, in adequate amounts and in the appropriate dosage forms to satisfy the health-care needs of the majority of the population. By developing a strategy to integrate the availability of opioid pain medication into palliative care for HIV/AIDS, cancer and other chronic diseases, WHO was already working towards achieving that goal. The Control Board would also work with WHO to develop guidelines on the use of opioids for the management of opioid dependence. The Commission on Narcotic Drugs, at its latest

session in March 2005, had adopted a resolution requesting the Board and WHO to consider the feasibility of an assistance mechanism to facilitate adequate treatment of pain.

He called for adoption of the draft resolution. The key to ensuring the appropriate use of controlled medicines and preventing their illicit use lay in educating health professionals in the rational use of drugs in general and psychotropic drugs in particular.

Mrs BLONDEAU (International Union against Cancer), speaking at the invitation of the Chairman, said that her Union was the only nongovernmental organization dedicated solely to all aspects of cancer control worldwide. She underlined the need for concerted action between international organizations, governments, public and private institutions and individuals to apply current knowledge in order to prevent cancers by eliminating known risk factors, implementing prevention strategies, such as the hepatitis B vaccination, and applying comprehensive tobacco-control policies – cost-effective interventions that had benefits beyond cancer. Also, where treatment was available, access to early detection and appropriate treatment could increase chances of survival and improve quality of life. In low-resource settings, developing and implementing appropriate screening methods, for example, for cervical cancer, could prevent malignancy and improve lives. For certain malignant cancers, such as acute childhood leukaemia, advances in treatment had greatly improved outcomes and increased the survival rate. The use of affordable treatment, coupled with research and development of new, less expensive technologies, would bring real benefits. The need was particularly acute in developing countries, where about 80% of cancer patients had late-stage incurable disease when they were diagnosed. Effective relief from pain and other symptoms should be an integral part of cancer management plans.

Controlling cancer in different environments required strategies tailored to make the most effective use of available resources. National cancer-control strategic plans encompassed prevention, early detection and treatment. Cancer claimed twice as many lives as AIDS and was a growing problem worldwide. The draft resolution was a step in the right direction and should be adopted.

Dr LE GALÈS-CAMUS (Assistant Director-General) affirmed that cancer was a matter of increasing concern but added that a growing body of knowledge was contributing to the development of more reliable prevention techniques. The draft resolution presented clear and comprehensive strategic orientations, of which the foremost was prevention. WHO had already launched initiatives aimed at prevention through tobacco control and the Global Strategy on Diet, Physical Activity and Health, which were being implemented at national level. Although cancer prevention represented a major line of attack in the fight against cancer, WHO also had a duty to ensure that all those who were currently suffering from cancer had access to safe, efficacious and affordable treatment. WHO would continue to make every effort to ensure that palliative care was safely made available to everyone who needed it. Replying to the delegate of Japan, she said that the draft resolution was closely linked to other technical programmes and would therefore have a significant effect on much of WHO's future work and funding allocations.

The battle against cancer required the formation and strengthening of partnerships, for example, to extend the scientific knowledge base, which was a prerequisite for the development of efficacious programmes. The relationship between WHO and IAEA exemplified the type of productive working arrangement that needed to be developed in order to successfully combat cancer.

The meeting rose at 12:50.

FOURTH MEETING

Friday, 20 May 2005, at 15:10

Chairman: Dr J. WALCOTT (Barbados)

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

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16) (continued)

Dr YOUNES (Secretary) read out the amendments to the draft resolution that had been proposed at the previous meeting.

Dr LARIVIÈRE (Canada) welcomed the presence of the Director of IARC, as cancer prevention and control was at the core of the Agency's mandate, and congratulated IARC on its 40th anniversary. The draft resolution acknowledged the Agency's superb contribution to research on cancer in the 40 years of its existence.

He said that he could endorse the proposed amendments, which would make the draft resolution more solid and comprehensive. The resolution was extremely ambitious, and its implementation would require close collaboration between Member States, the Secretariat, IARC and other multilateral bodies.

Dr AL-HUSSEIN (Saudi Arabia) noted that traditional and herbal medicine were unregulated in many countries of the world. He therefore suggested adding to the relevant paragraph of the draft resolution a reference to the need for documented and scientific evidence in that regard.

Dr YOT TEERAWATTANANON (Thailand) proposed the addition of a new subparagraph after subparagraph 2(2), reading "to provide technical support to Member States in priority-setting for cancer prevention, control and palliative care".

Dr KAMUGISHA (Uganda) said that he could accept the resolution as amended, but proposed the addition to paragraph 2 of a further subparagraph requesting the Director-General to report on the matter regularly to the Health Assembly.

Mr ESCUDERO MARTÍNEZ (Ecuador) proposed that subparagraph 1(11*bis*) should be re-worded to read: "to improve access to appropriate technologies, with support from WHO, for the diagnosis ...". Supported by Ms VALDEZ (United States of America), Mr FERRER RODRÍGUEZ (Cuba) and Dr QI Qingdong (China), he asked for a copy of the amended text to be distributed.

The CHAIRMAN said that an amended text would be produced for consideration the following day. The item would therefore remain open for discussion.

Dr BOYLE (Director, IARC) welcomed the expansion of WHO's cancer-control activities as outlined in the report and the draft resolution. IARC, which celebrated its 40th anniversary in 2005, was part of WHO, and was devoted to research on cancer etiology and prevention worldwide and to providing evidence for cancer-control policy. It had worked for 40 years in establishing techniques and cancer registries worldwide, and during its existence the number of States in which cancer

incidence data were available had risen to more than 60, many of which had obtained their registries with the assistance of the Agency. Currently 16 Member States contributed to funding its work.

One major programme was on the identification of causes of human cancers; so far, 900 chemicals and environmental and lifestyle exposures had been evaluated for carcinogenicity. IARC had played a strong role in the scientific evaluation of cancer-prevention strategies and approaches, such as healthy diet, population screening and physical activity. Globally, it conducted research into lifestyle and genetic causes of cancer, with an increasing focus on low- and medium-resource countries, where most new cases currently arose, and was undertaking three of the largest-ever screening studies for cervical and oral cancers in Africa and India. IARC estimated that some 11 million new cases of cancer would be diagnosed in 2005, and owing to the age of the population worldwide that figure was likely to rise to 25 million by 2030 unless action was taken. IARC was prepared to do everything possible to work with Member States to identify ways of reducing the global burden of cancer.

(For approval of the draft resolution, see summary record of the sixth meeting, section 4.)

Disability, including prevention, management and rehabilitation: Item 13.13 of the Agenda (Resolution EB114.R3; Document A58/17)

Dr OSMAN (Representative of the Executive Board), introducing the draft resolution contained in resolution EB114.R3, said that various measures could considerably improve the lives of people living with disabilities, including the provision of devices such as wheelchairs, prostheses or hearing aids, facilitation of access to education and employment, and the addressing of discrimination. The Executive Board had discussed the importance of the role of the public health sector in that connection. Members had expressed concern about the rapid increase in the number of people with disabilities as a result of chronic diseases, injuries, malnutrition, and HIV/AIDS, as well as growth in the ageing population. They had stressed the importance of the issue and welcomed a more active role by WHO, particularly in the area of data collection and in the development of a world report on disability and rehabilitation.

Dr QI Qingdong (China), commending the report, noted that developing countries bore a heavy burden of disability, which not only caused mental and physical suffering but also adversely affected the family of the patient and society as a whole. WHO's work on treatment and rehabilitation made an important contribution to helping disabled persons to find a place in society and to obtain work. The draft resolution did not sufficiently stress the role that could be played by prevention. Many causes of disability went beyond WHO's remit, but the health sector could do more to cooperate with relevant government services to make society more aware of the crucial nature of prevention. He proposed that after paragraph 1(1) a new subparagraph 1*bis* be added, to read "to increase awareness of the public at large of the importance of the issue of disability and to coordinate efforts of all sectors of society to participate in disability prevention activities". A new subparagraph 2(9) should also be added, to read: "to support Member States in taking the necessary steps to reduce risk factors that lead to disabilities".

Dr AL-HUSSEIN (Saudi Arabia) pointed out the importance of minimizing risk factors that might lead to disability. He proposed adding a subparagraph on provision of medical care to people with special needs, with a view to facilitating their access to treatment, and also that reference should be made to disabilities in children, especially in the context of inherited diseases sometimes caused by intermarriage. He advocated premarital testing to forestall such diseases, with family counselling and discussions in schools to raise awareness of such problems.

Dr TRAN TRONG HAI (Viet Nam) welcomed the inclusion of disability on the agenda particularly as his country had experienced the catastrophic effects of 30 years of war. His Government had for the past 20 years been implementing a nationwide programme, covering 45 out of

64 cities, and had recently introduced legislation expanding the provision for disability prevention and management and for rehabilitation. He strongly supported the draft resolution.

Mrs VIREM (France) supported the draft resolution, particularly the improvements that had been made to the text to cover prevention, accidents at work and in the home, recognition of the handicapped as a resource for society, and, above all, the need to coordinate programmes on incapacity and ageing in the light of increased life expectancy. France was reviewing how to promote and integrate fully the rights and dignity of the disabled into society. Her Government had recently passed a law to guarantee equality of rights and opportunities for handicapped persons. The draft resolution should stress the need for improving access to home care and giving greater consideration to the quality of life of the chronically sick, not only by research on morbidity, mortality and risk factors, but also by education designed to achieve better professional and social integration of the handicapped and their families.

Dr NABLI (Tunisia) endorsed the principles set forth in the report and thanked the Secretariat for helping Member States to develop their strategies. She proposed that wording should be included in the draft resolution to cover legislation on screening for disabilities at birth, in view of the crucial importance of prevention and management. Premarital testing and national counselling programmes were crucial to reduce the risk of childhood disability. Disabled people should be fully integrated into society, and her Government had launched appropriate programmes to that end.

Dr KAMUGISHA (Uganda) said that disability was a considerable burden in his country, as 10.4% of the population was handicapped. Most of those affected were the rural poor, and major causes included injuries due to armed conflict and landmines, HIV/AIDS, road traffic accidents and malaria. Under his country's Constitution, persons with disabilities had the right to respect and the provision of appropriate measures to ensure that they realized their full mental and physical potential. Standards and guidelines had been developed covering training of health workers, provision of equipment, research, and networking with civil societies. However, there were still challenges to be overcome, such as lack of health personnel trained in gerontology, limited resources, insufficient research, despite a general atmosphere of goodwill towards persons with handicaps.

Dr SOLOMON (Kenya), commending the draft resolution, said that 10% of Kenya's population was disabled and lived mainly in rural areas, where they had difficulty in accessing medical services. The Ministry of Health had set up a rehabilitation programme, which included the training and deployment of appropriate human resources in health institutions, and adopted a strategy to increase awareness of the availability of such facilities and services.

Primary health care was the key approach for the provision of health services geared to vulnerable and underprivileged groups. Achievements included the deployment of physiotherapists to health centres, the initiation of community-based rehabilitation services in some 25 districts, and the adoption of the Disability Act in 2003. A national plan of action was being developed. Continuing obstacles included poor accessibility of services in rural areas and limited supplies of the equipment needed for such services.

Dr CICOGNA (Italy), welcoming the report, expressed his concern at the rapid increase in the number of people with disabilities worldwide. Prevention was crucial. The Secretariat's strategy for community-based rehabilitation had proved successful in improving the quality of life of the handicapped and their participation in society. He supported the draft resolution.

Ms BLACKWOOD (United States of America) said that, since the adoption of the Americans with Disabilities Act more than a decade previously, her Government had strengthened its commitment to improving the capacity of persons with disabilities to participate in daily life. In 2001 the President had launched the New Freedom Initiative, which was designed to expand educational

opportunities and to increase the ability of the 54 million Americans with disabilities to integrate into the workforce. High-quality health care was essential for all citizens, but for the disabled it could mean the difference between living independently in a community or living in an institution. She strongly supported the emphasis given to making rehabilitation available to people of all ages, encouraging early identification of disabilities, identifying assistive technology needs, and promoting community-based programmes. Her Government would be pleased to share its experiences with WHO. She supported the draft resolution.

Dr NABAE (Japan) commended the report and expressed support for the draft resolution. The goal of a society in which the rights and dignity of people with disabilities were ensured should be pursued by all nations. Japan had participated actively in the drafting of the international convention to promote and protect the rights and dignity of persons with disabilities, and had contributed to the United Nations Voluntary Fund on Disability. It attached the utmost importance to prevention, management and rehabilitation, particularly in the light of the country's ageing population. As the incidence of strokes increased, more people suffered paralysis, and the increase in osteoporosis meant that more people suffered hip fractures that could make them bedridden. He endorsed the report's conclusion that disability should be seen in a broader context and that Member States should be urged to put in place effective preventive, management and rehabilitation measures. Japan had high expectations of the report on the subject to be produced by the Director-General.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) proposed that subparagraph 1(3) should read "to promote early intervention and identification of disability, especially during pregnancy and for children, ...". She also proposed adding a new subparagraph 1(8*bis*), reading "to ensure equality at work, on satisfactory terms for persons with disabilities" and a new subparagraph 2(5*bis*), reading "to promote studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation".

Dr CHETTY (South Africa), expressing support for the draft resolution, recalled that one of the objectives of the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities was to facilitate the development of disability policies in all Member States. The rules on medical care, rehabilitation and support services were the most relevant in the health context, and South Africa had made significant strides in implementing them. A national rehabilitation programme set up in 1996 ensured that medical care was available and accessible to people with disabilities, and a disability survey had been undertaken in 1999 to monitor the availability and accessibility of services. In 2003, free health care at the hospital level had been introduced for people with disabilities, giving them access to a whole range of health services, including rehabilitation and the provision and maintenance of assistive devices. Early intervention, identification of disability, and access to information were also being improved. Health workers had been trained in basic sign language to facilitate communication with deaf clients. South Africa was playing a leading role in preparatory work on the drafting of the international convention to promote and protect the rights and dignity of persons with disabilities. In dealing with issues of disability, it gave priority to vulnerable groups such as women and children.

Two important issues that required action were lack of access to everyday services such as transport, environmental obstacles to access to health care, and lack of resources for disability prevention, management and rehabilitation.

Dr SANGALA (Malawi) commended the report and expressed support for the draft resolution. In Malawi, there were between 700 000 and one million people with disabilities, and the number of persons disabled as a result of road traffic accidents was increasing dramatically. In its national health policy document for the year 2020 the Government had committed itself to expanding medical rehabilitation services for those in need, within the limits of available resources, giving priority to prevention and rehabilitation.

Malawi's only rehabilitation training centre had been destroyed by fire, but with assistance from Norway and Sweden a new and better centre had been built and two smaller centres producing prosthetic equipment would soon be operational. A 50-bed orthopaedic hospital had been opened in 2005 and would perform 1000 corrective and reconstructive surgical procedures a year. Malawi had a well-established orthopaedic training programme enabling paramedics to deal with most situations that required surgery. A programme encouraging rehabilitation technicians to do more work at country level had recently been initiated and a physiotherapy school was planned.

He proposed that the words "physical and mental" in the second preambular paragraph of the draft resolution should be deleted, and that "those injured by landmines" should be added after "malnutrition" in the fourth preambular paragraph.

Mr ASPLUND (Sweden), speaking on behalf of the Nordic countries Denmark, Finland, Iceland, Norway and Sweden, said that the objective of their disability policies was to enable persons with disabilities to participate fully in the life of the community. Disability affected all sectors of society and could not be isolated from other areas of policy. It was also a global concern; the entire health care system, and particularly primary health care, should ensure that people with disabilities received the necessary services, and WHO could play an important role by promoting equal access to medical care. The Nordic countries supported the development of specialized rehabilitation services for people with disabilities, including chronic disorders, and the integration of existing rehabilitation services within primary health care, including social support and access to assistive technology.

Both the Secretariat and individual Member States should continue to maintain a disability perspective in all their activities; indeed, all United Nations agencies had a responsibility to include such a perspective in their work. The Nordic countries encouraged the Secretariat to increase its cooperation with international organizations for the disabled, and to continue to focus on gender and child issues in the area of disability and rehabilitation, both internally and in Member States. Follow-up by Member States on the International Classification of Functioning, Disability and Health, a unique tool which took account both of individual capacities and of environmental factors, was also important. The Nordic countries supported the draft resolution.

Mr FERRER RODRÍGUEZ (Cuba) noted the link between disability and problems of development, even though the past two decades had seen improved ways of preventing loss of capacity or aiding its recovery. Advances in genetic research with specific applications to the prevention of growth abnormalities, the increasing availability of vaccines and medicines to prevent diseases leading to disability, and more technologically advanced rehabilitation had made it possible to improve the quality of life of the disabled and to prevent their suffering.

Cuba's health system paid special attention to disability prevention, comprehensive health care and the special needs of the disabled. In addition to having one of the most comprehensive vaccination programmes in the world, Cuba had for several years been developing a network for the early diagnosis of diseases of genetic or metabolic origin. Early diagnosis, medical or surgical interventions, and intensive rehabilitation had made disability-prevention programmes highly effective. In 2002, the Government had undertaken a massive research project into the causes of disability and the living conditions of disabled persons and to propose measures for improved care and prevention. It had also developed a community-based approach to rehabilitation designed to make services more accessible to the public; by the end of the year, each of the country's 444 polyclinics would have a physiotherapy and rehabilitation room. Access to specialized education for all disabled children and young people was guaranteed. In the case of persons with severe disabilities or living alone, the State paid carers to keep them company and to do their housework, while permanent paid leave was granted to mothers or family members caring for children or persons with severe disabilities.

Since the best solution was prevention, Cuba proposed the addition to the draft resolution of a new subparagraph 1(9*bis*), to read "to investigate and put into practice, in their specific conditions, the most effective actions to prevent the appearance of disabilities, with the participation of other sectors of the community".

Mr RYAZANTSEV (Russian Federation) said that disability was a key public health concern. While supporting WHO's policy on disability, he wished to see more emphasis on disabled children. The Russian Federation had 305 specialist centres and 296 rehabilitation units for children with disabilities, but more than 2500 were needed; vocational training and employment for people with disabilities were also strongly emphasized, more than 14 000 training places being provided for them in 259 institutions of further and higher education.

He welcomed the draft resolution, but proposed the addition, in the fifth preambular paragraph, of the words "particularly in the child population", and the addition in subparagraph 1(2) of the words "particularly by encouraging training and protecting employment".

Ms VALLE (Mexico), expressing support for the draft resolution, proposed amendments designed to reflect the progress made on the issue of disability in other forums, in particular the ad hoc committee on the drafting of an international convention to promote and protect the rights and dignity of persons with disabilities. The words "physical or mental" in the third preambular paragraph limited the kinds of disability that had been recognized internationally and should therefore be deleted. The fourth preambular paragraph should include violence, AIDS and environmental degradation among the factors that had contributed to an increase in the number of persons with disabilities. In the seventh preambular paragraph the words "equality of opportunities" should be added after "ensure", the words "for persons with disabilities" should be added after "quality of life" and the words "regardless of disability" deleted. In subparagraph 1(2), the words "and protecting" should be inserted after "promoting", and in subparagraph 1(9) the words "actively and constructively" should be added after "participate" and the words "in order that it may be adopted by the General Assembly" added at the end. A new subparagraph 1(4*bis*) should be added, to read "to contribute to the work of the ad hoc committee responsible for preparing a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities".

Dr GAMBOA PEÑARANDA (Costa Rica) said that people with disability should be a priority work area. They suffered prejudice, stereotyping and discrimination, and faced various physical and social obstacles which marginalized them in society. Costa Rica had adopted a law on equal opportunities for people with disabilities and established a special education centre for those with hearing, language or visual impairments, and mental retardation. However, much remained to be done to meet the needs of people with disabilities, and to ensure that they were able to exercise their rights to the full, and Costa Rica was a member of the committee responsible for drafting a United Nations convention for that purpose. WHO needed to build up its work on disability, and to be given the necessary human, technical and financial resources to support States in developing their own policies on disability. He supported the draft resolution, as amended by Mexico and the Bolivarian Republic of Venezuela.

Mrs AREEKUL PUANGSUWAN (Thailand) welcomed the support to Member States in framing appropriate policies on disability and in encouraging community involvement, as well as the strategy for community-based rehabilitation. Such strategies should be culturally sensitive, to fit each country's context. People with disabilities should be recognized as social capital, and sufficient resources should be invested in comprehensive rehabilitation services, to enable them to become productive to the full extent of their capacities. She strongly supported the draft resolution.

Dr EL ISMAILI ALAOUI (Morocco), welcoming the draft resolution, said that since 1956 Morocco had provided assistance for people with disabilities. The ministry responsible for the family, children and handicapped persons provided services of the kind specified in the draft resolution. A national survey had been conducted into the prevalence and distribution of disability, which was more frequent in rural than in urban areas, and into types of disability, their causes and severity, and the nature of the activities engaged in by people with disabilities. The findings would be used to develop a

national programme for disability, to be implemented by all government departments and by civil society and other partners.

Dr ZAHER (Egypt) said that in Egypt considerable emphasis was placed on the special needs of people with disabilities. Her country had implemented a treatment programme for thyroid diseases in newborn infants and was monitoring the incidence of thyroid diseases. Efforts were being made to extend its programme for those suffering from hereditary diseases to all regions of the country. Special provision was made for those with hearing and visual impairments.

Dr SOMBIE (Burkina Faso) suggested including in the preamble of the draft resolution a mention of disability caused in childhood by accidents while playing, such as disabilities resulting from injuries to the knee, which could result in precocious gonarthrosis, or to the eyes, which could lead to cataract and secondary glaucoma. Better strategies were needed to prevent disability from such causes.

Mr VOIGTLÄNDER (Germany) commended the Secretariat's efforts in the area of disability and rehabilitation and welcomed the draft resolution. It was, however, important to refer to the terminology used in the International Classification of Functioning, Disability and Health. He therefore proposed the addition, after the preambular paragraph beginning "Recalling the United Nations' Standard Rules ..." of a paragraph that would read, "Recalling the International Classification of Functioning, Disability and Health, officially endorsed by the Fifty-fourth World Health Assembly in 2001;".

Ms BAQUERIZO (Ecuador) said that, as all people who lived with disabilities needed at least one other person to look after them, disability affected some 25% of the world's population. The area of disability should therefore be prioritized at national and international levels, and tackled at the global level. In Ecuador, a law concerning people with disabilities had been passed and general and sectoral policies adopted. A national plan was being implemented through the national council on disability. A survey of the prevalence of disability and its geographical distribution, the individual profiles of those with a disability, public awareness of the risk factors for disability, and the characteristics of successful integration of persons with a disability had revealed that 13.2% of the population had some kind of disability. Prevention and treatment of disability, and the rehabilitation of people with a disability, were priorities. She supported the draft resolution and endorsed the amendments proposed by Mexico. She suggested that the reference to "violence" in the third preambular paragraph should be followed by a mention of domestic violence, which often resulted in disability for the victims. Subparagraph 1(9) should call for the United Nations convention on disability to be adopted as rapidly as possible, to reflect the resolutions adopted in other United Nations forums, such as the Commission on Human Rights.

Dr BELLO DE KEMPER (Dominican Republic) said that vulnerability to disability was greater in the developing countries because of the prevalence of accidents and chronic disease. The rights of people with disabilities needed to be promoted and protected. She endorsed the draft resolution and proposed, in the fourth preambular paragraph, after "growth", insertion of the words "growth of the ageing population" and addition of the words "AIDS, environmental degradation," after "violence". She supported the proposals by the delegates of Mexico and the Bolivarian Republic of Venezuela and that of the delegate of Cuba for a new subparagraph 1(9*bis*).

Ms WILSON (Canada), supporting the draft resolution, said that Canada was committed to advancing the full integration of persons with disabilities in Canadian society, and to guaranteeing their access to quality health care, rehabilitation services and disability supports. Each year, Can$ 7500 million were invested in providing benefits and programmes for people with disabilities. The most recent budget had also increased tax relief for persons with disability and their caregivers.

Canada played an active part in the working group engaged in drawing up a United Nations convention to promote and protect the rights and dignity of persons with disabilities, which specifically mentioned adequate and equitable access to primary health care and rehabilitation services.

Mrs SIBANDA (Zimbabwe) supported the draft resolution. In Zimbabwe, the Ministry of Health and Child Welfare was responsible for coordinating rehabilitation services throughout the country. Unfortunately, Zimbabwe had lost a number of trained physiotherapists, occupational therapists and rehabilitation technicians, just as it had lost other health workers. Rehabilitation was offered at both public and private health facilities; the poor, children under five and persons over 65 were exempt from payment. In Zimbabwe, a major cause of disability was road accidents. Everything possible was being done to integrate disabled children with their peers in school.

Dr AHMED (Pakistan) said that most people living with disability lived in poor countries and lacked access to basic services, including rehabilitation services. Moreover, their numbers were increasing day by day because of injuries resulting from armed conflict, landmines, accidents, and ageing. The reminder to Member States and the international community of their duty to provide equal opportunities and to promote the human rights of people with disabilities was timely. He acknowledged WHO's assistance in implementing the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities. The health and rehabilitation of persons with disabilities took top priority in Pakistan's national health programme. His country also had a community-based rehabilitation programme which it was implementing with the assistance of its international partners. In view of the magnitude of the health and rehabilitation needs of disabled persons, he strongly supported the draft resolution.

Mr AL-LAWATI (Oman) suggested that a reference be included to the *World report on road traffic injury prevention*.[1] Paragraph 9 of document A58/17 mentioned the provision of assistive devices such as wheelchairs and prostheses for people with disabilities. In the draft resolution, he wished to see included a mention of equipment to enable people with disabilities to drive their own vehicles, and subparagraph 1(3) should also urge Member States to provide such prostheses and equipment for people with disabilities.

Mrs CAMPBELL (Nicaragua) supported the draft resolution and endorsed the amendments suggested by the delegate of Mexico. In the fourth preambular paragraph, instead of the reference to "war", she proposed "war wounded" and "landmines and violence".

Dr LE GALÈS-CAMUS (Assistant Director-General) said that she had been struck by the frequent mention by delegates of road traffic accidents, the theme of World Health Day in 2004, which were increasingly a cause of disability. WHO was currently working with other organizations to prevent such injuries. Disabilities affected every age group, and she had noted the concern at the increase of disability among the younger population. WHO was working closely with UNICEF and other organizations to develop an efficient strategy to prevent trauma in children, which often caused death and disability. It was the duty of WHO to ensure that the prevention of disability and the question of access by people with disabilities to high-quality care and rehabilitation remained at the heart of its work. WHO would continue to contribute to the development of the United Nations comprehensive and integral international convention on protection and promotion of the rights and the dignity of persons with disabilities.

[1] Peden M et al, Eds. *World report on road traffic injury prevention.* Geneva, World Health Organization, 2004.

The CHAIRMAN suggested that the agenda item should remain open until a later meeting, when a new version of the draft resolution incorporating the amendments proposed would be considered.

It was so decided.

(For approval of the draft resolution, see summary record of the sixth meeting, section 4.)

International Plan of Action on Ageing: report on implementation: Item 13.15 of the Agenda (Resolution EB115.R7, Document A58/19)

Dr OSMAN (Representative of the Executive Board) said that the Executive Board at its 115th session had discussed the report on implementation of the International Plan of Action on Ageing adopted in 2002. Members had agreed with WHO's focus on a holistic approach to policies on active and healthy ageing and the importance of primary health care for health and well-being, in addition to highlighting emerging issues such as the older person caring for family members with HIV/AIDS and the issue of abuse of older people. The Board had adopted resolution EB115.R7 on strengthening active and healthy ageing recommending a draft resolution for adoption by the Health Assembly.

Dr MORICONI (Italy) agreed that priority should be given to access to primary health care for elderly people and supported WHO's projects focusing on the provision of integrated health-care systems for ageing populations. He supported the draft resolution which was well balanced and reflected the interventions needed to ensure healthy ageing for all populations.

Dr AMIN (Bahrain) said that his country gave special attention to helping its ageing population to remain active. Its national plan on ageing was based on the Madrid Political Declaration. Bahrain, like other countries in the Eastern Mediterranean Region, was currently experiencing demographic changes, and the proportion of the elderly in the population was projected to increase from 35% to 50%. WHO needed to play a pioneering role, by encouraging the countries of the Region to set up the health systems that would enable them to respond to the changing age structure. That would require financial resources, but the Programme budget 2006-2007 did not appear to make any additional funding available for activities to help the aged. WHO should give priority to preparedness and appropriate response to the needs of older people and to enabling Member States to implement the resolution. He supported the draft resolution, on condition that the necessary funds were provided to enable attainment of the objectives.

Dr ST JOHN (Barbados) said that her country had been working with the public and private sectors, civil society, nongovernmental and international organizations and older people to formulate a national policy on ageing. Already, 12% of its population was aged 60 years or more. The six leading causes of death were chronic diseases, which disproportionately affected older people. People should be encouraged to make healthier life choices, and governments should provide supportive environments. Barbadians of 65 years and over received free services and medicines. A gerontology clinic, established in collaboration with PAHO, would be opened in 2005, and further clinics would follow. The Government also provided chronic-care facilities. Collaboration between the public and private sectors had resulted in the placement of people with chronic conditions in private nursing homes near their community of origin, thus alleviating the problem of relatives refusing to care for older people suffering from ill-health, and a regulatory body ensured that private facilities met legal requirements. Other actions had included construction of a senior citizen's complex, establishment of a network of centres for day activities and an intergenerational programme, and provision of home help and district nurse services. The traditional extended family structure still existed, but younger women needed to work and older women were becoming less productive because of chronic disease. It

was to be hoped that the policy framework and legislation would reverse the tide of injustice, which was often even meted out by relatives. The retirement age had recently been extended to 65 and a new pension structure had been introduced. Tax incentives to encourage savings and education on active healthy ageing were provided. She supported the draft resolution.

Mr INFANTE CAMPOS (Spain) said that in 2003 his Government had developed an action plan for the elderly for 2003-2007, in pursuance of the International Plan of Action on Ageing, and had recently submitted a white paper on dependence. Dependency in carrying out everyday activities affected people of all ages, but in Spain one third of people over 65 suffered from that problem, and his Government therefore planned to introduce legislation on social benefits for dependency. He supported the draft resolution.

Mrs YOUNG (Jamaica) said that Jamaica was one of the 12 countries implementing WHO's project to formulate an integrated approach to primary health-care services for the elderly. Communicable diseases had decreased in Jamaica and in other countries of the Caribbean Community, but noncommunicable diseases had increased. People were living longer (in Jamaica life expectancy for men was 71 years and for women 75 years) and their quality of life was being affected by noncommunicable diseases and situations relevant to their social welfare. Her Government had instituted a national council for senior citizens 20 years previously and the national health insurance scheme covered hospitalization and tests for the elderly, and the provision of free treatment for chronic diseases for the elderly had recently been increased. She strongly supported the resolution.

Mrs GUSTIN (Belgium) said that her country attached great importance to the subject of ageing and to health care for the elderly. She supported the draft resolution, but suggested two minor amendments: in subparagraph 1(4), the words "the family" should be replaced with "their family" in order to give the concept of family a broader significance; and in subparagraph 3(3) "economy" should be replaced with "community", so that the wording was in keeping with subparagraph 1(4), which should refer to "their family and community".

Dr EL ISMAILI ALAOUI (Morocco) said that his country was experiencing a demographic shift, with a markedly falling fertility index, lengthening life expectancy, and increasing numbers of older people. Morocco had participated in the work of the United Nations Second World Assembly on Ageing and had drawn up a report on ageing, which would serve as a basis for developing a national strategy, action plan and follow-up measures for the elderly. Elderly people were often cared for by their children, but society was changing and that type of family solidarity was on the wane, often because of a lack of resources. In the draft resolution, he proposed the introduction of a new subparagraph after paragraph 1(4), to read "to take measures and to provide incentives designed to ensure that are resources for those caring for the elderly".

Dr NISHIJIMA (Japan) said that his country had taken various measures designed to help it cope with its ageing society and ensure that the elderly were able to lead a dignified life. The long-term care insurance system begun in 2002, for instance, systematically ensured the basic right of the elderly to select the care service which they wanted. Domestic violence against the elderly was a problem that should receive full attention; while it was difficult to assess the extent of the problem, it was nevertheless essential to provide support for victims. Japan fully supported WHO's ageing-related activities and the draft resolution.

Mr HARTOG (Netherlands) stressed the importance of the International Plan of Action on Ageing as a framework for the implementation of age-sensitive actions in a world where population ageing was a matter of growing concern. Referring to his country's recent sponsorship of a WHO project on integrated primary health care for older persons in low-income countries, he suggested continued implementation of similar projects and emphasized the significance of ageing activities in

the context of the United Nations, as articulated in the draft resolution. WHO should pursue its commendable efforts to keep ageing on the international agenda.

Mr HOHMAN (United States of America) said that his country had suggested inclusion of the current item on the agenda in view of the increased attention given to active ageing and its belief that WHO programmes should accord higher priority to ageing issues. WHO's technical cooperation should include the development of policies and programmes in support of healthy and active ageing, and the promotion of research and exchange of best practices on the two critically important issues of older persons and HIV/AIDS and prevention of elder abuse. Continuing improvement in the lives of older citizens was a priority of his Government, as demonstrated by the focus of its ageing-related programmes. The International Plan of Action on Ageing was a blueprint for the development of such programmes and policies. Its effective implementation by all Member States and United Nations agencies, including WHO, was therefore important, to which end the draft resolution would serve as a guide for future action and reinforce the collective efforts to support public health policies and programmes that focused on the growing numbers of older people in both developed and developing countries.

Mrs HESSEL (Denmark) welcomed the priority given to healthy ageing, as illustrated in the draft resolution. With increasing numbers of elderly people, the preparation of age-friendly societies posed such challenges as the efficient management of chronic diseases. She was therefore pleased to note WHO's strong emphasis on primary health care and urged WHO to support the efforts of Member States to strengthen and broaden the primary health sector.

Dr CHETTY (South Africa), after expressing her support for the draft resolution, said that her country had instituted policies, strategies and guidelines that were designed to promote healthy and active ageing. Emphasis was placed on the provision of primary health-care services and special efforts were made to include older persons in community-based care programmes, despite the already heavy burden of AIDS patients. The integration and coordination of such sectors as health and welfare were essential to the success of those programmes. Other important issues to be highlighted were the negative impact of HIV/AIDS on the economic, social and health status of older persons, the increased abuse of the elderly, and the inclusion of geriatric medicine in the training curricula for health-care professionals.

Mrs AREEKUL PUANGSUWAN (Thailand) said that progress in implementing the International Plan of Action on Ageing had been impressive. Preparation was the key to ensuring that ageing citizens remained active and healthy. Elderly persons had a valuable contribution to make to society, to which end appropriate work opportunities should remain available to them. Those in need, however, should receive special support and care, in which context she commended the WHO age-friendly primary health-care project aimed at reducing the barriers to the provision of such care.

Professor PEREIRA MIGUEL (Portugal), after welcoming the draft resolution, said that considerable work had been done at the regional level on the provision of community-based primary health care to growing numbers of older people. Within Europe, common challenges and shared solutions for the maintenance of a healthy, active and productive society had been discussed. His Government had instituted a national health programme for the elderly, to whom it afforded high priority by building capacity in such settings as the family, health centres, hospitals and community services. He shared WHO's views on the importance of a holistic life-course approach to ageing in which due attention was paid to the determinants of health and emphasis placed on a continuum of health and social care services with a view to ensuring that older people remained healthy and productive. He also supported WHO's efforts to integrate ageing issues into policies and programmes for attainment of the Millennium Development Goals.

Mr DE CASTRO SALDANHA (Brazil) expressed his strong support for the draft resolution, which was fundamental to raising awareness of the challenges posed to society by ageing. It was vital to renew the commitments spelt out in the International Plan of Action on Ageing and stress the need for WHO to prioritize the issue of active and healthy ageing as a matter of urgency. Allocation of the requisite financial resources for that purpose was thus imperative.

Dr DELAVAR (Islamic Republic of Iran) said that disease-prevention and health-promotion programmes should be started early in life in order to prevent chronic disease and disability in older persons, thus guaranteeing a better quality of life. Strengthening healthy ageing programmes, which covered all aspects of well-being, could change the process of implementing vertical disease-prevention programmes. The integration of interventions for service providers and clients would be more cost-effective for the developing countries in particular. He fully supported the draft resolution, but provision for the activities concerned should be made in WHO's budget allocation plan.

Mr RYAZANTSEV (Russian Federation) supported the initiatives for the development of a new sectoral approach to ageing, in partnership with intergovernmental, governmental and community organizations. In that regard, the Madrid Political Declaration and International Plan of Action on Ageing provided a guideline for work, in the context that respect for the elderly remained a mark of civilization. His country supported the draft resolution and would join in further international cooperation on ageing-related matters.

Mr ASPLUND (Sweden) said that the fact that people were living longer and more autonomous lives was not only a major achievement but also testimony to the success of comprehensive and multisectoral actions for health and social development. Disease prevention and health promotion among the elderly were also particularly important, as were systemic interventions such as good eating habits and physical exercise, which could even be introduced later in life with positive effect. With that in mind, he proposed that, in subparagraph 3(4) of the draft resolution, the words "strategies, policies and interventions" should be inserted after the phrase "health promotion and disease prevention".

Mrs INGÓLFSDÓTTIR (Iceland) said that the ageing of the world population raised three major issues: increasing numbers of active older people demanding new social structures and opportunities; increasing numbers of disabled older people requiring new interventions and improved health and social care, which had economic implications; and resolving the complex economic, technological, organizational and social problems posed by the ageing of society. Innovative social, organizational and technical responses were therefore needed. The draft resolution, which Iceland supported, would have a positive impact on the promotion of healthy ageing and on the quality of life and independence of older people.

Mr LANGAT (Kenya) said that the proportion of older people in the population in Kenya was set to rise well above the current figure of 4% by 2050. Already, the increase in demand for health services by older people suffering from chronic disease or disability was unprecedented. In order to address that problem and the other hardships faced by older people, Kenya had implemented several strategies in the three years since the adoption of the International Plan of Action on Ageing, covering such areas as community advocacy, food security, nutrition and primary health-care services. Achievements included the development of support groups for older people, the drafting of a national social health insurance bill and training for health personnel in the health problems of older persons. Challenges included lack of comprehensive and coherent policies and programmes for older persons, poverty and lack of sustainable livelihood, the large dependent population and lack of resources for the creation of an enabling environment for older persons. Further strategies for the next three years were also planned with a view to, inter alia, strengthening primary health-care services for older persons, establishing community structures for the support and care of older persons and introducing a

comprehensive social security scheme for those over 60 years of age. He supported the draft resolution.

Dr SINGH (India) said that India, as a country that recognized the welfare of older persons as an issue of crucial concern, endorsed the draft resolution. The availability and accessibility of health-care facilities were important determinants of the present and future health of the elderly, who were frequently unable to reach medical centres without assistance and lacked the resources needed to meet their various health care needs. Training medical officers and multipurpose health workers about risk factors for illness among the elderly would therefore make a significant contribution to management of the major chronic diseases. He endorsed a multipronged approach in the field of gerontology with a view to preventing or delaying the onset of such diseases. He also recommended the inclusion of geriatric medicine in medical curricula and research into the health status of older women, with particular reference to such conditions as dementia, osteoarthritis and osteoporosis.

The meeting rose at 18:05.

FIFTH MEETING

Saturday, 21 May 2005, at 09:00

Chairman: Dr J. WALCOTT (Barbados)

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

International Plan of Action on Ageing: report on implementation: Item 13.15 of the Agenda (Resolution EB115.R7; Document A58/19) (continued)

Dr SEVER (Israel) said that in most countries older people were considered to be a weak population group lacking the political power to claim the basic human rights they deserved, including the right to good health and well-being and to live in proper relief conditions. He regretted that governments did not give high priority to geriatric care and healthy ageing. He praised the Secretariat's efforts in that area, particularly its encouragement of health ministries to improve the situation of older people by promoting comprehensive health action plans in the fields of prevention, medical care for acute and chronic diseases, rehabilitation and nursing care. However, he queried how the Secretariat could be expected to advance its healthy ageing policy without any budget; without the necessary financial resources, its discussions on the subject would never have any tangible purpose or outcome.

Dr YAN Jun (China) commended the report. China was a developing country with an increasingly ageing population, which created a public health issue, and it was therefore adjusting its social security system to provide primary health care for older people living in the community with a view to promoting healthy ageing. Its health-promotion activities included training health professionals in the care of the elderly. Risk factors should be addressed in order to prevent accidents, and support should be given to older people so that they might live independently and remain active.

HIV/AIDS placed a heavy burden on older people, especially in developing countries; older people not only suffered from the loss of their children, but also bore the responsibility of bringing up their orphaned grandchildren when they themselves needed care. WHO should play a key role in coordinating health and social security systems to help older people in families affected by HIV/AIDS. The abuse of older people should not be neglected. Regardless of the varying cultural definitions of abuse, the international community should uphold the importance of respecting older people, and legislation to protect their rights was needed to solve the problem. She supported the draft resolution.

Ms VALLE (Mexico), speaking on behalf of the Group of the Americas, supported all global efforts to address the care of older people, particularly when they focused on primary health care and preventing physical and mental abuse, because all countries were increasingly facing an ageing population. She recognized that continued efforts were needed to ensure that the growing population of the elderly enjoyed the highest possible level of health and well-being, and therefore firmly supported the draft resolution.

Mrs TAFA (Botswana) commended both the report and the Secretariat's support to developing countries in raising awareness of the challenges of ageing societies and in meeting the health and social needs of older people. Botswana was participating in the project to formulate an integrated response of health-care systems to rapid population ageing, which had provided a unique opportunity to assess the performance of the health system in meeting the needs of older people. The research had

generated important data on the burden of diseases such as diabetes and hypertension. The results would inform policy and programme development in noncommunicable disease control and health-system capacity to meet the specific needs of older people. The preliminary findings had recently been given to key stakeholders in Botswana. The study had also provided useful information on deficiencies in the current health facilities in relation to the health needs of the elderly. She looked forward to using the findings of the WHO age-friendly primary health-care project to improve their primary care services. She also looked forward to WHO's support in implementing the STEPwise approach to surveillance and control of noncommunicable diseases in order to reduce the burden of those diseases on older people. She supported the draft resolution.

Mr RAMOTSOARI (Lesotho) recognized the importance of the International Plan of Action on Ageing. Older people in Lesotho still fulfilled important traditional roles, such as birth attendance. However, homes for the elderly and orphanages, which were not part of traditional African culture, were becoming more common because of increasing poverty, and the provision of such services needed special attention. The increasing responsibility placed on grandparents to raise their orphaned grandchildren as a result of HIV/AIDS was also cause for concern. He fully supported the draft resolution.

Ms LIODAKI (Greece) recognized the importance of training health workers at all levels and teaching geriatric medicine as a specialized subject. It was also important to integrate care for the elderly into the primary health-care sector of existing national health-care systems. Any society that mistreated children and older people should be criticized.

She supported the draft resolution, subject to two minor amendments. In subparagraph 1(5), she proposed adding the word "economic" and a comma after "eliminate". A new subparagraph should be inserted between paragraphs 1(8) and 1(9) that would read: "to develop health care within the existing national health-care systems for primary health care;".

Mrs VEERAPEN (Mauritius) said that, within 25 years, 20% to 25% of the population in Mauritius would be over 60 years of age, owing to reduced fertility rates and longer life expectancy. Her Government had formulated a national policy on the elderly that included programmes to strengthen preventive care at the primary health-care level and to fast-track older people at all levels of the health-care system in order to meet their specific needs. Capacity building in gerontology and geriatrics among health-care providers had also been strengthened and a community-based rehabilitation programme was in place for older people with physical disabilities. Existing physiotherapy, occupational therapy and speech therapy services were being strengthened and decentralized in order to cope with the specific health needs of older people. Mauritius provided the elderly with food supplements, glasses, prostheses and transport at reduced rates, and vaccinated people aged over 60 against influenza. She strongly supported the draft resolution.

Dr ELSAYID (Sudan) said that Sudan too was facing an increasingly aged population: the proportion of older people was projected to rise from 5% in 1999 to 8% by 2025. Although extended families in Sudan traditionally took care of older people, ensuring the highest attainable standards of health and well-being for the country's older citizens was a challenge. Sudan's national health policies included appropriate support mechanisms for older people. They should be regarded as contributors to development rather than consumers, which required both technical and financial support. She endorsed the draft resolution.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that a regional strategy for the health care of older people had been in place since 1992. His Region had been among the first to deal with the problem of ageing and had emphasized better use of extended families in taking care of older people. Some governments provided direct support to families in the form of a government-

funded worker to assist in caring for older people at home rather than in hospital or hospices. Interregional activities were also being undertaken which were supported but not initiated by WHO.

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked delegates for their positive comments and suggestions on ways to further WHO's work on active and healthy ageing. Despite limited resources, WHO would continue its efforts to implement the International Plan of Action on Ageing, focusing in particular on promoting health and well-being among older people. Its active-ageing policy framework would guide its activities both at the global level, particularly in its collaboration with other United Nations organizations, and at the regional level, in its technical assistance to Member States.

Dr YOUNES (Secretary) read the amendments proposed: an additional subparagraph should be inserted after subparagraph 1(3), to read: "to adopt measures and incentives aimed at providing resources on behalf of persons responsible for the elderly;". In subparagraph 1(4), the words "the family and community" should be replaced with "their family and the community". In subparagraph 1(5), the word "economic" and a comma should be inserted after "eliminate". An additional subparagraph should be inserted after subparagraph 1(8), to read: "to develop health care of older people within the existing national health-care systems for public health care;". In subparagraph 3(3), the word "economy" should be replaced with "community". In subparagraph 3(4), the word "health" should be inserted before "research" and the words "strategies, policies and interventions" inserted after "disease prevention".

Mr HOHMAN (United States of America) proposed the following amendments: in the proposed additional subparagraph to be inserted after subparagraph 1(3) replace the word "elderly" with "older persons" and in subparagraph 1(4) replace the word "family" with "families". In subparagraph 3(3), he suggested that the reference to the economy should be retained as older people could make a contribution in that regard.

Mrs MEULENBERGS (Belgium) agreed to that proposal but requested that the reference to community should also be retained.

Dr EL ISMAILI ALAOUI (Morocco) amended the wording of the additional subparagraph to be inserted after subparagraph 1(3) that he had proposed earlier to read: "to adopt measures and incentives aimed at ensuring resources for persons, be they physical or moral, who are responsible for the elderly;".

Ms WILSON (Canada), referring to the proposed insertion in subparagraph 3(4) of the word "health" before "research", expressed concern that, by specifying health research in the resolution, WHO might exclude other useful forms of research, such as economic modeling for the care of older persons or provisions for caregivers that might enhance the research agenda.

Ms BAQUERIZO (Ecuador) asked whether the new subparagraph 1(4) included a reference to both moral and physical persons; she would support the inclusion of such a reference.

Dr YOUNES (Secretary) re-read the proposed amendments to the draft resolution.

Mr HOHMAN (United States of America) requested further clarification regarding the amendment to include the words "moral and physical care" in the additional subparagraph proposed by the delegate of Morocco for insertion after subparagraph 1(3).

Ms BAQUERIZO (Ecuador) repeated her support of the proposed inclusion of the words "physical and moral persons caring for older people".

Mr HOHMAN (United States of America) said that, while he understood the difference between physical care and having legal responsibility for care, the legal aspect was not captured by the word "moral".

Ms BAQUERIZO (Ecuador) explained that the word "moral" had been introduced because of an earlier confusion regarding the terminology used for physical and legal persons.

Dr YOUNES (Secretary) proposed the following wording: "to take steps and encourage measures to ensure resources for persons who take physical care or who have legal responsibility for older persons;".

Ms BAQUERIZO (Ecuador) said that the proposed new wording sought to distinguish between individuals and legal entities, such as organizations or foundations, that took care of older people.

Dr YOUNES (Secretary) suggested that the following wording would express the intended meaning: "to take steps and encourage measures to ensure resources for persons or legal entities who take care of older persons;".

Ms BAQUERIZO (Ecuador), supported by Dr BELLO DE KEMPER (Dominican Republic), endorsed that proposal.

The draft resolution, as amended, was approved.[1]

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18)

Dr OSMAN (Representative of the Executive Board) recalled that the Board had reached a consensus on the need to address the medical, social and economic consequences of the harmful use of alcohol. The Organization's efforts in that area had been supported, but different views had been expressed regarding the potential recourse to a strategy similar to that used for tobacco control, namely, an international legal framework for regulating alcohol, as well as in relation to the role of the alcohol industry. In that context, the beneficial effects of alcohol consumption on health as demonstrated in some studies and the dangers associated with illicit alcohol production and consumption had been mentioned. Some members had stated that the Secretariat must ensure transparency, impartiality and a balanced regional and gender representation in the selection of experts on advisory panels for technical consultation on alcohol and its activities. The need to include the following specific measures to control alcohol-related harm had also been emphasized: the dissemination of scientific information on, and increasing awareness of, the effects of alcohol use; the introduction of taxation and the licensing of alcohol sales; the targeting of advertising agencies and the media to ensure the de-glamorization of drinking; addressing the marketing of alcoholic beverages under free trade agreements; the promotion of mental health and the empowerment of individuals, families and communities against external pressures to consume alcohol; tackling domestic violence associated with alcohol consumption; the promotion of education on healthy lifestyles and a responsible attitude towards alcohol; and the need to strike an appropriate balance when addressing alcohol-related issues with a focus on public health problems induced by alcohol. The Board had adopted resolution EB115.R5 containing a draft resolution recommended to the Health Assembly.

Mrs SCHLEDER-LEUCK (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, and the candidate countries Croatia

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA58.16.

and Turkey, reiterated their support for the draft resolution contained in resolution EB115.R5, of which they had been cosponsors. The Board at its 115th session had engaged in an intense debate and had reached a balanced compromise which should be acceptable to all Member States, and she urged them to adopt the draft resolution.

Mr RYAZANTSEV (Russian Federation) said that the report justifiably placed the harmful use of alcohol among the world's worst health risk factors. It was a major cause of concern in the Russian Federation. More than two million people were currently receiving treatment for the effects of alcohol use and more than two million new cases of alcoholism were recorded each year. Beer consumption among young people and adolescents was widespread and a matter of particular concern. People were therefore being informed of the dangers of alcohol use. The advertising of alcoholic beverages other than beer was illegal and it was expected that the legislation would be extended to cover beer. Anyone caught driving under the influence of alcohol could have their licence withdrawn for up to two years. People suffering from the harmful effects of alcohol had access to medical institutions, although the treatment available was not particularly effective and needed to be improved. The Russian Federation supported the Secretariat's proposed work on alcohol and the development of recommendations to reduce the alcohol-related burden. While he supported the draft resolution, he observed that there was no satisfactory equivalent in Russian for the English phrase "harmful use of alcohol". He therefore proposed using the phrase "alcohol consumption with harmful consequences".

Dr THAKSAPHON THAMARANGSI (Thailand) said that alcohol was the third most dangerous health risk factor in Thailand. More than 25% of mental health problems were caused by alcohol, and drinking and driving contributed to the high morbidity and mortality from traffic accidents. Alcohol consumption by young people had also led to violence, drug addiction, teenage pregnancy, unsafe sex and HIV infection. In 2000, Thailand had been classified as one of the 10 countries with the highest level of alcohol consumption. The Government had passed legislation restricting the duration and the content of television advertising of alcoholic beverages. The 10 best practices that had been selected from a wide range of policy options and were listed in the report would assist countries in their choice of effective strategies. Since alcohol, unlike illegal drugs, was freely available, countries needed effective alcohol policies to reduce both consumption and the harm it caused.

Resolution WHA36.12 on alcohol consumption and related problems, which had identified the topic as a theme for a World Health Day, had been adopted 22 years ago but not implemented. He therefore requested that the topic be designated as the theme for World Health Day in 2010. He strongly supported the draft resolution and looked forward to its wide implementation. He proposed the following amendments: the replacement at the beginning of the first preambular paragraph of "Recalling" with "Reaffirming"; and the addition in subparagraph 1(1) of a footnote after "strategies" to read, "for example, the '10 best practices' as described in the report contained in document A58/18".

Mr GUNNARSSON (Iceland), speaking on behalf of the Nordic countries, underlined the importance they attached to the draft resolution. Alcohol-related problems accounted for a major share of the global burden of disease. If WHO was to maintain its authority as the global leader in health, it must urgently take steps to address such a serious health risk. Reaching consensus on the text of the draft resolution had been challenging, given the many divergent views of members. The current text represented the best achievable outcome, and he therefore urged delegates to adopt it with the two amendments proposed by Thailand.

Dr SINGH (India) supported the draft resolution and proposed the following amendments: the insertion after subparagraph 1(1) of an additional subparagraph to read: "to consider provision of a cess on the sale of alcohol and the revenue generated to be used for programmes for the prevention of alcohol abuse and treatment of dependent individuals", and after subparagraph 2(5) of a further

subparagraph to read: "to produce a report on linkages between alcohol consumption and high risk behaviour including the spread of HIV/AIDS and methods to reduce the risk".

Mr DE CASTRO SALDANHA (Brazil) strongly supported the draft resolution, which highlighted the impact of alcohol use on public health and the need to include it as a main priority area in the global health agenda. His Government had implemented a national programme on alcohol in order to extend the medical coverage available to alcohol and drug users and their relatives and to accelerate their rehabilitation and social insertion. It was essential to implement health promotion activities in schools, workplaces, health centres and communities to undermine the stereotypical images associated with alcohol use. The health ministry was developing a plan to prevent the harmful use of alcohol. Given the scale of the problem and the damage it caused, it was crucial to involve society as a whole in order to gain support for public policies on alcohol use.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Latin American Group, said that its countries were well aware of the health problems associated with the harmful use of alcohol and therefore had actively participated in the drafting of the resolution. The draft resolution, which the Group supported, represented a delicate balance between a number of different positions and he therefore urged its adoption as it stood.

Mr LANGAT (Kenya) said that about a third of the global population consumed alcohol and the harmful effects were of serious concern, not least in Kenya. A recent national health survey had shown that alcohol consumption was one of the major health risk factors and that it had serious implications for HIV infection, particularly among young people. Kenya had been addressing the problem by raising awareness among the public and by enforcing the rules on alcohol advertising and other forms of substance abuse. It had established a national campaign to inform and educate the public, but its activities were hampered by a lack of funding. The consumption of illicit alcohol was a major concern as it had been the cause of many hundreds of deaths in recent years. Counselling centres were currently being set up to tackle the problem. Kenya supported the draft resolution.

Mr VAN DER HEIDEN (Netherlands) said that the harmful use of alcohol contributed substantially to the global burden of disease, and for that reason his country had been a sponsor of the draft resolution. Although Member States were ultimately responsible for implementing the necessary measures, WHO had a vital role to play at the global and regional levels in providing the necessary information, an area in which the Netherlands would be willing to provide support within the framework of a joint partnership. WHO should also begin discussions with all the relevant authorities and stakeholders, including the alcohol industry.

Dr MATHESON (New Zealand) commended WHO's leadership role, given the significance of alcohol as a risk factor for noncommunicable diseases and injuries. Alcohol use was responsible for 4% of the global burden of disease, a similar proportion to that attributed to tobacco use. A key principle informing New Zealand's position on the issue was the balance between the benefits and harms associated with alcohol use. For some groups and in some contexts, even small amounts of alcohol carried a risk of harm. Similarly, the current evidence suggested that for some noncommunicable diseases, such as breast cancer, the risk increased in proportion to consumption with no apparent safe lower limit. Given the increasing impact of alcohol use, New Zealand supported the draft resolution, together with the amendments proposed by Thailand.

Mrs YOUNG (Jamaica) said that, although alcohol use continued to be a problem in Jamaica, there had been a steady reduction in consumption rates. The prevention strategies implemented were in line with those outlined in the report. She was not in favour of the introduction of taxation, which was outside the remit of health ministries, preferring to focus on education and health-promotion programmes, which in Jamaica had led to reduced consumption by all age groups. She supported the

draft resolution, thanked the Nordic countries and Thailand for their work, and endorsed the idea of basing the theme of World Health Day 2007 on the title of the draft resolution.

Mr WANGCHUK (Bhutan), commending the report, recorded his concern at the significant, and rising, rates of disease, injury, disability and premature death related to alcohol in Bhutan. Considerable resources were allocated to that problem, which had a significant social and economic impact. He welcomed WHO's holistic approach to dealing with alcohol-related problems, and its focus on policies to restrict consumption and on effective health-promotion strategies, particularly those aimed at young people. He supported the draft resolution, as amended by Thailand.

Dr BELBEISI (Jordan) said that Islam prohibited alcohol consumption, which had dire health consequences, both directly and indirectly, for example, through the increased propagation of HIV related to unsafe sex. Jordan had adopted several policies, including the setting of a minimum age of 18 for the purchase of alcohol, the levying of heavy taxes on alcohol, a total ban on alcohol-impaired driving and on alcohol advertisements, and the provision of rehabilitation programmes for alcoholics. He therefore fully supported the draft resolution.

Professor PEREIRA MIGUEL (Portugal) commended the report and, in line with the European Union position, expressed his support for the draft resolution. The Secretariat should support Member States in monitoring alcohol-related problems in order to reinforce the scientific and empirical evidence of the effectiveness of policies, such as those to prevent alcohol-impaired driving, alcohol consumption during pregnancy and alcohol consumption by young people. Portugal had high rates of alcohol consumption and alcohol-related problems, and had established a national action plan to combat them, under which various projects on health promotion, education and legislation had been set up. Data were currently being gathered on alcohol-related problems. Training programmes were being designed for health professionals on hazardous and harmful drinking, and a task force had been set up to coordinate national action in that area. Portugal was also involved in the Primary Health Care European Project on Alcohol and the International Network on Brief Interventions for Alcohol Problems, and he looked forward to collaborating with the Secretariat in furthering that work.

Dr YAN Jun (China), welcoming the report, said that insufficient attention was paid to the disease burden related to alcohol use, especially in developing countries. The problem of excessive alcohol use existed in China, where nearly 100 million people drank, 21% of whom were young people over the age of 15 (especially males), and treatment interventions were therefore being planned. China would be actively participating in WHO's future work on alcohol problems, and wanted to receive technical guidance from the Secretariat. WHO should step up research on the impact of the harmful use of alcohol on health and the disease burden, in order to provide evidence to support the formulation of relevant strategies. She fully endorsed the draft resolution, as amended by the delegate of Thailand.

Ms DEL VALLE MATA LEÓN (Bolivarian Republic of Venezuela) said that the legal measures being implemented in her country to tackle health problems related to harmful alcohol consumption included the introduction of a minimum legal age to buy alcohol, restrictions on hours of sale of alcohol, taxation of alcohol, and restrictions on alcohol-related advertising. However, the extent of alcohol-related problems was greater than the scope of the measures implemented, which had therefore not had the desired effect. The problem was exacerbated by the cultural phenomenon of social drinking in the country. A policy for the prevention of alcohol consumption should be introduced for people who blatantly transgressed social norms, with punitive or financial sanctions, in order to encourage health-oriented behaviour. She supported the draft resolution.

Dr CHETTY (South Africa) expressed in advance her support of the statement that would be made on behalf of Member States of the African Region. Her country was experiencing alcohol-

related public health problems in line with those described in the report. Alcohol misuse was implicated in a range of chronic health problems and contributed significantly to the increase in mortality and morbidity from injuries, road fatalities, fetal alcohol syndrome, and crime and violence. South Africa had set up a surveillance system on the nature and extent of alcohol abuse. A recent survey of risk behaviours in young people had provided valuable information on which to base policies and programmes. Substance abuse-prevention training had been provided in schools, complemented by a policy on the prevention and management of substance abuse. Regulations had been drafted on the labelling of all alcohol containers. She supported the draft resolution as amended by Thailand.

Mr HOHMAN (United States of America) said that alcohol abuse was a complex problem that caused significant public health problems. Prevention held the key to solving that and other substance-related problems and more research was needed to find ways of increasing the age of first alcohol use. WHO's work on alcohol-abuse issues in the past had not been transparent and had not engaged all relevant stakeholders, an approach that would reduce the efficiency of any programmes developed. He welcomed the assurance given at the 115th session of the Executive Board that the Secretariat would embrace transparency and its promise to work collaboratively with the alcohol industry.

The following principles should frame WHO's future work on alcohol: full disclosure of the scientific and epidemiological studies on which its findings and conclusions were based, and willingness to accept peer review of those studies; willingness to accept scientifically rigorous data generated by industry, or financed by it, as was the case with the food, chemical, pharmaceutical and other industries, as long as there was full disclosure of funding sources; transparency to ensure that Member States and relevant stakeholders were fully informed of WHO's activities and initiatives in that area; impartiality in the selection of experts for technical consultations on alcohol, expert reviews of evidence relating to the health effects of alcohol, and expert advisory committees for policy recommendations; and willingness to engage and consult with all relevant stakeholders, including the beverage alcohol industry, in the elaboration of alcohol policy.

He did not endorse the amendments proposed to the draft resolution, including the Thai proposal on the inclusion of a footnote relating to best practices, which were not, in his Government's view, evidence-based. Nevertheless, if a consensus emerged to accept that amendment, he would not go against it. However, he was unable to accept the amendment proposed by the delegate of India.

Dr AL-HUSSEIN (Saudi Arabia) commended the report and draft resolution. In view of the negative effects of alcohol consumption on health, he proposed an amendment whereby "harmful" be deleted from the phrases "harmful use of alcohol" and "harmful alcohol consumption" occurring in the operative paragraphs and the title of the draft resolution. Also, he asked for the words "and distributors of alcoholic beverages" to be deleted from subparagraph 2(8). With those small amendments, he would support the draft resolution.

Professor KINDE-GAZARD (Benin), speaking on behalf of the Member States of the African Region, affirmed that the public health problems associated with the consumption of alcohol, as described in the report, had reached alarming proportions; it had become the primary risk to health in developing countries. Alcohol was often used as a way of escaping from day-to-day problems; hence the rate of alcoholism was frequently high among young people. She consequently favoured the setting up of databases to monitor developments in that area.

The African Region was aware of the public health challenges involved. The various problems it faced included lack of appropriate alcohol-treatment centres, the invasion of African countries by alcoholic products of dubious quality, and aggressive publicity for alcoholic beverages. The Region, which was already gravely affected by endemic diseases such as malaria, HIV/AIDS and tuberculosis, nonetheless reaffirmed its commitment to the health of mothers and children. It consequently

encouraged WHO's strategies to combat alcohol abuse and its effects, including prenatal screening and help for the victims of alcoholism. She supported the draft resolution.

Dr SINGH (India) suggested that WHO should study the issues that he had raised earlier and expressed his willingness to withdraw his proposed amendments.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the report had shown that issues linked to alcohol consumption constituted an important public health risk. In the Region of the Americas, there had been an increase in alcohol consumption during the 1980s, owing to greater financial means and availability of alcohol on the market. In Cuba, a prevention programme had already produced results, including a halving of alcohol consumption. Hence it was important to decrease the availability of such products and propose other solutions to dependent people, conducive to a change in their lifestyle. His country had developed strategies to identify high-risk groups and to involve all stakeholders in the health field, particularly in primary health care. He supported the draft resolution, but asked for the amendment proposed by the delegate of Thailand to be submitted in writing.

Dr NABAE (Japan) also supported the draft resolution and expressed his appreciation for the Secretariat's commitment to furthering the work carried out by Member States. Problems caused by the harmful use of alcohol extended well beyond health issues, to encompass a wider social sphere including crime, violence in the family and unemployment. His country relied on WHO to provide assistance, on the basis of scientifically well-founded schemes, through the collaborating centres in various Member States.

Dr AKBARI (Islamic Republic of Iran) recognized that the consumption of alcohol affected the four essential aspects to health, namely biological, psychological, social and spiritual well-being. He proposed the following amendments to the draft resolution: in the fourth preambular paragraph, the word "particularly" should be added after the word "consumption"; in the sixth preambular paragraph, the phrase "and violence" should be added at the end; the word "harmful" should be deleted throughout the text; in subparagraph 1(2), the words "religious figures" should be inserted after the word "including" in the second line; subparagraph 2(2) should be replaced by the following text: "to convene an expert group with the aim of drafting a convention or legal instrument such as the Framework Convention on Tobacco Control to restrict production, distribution, marketing and consumption of alcohol;".

Mr RAMOTSOARI (Lesotho) welcomed the report. In his country, wide abuse of alcohol had led to a deterioration of social life, such as an increase in the divorce rate and abuse of children. It also caused significant public health problems, including traffic accidents. Consequently it was important that WHO should continue to engage all stakeholders, particularly alcohol manufacturers, in order to involve them in problem-solving. He favoured the adoption of a scientific and transparent approach by WHO in that connection. His Government had already studied concrete programmes to address alcohol abuse, in conjunction with brewing companies. He urged adoption of the draft resolution.

Dr CHITUWO (Zambia) said that his country had experienced an increase in road traffic accidents, violence against women, and HIV infections. Before the commercialization of alcohol, alcoholic beverages had been consumed only in a cultural context such as weddings. However, owing to aggressive advertising, especially on television, alcohol consumption had come to be regarded as fashionable. He therefore welcomed WHO's strategies to reduce harmful use of alcohol, which should be incorporated in the wider context of campaigns to reduce poverty. He consequently supported the draft resolution.

Dr MACHATINE (Mozambique) said that alcohol misuse was a matter of public concern in her country, owing to the consequences such as domestic violence, road accidents and physical disorders, especially among young people. She supported the draft resolution.

Dr ST JOHN (Barbados) also supported the draft resolution and welcomed WHO's work in the area. At the national level, governments were able to enforce appropriate nondiscriminatory policies to protect public health and, in her country, such a control programme had produced excellent results. Its underlying principles were collaboration between all stakeholders, the government, nongovernmental organizations and the private sector. The alcohol industry in Barbados had demonstrated its commitment to positive interaction with WHO by promoting drink-driving prevention, as part of the World Health Day 2004 focus on road safety. Consideration had also been given to sponsorship of an international conference on best practices in industrial self-regulation. Policy in her country was geared to advocating responsible use of alcohol, the inclusion of prevention strategies in primary health-care promotion services, such as the adolescent education programme, the introduction of substance abuse cessation programmes, and public awareness campaigns, as well as control measures for reducing road accidents, introducing seat-belt legislation and breathalyser use.

Ms GILDERS (Canada) said that Canada fully supported the resolution as drafted, and particularly the language that had been strengthened to underscore the importance of collaboration with various stakeholders, including industry, on initiatives to reduce the harmful effects of alcohol use. She affirmed the delicate balance on the wording negotiated in discussions at the 115th session of the Executive Board. In November 2004, the Canadian Addictions Survey had revealed that most Canadians aged 15 and over drank in moderation and without harm, but the increase in heavy drinking among young people that had also been identified by the Survey gave cause for concern, and there was a need for awareness and prevention campaigns targeting that age group.

Canada welcomed the report and the initiative taken by the Board, and looked forward to the adoption of the draft resolution by the Health Assembly. In the interests of consensus, Canada could accept the minor amendments proposed by Thailand and thanked India for the flexibility it had shown.

Dr NABLI (Tunisia) expressed support for the draft resolution. She proposed that the limits of harmful and non-harmful use of alcohol should be defined and that the international exchange of information on harmful alcohol use, as well as implementation of strategies targeting young people, should be strengthened, as such strategies were new in countries such as hers. All strategies for preventing at-risk behaviour generally and the consumption of psychoactive substances in particular should be integrated into a single programme, for instance a mental health programme, and made part of primary health care in order to rationalize use of existing resources. Consideration should be given to the advisability of drafting a framework convention to combat the harmful use of alcohol, along the lines of the WHO Framework Convention on Tobacco Control.

Dr DAHL-REGIS (Bahamas) said that she shared most of the concerns expressed about alcohol misuse, a problem that contributed significantly to the disease burden in the Bahamas and showed no sign of abating. She agreed with the delegate of Zambia that the issue should be considered in the context of poverty reduction and of advertising that targeted young and poor people. She supported the appeals for consensus. She shared the concern of the delegate of the United States of America regarding the derivation of best practices, and supported the draft resolution as currently worded.

Dr ABDULLA (Sudan) strongly supported the draft resolution. The report stated that low or moderate consumption of alcohol had a protective effect on the heart, but that was not a scientific fact and ignored the findings of other valid research, conducted in cooperation with WHO, which had reached completely different conclusions. For instance, the 2001 European Comparative Alcohol Study conducted in 15 European countries had concluded that there was no evident benefit to heart health.

With regard to policy development, there was need to draw up evidence-based policies, making use of the mass of high-quality international research available on the subject. Such policies must be formulated and implemented at both national and local levels in such a way as to be mutually supportive, and they should not focus purely on extreme cases. There was also need to develop nationwide plans with specific timeframes; existing regional and multinational plans could be used as guidance for that process. National plans must be adapted to local conditions, and WHO's technical expertise would be needed to assist countries in that regard.

Mr VOIGTLÄNDER (Germany) said that greater emphasis should be given to prevention of excessive alcohol consumption by young people, notably by encouraging a critical attitude towards excessive drinking patterns. That was not an easy task, but it was necessary because young people were sometimes aggressively targeted by marketing and advertising strategies. As a result, support should be given to integrated approaches aimed at increasing a sense of responsibility among all social groups. There was also a need for more training of health professionals in counselling patients whose alcohol consumption posed risks.

When implementing the WHO strategy, all relevant stakeholders, including the alcohol industry, must assume their share of responsibility for the development of effective methods for reducing harmful drinking patterns. He welcomed the announcement that a report on evidence-based strategies and interventions to reduce alcohol-related harm was to be submitted to the Sixtieth World Health Assembly. The German Government and the German Federal Centre for Health Education were willing to cooperate in implementing a comprehensive alcohol-prevention strategy both nationally and internationally.

Dr SANGALA (Malawi) expressed appreciation of the report. An aspect of particular importance to his Government was road traffic accidents, which in Malawi were reaching epidemic proportions and having enormous economic and social consequences. The Ministry of Health had been forced to open new trauma units in referral hospitals to cope with the growing numbers of patients, further loading an already overburdened health-delivery system. He therefore suggested that a new subparagraph should be inserted between subparagraphs 2(4) and 2(5), to read: "to assist and support Member States with technical information on appropriate breathalyser technology for use by medical personnel and law-enforcement agents".

Dr CICOGNA (Italy) commended the draft resolution, which reaffirmed earlier commitments, gave a clear picture of the situation, and identified priority action to be taken; he urged delegations not to upset the delicate balance achieved. Flexibility, goodwill and common sense were needed to reach a consensus on a text that had been very difficult to draft. The issue was far too important to risk a lack of consensus. The draft resolution should be adopted with the two minor amendments proposed by Thailand.

Dr AL-HUSSEIN (Saudi Arabia) said that he could support the draft resolution, provided that a reference to those involved in the trade in alcoholic beverages was included in subparagraph 2(8).

Mrs NADAKUITAVUKI (Fiji) said that alcohol consumption in the Pacific region was one of the key risk factors for ill-health and premature death related to noncommunicable diseases. It had serious economic and social consequences and could lead to violence, including domestic violence, motor vehicle accidents, and suicides. In Fiji, alcohol and substance abuse was an emerging public health problem; according to a survey in 2002, 45% of the population had used alcohol and 24% were currently using it, binge drinking being most common in the 35-44 year age group for both men and women. The Government had established an Alcohol and Substance Abuse Council. Taxes on alcohol rose yearly and the minimum age for buying alcohol was to be raised from 18 to 21 years. Drinking hours were restricted and alcohol sales were prohibited on Sundays and public holidays, with heavy penalties imposed on bootleggers. Positive results of random breathalysing of motorists by police

could lead to suspension of driving licences and heavy court penalties. Given the increasing burden of noncommunicable diseases and HIV/AIDS and their links with alcohol consumption, the Ministry of Health had drawn up a strategic plan for noncommunicable disease control in cooperation with such bodies as the National Road Safety Council. Alcohol control legislation should be in place by later in the year, and education on the subject via schools and the mass media was ongoing. The National Centre for Health Promotion, in conjunction with WHO, had recently held a workshop for health workers on screening and intervention in cases involving alcohol problems. Efforts were also under way to set up support groups on the lines of Alcoholics Anonymous. She strongly supported the draft resolution.

Dr EL ISMAILI ALAOUI (Morocco) also strongly supported the draft resolution. Alcohol use was a complex phenomenon. For instance, what was meant by "harmful" use, and what were its quantitative limits? The issue was also complicated by religious, cultural, traditional, social and economic factors. He therefore suggested that WHO should act through its regional offices to conduct research aimed at a better understanding of the phenomenon and the development of appropriate strategies to deal with it. The fact that Morocco was a Muslim country did not mean that it did not face problems of alcohol misuse.

Mr AL-LAWATI (Oman) said that he could support the draft resolution provided that the word "harmful" was deleted throughout. There was no scientific evidence for the concept of "harmfulness" and he agreed with the delegates of the Islamic Republic of Iran and Tunisia that such a concept needed to be defined more clearly. He urged the Director-General to hold consultations with a view to arriving at a legally meaningful term and establishing a framework for alcohol use worldwide.

Mrs TAFA (Botswana) said that her Government was particularly concerned about the contribution of alcohol consumption to high mortality and morbidity rates as a result of road traffic injuries, interpersonal violence, especially violence against women and children, and irresponsible sexual behaviour that could result in the spread of HIV and other sexually transmitted diseases.

She strongly supported the draft resolution and suggested that emphasis should be placed on assistance to Member States in developing multisectoral frameworks to address the problem of alcohol misuse. A greater effort should also be made to educate young people about alcohol-related problems as part of school health programmes.

Ms VALLE (Mexico) said that her country had some national programmes for combating harmful use of alcohol. It was strongly committed to developing educational programmes and policies on alcohol, and to researching fetal alcohol syndrome. Its National Panel on Addiction was working on patterns of alcohol consumption.

She said that the text of the draft resolution, which struck a careful balance between extreme positions, should not be renegotiated. She looked forward to implementation of the resolution, and to receiving a report on progress at the Sixtieth World Health Assembly. She fully agreed with the comments made by the delegate of Italy. Further amendments would jeopardize the adoption of a resolution of great importance for public health.

Dr SANGALA (Malawi) endorsed the comments made by the delegate of Italy, and said that in the interests of achieving consensus he was willing to withdraw his earlier amendment. He also requested the Secretariat to produce a report for the Sixtieth World Health Assembly in order to assist countries in devising their own policies.

Ms BAQUERIZO (Ecuador) said that she had no wish to renegotiate the resolution. The discussions leading to its adoption by the Executive Board had been difficult enough, and the resulting consensus text was well-balanced and reflected the positions of all the participating countries.

Dr RAJALA (European Commission) said that Europe had the highest alcohol consumption in the world, and binge drinking by young people was a cause of special concern. In 2001 the Council of Ministers had adopted a set of recommendations to Member States to undertake to reduce alcohol consumption among the young. The Commission was preparing a European Union strategy to combat alcohol-related harm, and was in the process of consulting widely on the draft strategy with experts from the Member States and stakeholders, with a view to its adoption in early 2006. The European Policy Centre had initiated a round table on alcohol policy in an effort to obtain a consensus. One especially important stakeholder was the alcoholic drinks industry itself. The European Commission had asked members of the industry numerous questions, seeking its agreement to devising benchmarks for good practice which could be independently verified and adjusted if necessary. He looked forward to reporting on the outcome of that exercise, and hoped that the results would prove to be applicable internationally.

The CHAIRMAN proposed that the meeting be suspended to enable delegations to make progress in reaching a consensus on the draft resolution.

The meeting was suspended from 11:55 to 12:40.

Mr GUNNARSSON (Iceland) said that consensus had been elusive but, given extra time, it might prove achievable. Supported by Dr SUWIT WIBULPOLPRASERT (Thailand) and Ms GILDERS (Canada) he suggested that the Committee postpone further consideration of the item until the next meeting.

Mr HOHMAN (United States of America) also favoured postponement. He requested that, in the meantime, the Secretariat should prepare a statement on the implications of the draft resolution for both the current programme budget and the Programme budget 2006-2007, together with the implications of the proposed amendments. It should be borne in mind that the costs associated with developing a convention would be significantly greater than those incurred in developing the WHO Framework Convention on Tobacco Control, owing to inflation and exchange rate fluctuations.

The CHAIRMAN suggested that the item be taken up again at the next meeting.

It was so agreed.

(For continuation of the discussion, see summary record of the sixth meeting, section 4.)

International migration of health personnel: a challenge for health systems in developing countries: Item 13.21 of the Agenda (Resolution WHA57.19; Document A58/23)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Algeria, Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Comoros, Congo, Côte d'Ivoire, Democratic Republic of the Congo, Eritrea, Ethiopia, Gambia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritius, Mozambique, Namibia, Nigeria, Senegal, Seychelles, South Africa, Swaziland, Zambia and Zimbabwe, which read as follows:

> The Fifty-eighth World Health Assembly,
>
> Having examined the report on international migration of health personnel: a challenge for health systems in developing countries;[1]

[1] Document A58/23, Section F.

Concerned that migration and recruitment of health personnel, particularly highly trained and skilled health personnel, from developing to developed countries continue to be a major challenge for health systems in developing countries;

Recalling the requests directed to the Director-General in resolution WHA57.19, and noting with satisfaction that the Director-General has taken steps to address some of them;

Noting that there are additional areas related to international migration of health personnel, within the context of resolution WHA57.19 that require further attention by the Director-General;

Bearing in mind the high-level debate to be held at the United Nations General Assembly in 2006 on international migration,

1. EXPRESSES GRATITUDE to the Director-General for the steps he has taken to implement some of the requests directed to him in resolution WHA57.19;

2. REQUESTS the Director-General:

(1) to intensify his efforts to implement fully resolution WHA57.19;

(2) to strengthen WHO's programme on human resources for health by allocating to it adequate resources, in particular financial and human resources;

(3) to report on implementation of this resolution to the Fifty-ninth World Health Assembly.

Ms MAFUBELU (South Africa), speaking on behalf of the Member States of the African Region, welcomed the decision of the Health Assembly to consider the question of the international migration of health personnel as a substantive item of its agenda. The African group had taken a leading role in drafting resolution WHA57.19. The issue of human resources for health was a top priority for Heads of State and Government in Africa, which had decided to declare 2004 the "Year for Development of Human Resources in Africa". The Director-General had already responded to some of the requests addressed to him in resolution WHA57.19: she welcomed in particular the appointment of the Special Envoy on Human Resources for Health, and the work being done to compile a minimum database for migration, so as to improve information systems related to human resources for health. Although some work had also been done on multilateral agreements, it was crucial to identify their adverse effects and possible ways of dealing with those. She called on the Director-General to provide information on the progress made in developing a code of practice, as requested in resolution WHA57.19, and asked for details on the education initiative set up to provide support for the rapid production of new health workers in African countries. The choice of the development of human resources for health as the theme for *The world health report* and World Health Day in 2006 was welcome, but that area of work was underfunded, and inadequate resources had been allocated to it in the Programme budget 2006-2007.

She requested the Director-General to inform the Health Assembly of the outcome of consultations with the United Nations and specialized agencies on the possibility of declaring a year or decade of Human Resources for Health Development. What new steps had been taken to help to develop fair practices in the international recruitment of health personnel? The group was awaiting a progress report on the feasibility, cost and appropriateness of an international instrument on the subject, as well as recommendations by the Director-General on ways of offsetting the effects of the loss of health personnel on countries concerned.

A further paragraph should be added to the draft resolution, reading as follows:

3. DECIDES to have "International migration of health personnel: a challenge for health systems in developing countries" as a substantive agenda item during the Fifty-ninth World Health Assembly."

Mr AL KHAILI (United Arab Emirates) noted with pleasure that the subject would be the theme of World Health Day in 2006. While aware that his country attracted health personnel from abroad, he was conscious of the negative impacts of international migration. His country often entered into agreements with certain States to recruit nurses, and the recruitment process was cumbersome, involving examinations, interviews and training in the regulations applicable in local hospitals. However, the incoming personnel often left after a short time to work elsewhere. He could therefore endorse the draft resolution.

Dr AKASHI (Japan) expressed appreciation of the progress made by WHO in implementing resolution WHA57.19. Japan recognized the importance of developing human resources, and was cooperating for that purpose in developing countries. Nongovernmental organizations and the private sector were often important providers of medical services, but, it was important to strengthen public health systems in case donors withdrew by means of fostering human resource development and preventing a "brain drain" of skilled health personnel. Internal migration from the public sector to the private sector, which weakened public health systems, should also be taken into account.

Mr NESVÅG (Norway) said that the global health workforce crisis threatened to undermine efforts to attain health improvement goals and to affect countries' capacity to fight AIDS and to achieve the Millennium Development Goals. The gross mismatch between financial resources allocated in support of health goals and the personnel necessary to produce practical results undermined the credibility of development partnerships and the whole structure of global health.

Member States needed to come to grips with the situation. They had failed to stem the exodus of health personnel from the developing countries to the rich countries by means of appropriate codes of practice, or to consider the negative impact that exodus had on developing countries that had invested in their training. The challenges were not only technical and financial, but political: appropriate legislation and policy decisions were needed in source countries and host countries alike. Conflicting interests had to be recognized and negotiated, and the Secretariat had to engage in monitoring and brokering and, perhaps most of all, give visibility to the impact of policies that underlay the crisis and forge alliances to overcome it. Even before publication of *The world health report 2006* action was needed. Norway strongly endorsed the draft resolution and wished to be included among its sponsors.

He urged WHO to make full use of its capacities at global, regional and country levels to help solve the problem of migration of health personnel. A special effort was also required to bridge WHO's work on health and development with AIDS and the impact of AIDS on health systems. He looked forward to the substantive discussion of those issues at the Fifty-ninth World Health Assembly.

Dr BELLO DE KEMPER (Dominican Republic), acknowledging the importance of the subject under discussion, drew attention to paragraph 43 of the report, which stated that the Secretariat was developing evidence-based approaches to strengthening "production" of human resources for health. Human beings should never be considered as merchandise, and she therefore proposed that the word "production" should be replaced by "training".

Dr SUWIT WIBULPOLPRASERT (Thailand) pointed out that resolution WHA57.19 requested the Director-General to give "top priority" to human resources for health in WHO's Eleventh General Programme of Work 2006-2015. Analysis of the Programme budget 2006-2007 showed, however, that, while the overall programme budget had increased by 17%, the budget for human resources for health had increased by only 6%. It had been explained that human resources for health were also included in other budget areas, but no proper analysis had been provided. If a solution to the problem of human resources for health was to be found, resolution WHA57.19 must be complied with.

Dr QI Qingdong (China) agreed that the international migration of health personnel was an important issue. He appreciated the efforts made by the Director-General in the past year to implement

resolution WHA57.19 and encouraged their continuation. His country could contribute to progress in the area of human resources development, and he supported the draft resolution.

Mrs AL-SABIRI (Oman) said that the international migration of health personnel was one of the major problems facing health systems worldwide. Shortage of nurses was common to developing and developed countries alike, and it was therefore essential to develop strategies to keep them once they had been recruited. She supported the draft resolution, and welcomed the designation of human resources for health as the theme for World Health Day 2006. She also endorsed the comments made by the delegate of the United Arab Emirates.

Mrs NADAKUITAVUKI (Fiji) said that the shortage of skilled health professionals, especially doctors and nurses, had become a global problem as personnel tended to move from less developed to more affluent countries where conditions of service were more attractive. Fiji had commissioned studies on the impact of skill losses on health services, and had developed a five-year retention strategy plan to mitigate and control those losses. It was also signatory to the Commonwealth Code of Practice for International Recruitment of Health Workers, which had been adopted in 2003. She acknowledged the role played by WHO in that area and fully supported the draft resolution.

Dr ZOTOUA (Côte d'Ivoire) congratulated the Organization on the way it had dealt with an important subject which represented a continuing dilemma for developing countries. In his country only 50 of the 200 doctors trained every year were recruited to the health service, and the remainder were left without employment, resulting in a brain drain, notably to the Nordic countries. He strongly supported the views expressed by the delegate of Oman.

He suggested that a mechanism be set up to collect data on the migration of health personnel, and that a strategy should be developed by WHO, in collaboration with the countries or regions concerned, to support unemployed doctors.

Mrs YOUNG (Jamaica) also supported the draft resolution. The Caribbean region was one of the areas where the migration of health personnel to the developed world significantly affected health services. Jamaica was therefore exploring strategies to increase the numbers trained under "training for export" and "planned migration" schemes, designed to ensure rotation of health staff. As a member of the Commonwealth, her country followed the Commonwealth Code of Practice in that respect. Her region would welcome inclusion in any proposed initiatives to increase the number of new health workers trained.

The Caribbean Community supported the proposed theme of the *The world health report 2006* and World Health Day 2006. She requested that Jamaica be added to the list of sponsors of the draft resolution.

Ms AMIN OUMER (Ethiopia) said that migration of health personnel was a major problem in Africa in general and in the least developed countries in particular, and she strongly supported the view expressed by the delegate of Norway. The problem had become worse and had had a strong negative impact on her country's health strategies. Ethiopia was one of the countries with the highest HIV infection rates, and the emigration of health personnel hindered national and international efforts in that area. She emphasized the importance of the draft resolution, and urged the international community to seek an immediate solution to the problem.

Dr PARIRENYATWA (Zimbawe) endorsed the statements made by the delegate of Norway. Migration of health personnel was debated in various forums year after year, but the situation continued to deteriorate. It was time for urgent measures to be taken, including compensation to the developing countries and support for their training institutions. He asked what steps had been taken by the Director-General to deal with the issue since the adoption of resolution WHA57.19, and what

progress had been made with the ethical guidelines and the education initiative to provide support for training.

Ms BLACKWOOD (United States of America) said that, although she recognized the right of individuals to seek better opportunities for themselves and their families, the potential impact of migration on health systems must also be addressed. The Secretariat had acknowledged the need to focus within its own competencies and mandate, and to work with Member States and other relevant partners to produce an evidence-based approach to the recruitment and retention of health professionals. Such collaboration would improve countries' capacity to analyse trends, project human resource needs and identify action to be taken. Collaboration would also ensure optimum use of collective resources. Given the complexities of migration and human resource development, a range of competencies and expertise from outside WHO would be needed.

Dr BOUDIBA (Algeria) said that migration of health personnel was indeed an increasing problem in developing countries, for the success of whose health activities human resources were essential. It was therefore imperative that the problem be solved by concentrating on the setting up of mechanisms for training such personnel in their own countries.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that the shortage of trained health staff had led to a serious crisis in many countries, particularly in those whose health systems were near collapse owing to a large population of HIV patients and a shrinking workforce. Given the shortage of nurses, it was a daunting challenge for those systems to meet WHO targets and attain the health-related Millennium Development Goals. Evidence suggested that most professionals, especially nurses, did not wish to migrate and only did so when strong "push" factors were involved. Patchy statistics indicated that existing pay and working conditions were the main factors underlying the shortage of nurses, in which case emphasis should be put on sound retention measures in both industrial and developing countries. Members of the nursing faculty were in equally short supply. Paradoxically, however, nursing shortages existed in parallel with the unemployment of thousands of nurses, for example in cases where a freeze on new employment was imposed by donors. Moreover, many nurses chose not to work in the health sector; it was therefore vital to create viable work practices, supportive infrastructures and targeted incentives in order to attract them back to work and reduce international demand. Meanwhile, the comparatively poor salaries and lower percentage of allowances received by nurses conveyed the demoralizing message that their work was not valued, leading to high turnover and migration.

The magnitude and nature of migration was, however, frequently unclear owing to the lack of any systematic data collection. Her association therefore strongly supported the establishment of information systems and databases and would work in partnership with WHO to achieve the goal of retaining nurses in active practice.

Dr EVANS (Assistant Director-General) said that scenarios for a code of practice were currently being developed with a view to offering greater feasibility and effectiveness than did the codes of practice already in existence. WHO was working towards the goal of fair practices in recruitment in conjunction with partners including the Caribbean Community, ILO, IOM and the Global Commission on International Migration.

Efforts to compensate for the negative effects of migration should be framed in the larger context of human resources for health. To that end, WHO, in conjunction with partners, had tabled a plan of action at the High-Level Forum on the Health Millennium Development Goals (Abuja, December 2004), following which Norway had hosted a consultation on the subject in February 2005. The imperative of developing comprehensive strategies for human resources for health at country level had thus already been identified. The flow of international volunteers was likely to increase in the short term, which might offset or exacerbate migration. Also consideration could be given to the use of auxiliary and para-professional workers, who could be trained faster and were less likely to migrate.

Efforts were also under way to assess the evidence on the feasibility and effectiveness of strategies to produce more than workforce needs, since the pressures on staff to migrate were set to persist. Investment by major funds with a view to improving workforce conditions was also under consideration.

In reply to the delegate of Japan, he agreed that it was important to strengthen public sector leadership in the context of human resources for health strategies. In the event of a major withdrawal of donor support, however, some public sectors would have difficulty in supporting an expanded workforce, the financing strategies for which were part and parcel of moving forward responsibly.

In response to the delegate of Norway, he confirmed that, across departments and regions, the Secretariat was working with its priority programmes to develop clear strategies for strengthening the workforce that went beyond simply training. Thus far, the engagement of WHO's regional and country offices in that process had been encouraging. Taking into account its strengths, WHO was well positioned to offer guidelines and normative advice, develop technical assistance and strengthen capacities and the evidence base. Such core competencies, however, were not exclusive to WHO, which therefore needed to work effectively with partners in order to fulfil its role.

Replying to the delegate of Thailand, he pointed out that, during the past biennium, there had been no Department of Human resources for health, and the budget calculations in that connection were not therefore as straightforward as they might appear. During the biennium 2006-2007, the Secretariat would for the first time be dedicating an area of its work to human resources for health, in which connection it was also aggressively developing a relevant strategy. Such steps were indicative of a move in the right direction.

The studies mentioned by the delegate of Fiji were crucial and reflected an opportunity to invest in the evidence base. He acknowledged with gratitude the support that had been provided by Australia. Concerning the comments of the delegate of the United States of America, he said that, given its clear but specific role, WHO was required to articulate its response with partners, including ILO, IOM, the World Bank, bilateral and donor parties and professional associations.

WHO shared a responsibility with partners to identify the negative consequences of current fiscal regulations in order to develop fiscal circumstances that were more conducive to rapid expansion of the workforce than was sometimes the case. WHO would also be exploring ways of enhancing the recruitment and deployment capabilities needed in order to cope with workforce expansion.

The draft resolution, as amended, was approved.[1]

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5)

The CHAIRMAN said that there were two draft resolutions for consideration under the agenda item. The first, on the achievement of health-related Millennium Development Goals, was contained in paragraph 20 of document A58/5. The second, on working towards universal coverage of maternal, newborn and child health interventions had been proposed by the delegations of Algeria, Angola, Benin, Botswana, Brazil, Burkina Faso, Canada, Cape Verde, Central African Republic, Comoros, Congo, Democratic Republic of the Congo, Denmark, Eritrea, Ethiopia, Gabon, Gambia, Ghana, Guinea-Bissau, Japan, Kenya, Lesotho, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Norway, Pakistan, Portugal, Sierra Leone, South Africa, Swaziland, Uganda, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Zambia and Zimbabwe, and read as follows:

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA58.17.

The Fifty-eighth World Health Assembly,

Concerned by the high level of maternal, newborn and child morbidity and mortality in the world, the slow pace of progress in improving maternal, newborn and child health, by the growing inequalities between and within Member States, and the continuing need to address gender inequalities;

Alarmed by the inadequate resources for maternal, newborn and child health and by the lack of appreciation of the great impact of maternal, newborn and child health in sustaining socioeconomic development;

Mindful that cost-effective interventions exist to meet the health needs of women, newborns and children;

Aware that care needs to be provided as a seamless continuum both throughout the life-cycle and spanning individuals, families, communities and the various levels of the health system, thus creating an integrated approach to reproductive, maternal, newborn and child health;

Convinced that only through coordinated and concerted action and unprecedented resource mobilization at international and national levels will it be possible to deal with the global crisis that currently affects the health workforce and strengthen health systems in order to end the exclusion of the poor, the marginalized and the underserved;

Welcoming the increased commitment of the international community and WHO to the health of women, newborns and children, and to meeting the development goals contained in the Millennium Declaration and other international development goals and targets;

Recalling resolution WHA56.21 adopting the strategy for child and adolescent health and development and resolution WHA57.12 adopting the strategy to accelerate progress towards the attainment of international goals and targets related to reproductive health and aware of the need for stepping up efforts to achieve international goals for reproductive, maternal, newborn and child health and development;

Reaffirming the outcomes of the World Summit for Children (New York, 1990), the Programme of Action of the International Conference on Population and Development (Cairo, 1994), and the Beijing Platform for Action of the Fourth World Conference on Women (Beijing, 1995);

Recalling also the Delhi Declaration on Maternal, Newborn and Child Health (April 2005);

Welcoming *The world health report 2005: Making every mother and child count* and the guidance offered by the associated policy briefs,

1. URGES Member States:

   (1) to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care;

   (2) to establish or sustain national and international targets and monitoring mechanisms for measuring progress towards the achievement of agreed goals;

   (3) to involve all key stakeholders, including civil society organizations and communities, in setting priorities, developing plans and programmes, measuring progress and evaluating impact;

   (4) to adopt and implement, in line with international agreements, the legal and regulatory frameworks to promote gender equality and protect the rights of women and children, including their entitlement to equal access to health care, with special attention for those thus far excluded, particularly the poor, the marginalized and the underserved;

   (5) to ensure that national strategic-planning processes include interventions at political and programme level to strengthen health-care delivery systems for effective and rapid advance towards universal coverage, including:

(a) realigning the content of programmes for maternal, newborn and child health and nutrition, incorporating their management structures and services, and embedding them in core development processes for health systems in order to ensure that reproductive health and rights are fully integrated;
(b) addressing the workforce crisis by drawing up national plans for development of human resources for health that include mechanisms for equitable deployment and retention;
(c) building realistic scenarios, with their costing and budget implications, for scaling up the health systems required for delivering maternal, newborn and child health care;
(d) building the institutional capacity to move from user fees to prepayment mechanisms and pooling systems, including tax-based and insurance systems in order to ensure universal access and financial and social protection;
(e) building a national consensus around the need for moving towards universal coverage, with mechanisms for predictable, sustained and increased funding, maternal, newborn and child health at the core of the citizen's health entitlements, and human resources for health as a national priority;
(f) creating partnerships between government, civil-society organizations, private sector entities and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources;
(g) establishing participation mechanisms for not-for-profit civil-society organizations, in order to strengthen accountability mechanisms and systems of checks and balances;

2. REQUESTS the Director-General:
(1) to strengthen the coordination, collaboration and synergies of WHO's programmes on reproductive, maternal, newborn and child health, its programmes on malaria, HIV/AIDS, tuberculosis and health promotion, and its programme on health systems development, in support of countries;
(2) to ensure that WHO fully participates in harmonization efforts within the United Nations system, supports efforts of Member States to establish policy coherence and synergies between and within national and international initiatives in maternal, newborn and child health, particularly between those taken by partners within the United Nations system and others;
(3) to support the efforts of national health authorities to ensure that reproductive, maternal, newborn and child health are systematically included in frameworks for socioeconomic development and plans to ensure sustainability;
(4) to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems;
(5) to mobilize the international community so that it commits the additional resources required to achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care;
(6) to declare an annual world maternal, newborn, and child health day in order to ensure continued global visibility of the reproductive, maternal, newborn and child health agenda and to provide an opportunity for countries and the international community to reassert their commitment to this issue;
(7) to report biennially to the Health Assembly on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care, and on the support provided by WHO to Member States to attain this goal.

A working group would meet to discuss the texts of the two draft resolutions.

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

The meeting rose at 13:40.

SIXTH MEETING

Monday, 23 May 2005, at 09:30

Chairman: Dr M.A. RAHMAN KHAN (Bangladesh)

1. SECOND REPORT OF COMMITTEE B (Document A58/58)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft second report of Committee B.

The report was adopted.[1]

2. FINANCIAL MATTERS: Item 17 of the Agenda

Unaudited interim financial report on the accounts of WHO for 2004 and comments thereon made by the Programme, Budget and Administration Committee: Item 17.1 of the Agenda (Documents A58/26, A58/26 Add.1 and A58/27)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee (PBAC), said that the Committee had noted the interim financial report for the year 2004, with its improved analytical presentation of financial information, and the significant progress in respect of governance, accountability, income and expenditure trends, and the overall financial stability of the Organization. It had also noted that implementation rates had varied significantly across areas of work. The Secretariat had identified the need for a long-term financing plan and for setting parameters for efficient and effective funding from all sources and for expenditure.

Mr KOCHETKOV (Russian Federation) noted that unpaid obligations from 2003 had increased to more than US$ 400 million and asked how it was planned to resolve that issue. He also enquired as to the expected results of the first year of the current biennium.

Ms WILD (Comptroller) said that there were two reasons why unpaid obligations had been higher than at the end of the previous biennium. First, there had been an increase in the level of expenditure, hence a higher level of unliquidated obligations was to be expected. Secondly, at the end of the biennium, it was necessary to close down some unpaid obligations, so that the level reflected accounts payable, namely money owed to providers of services and work to the Organization.

Dr NORDSTRÖM (Assistant Director-General) said that comparison of the mid-term figures for 2004 with those of 2002 would provide a better picture of the current status than the end-of-biennium figures.

Replying to the question on expected results, he said that progress had been made in reporting back on each expected result for 2002-2003 in the performance assessment report. For 2004, a medium-term interim report had been presented to PBAC. That work might be carried forward to

[1] See page 356.

2006, so that the next Health Assembly could be presented with the audited financial report and the performance assessment report, although a breakdown by expected result was unlikely to be ready by that date. The Secretariat was moving towards better initial costing and monitoring of costs in order to obtain specific results.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A58/27.

The draft resolution was approved.[1]

Interim report of the External Auditor: Item 17.2 of the Agenda (Documents A58/28 and A58/29)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that the Committee, having reviewed the interim report, had noted that the audit had been conducted at all levels of the Organization through a consultative process that had resulted in an effective working relationship and optimal use of audit resources. The Committee had noted that more progress was needed to finalize work in respect of recommendations covering several areas, and had recommended that the External Auditor's report for the biennium should include a schedule for implementation of significant recommendations.

Mr MENON (representing the External Auditor) said that the Comptroller and Auditor-General of India had been assigned the audit of the Organization for the financial periods 2004-2005 and 2006-2007. His opinion on the WHO financial statements for the 2004-2005 period would be presented to the Health Assembly in 2006, but the interim report would apprise the current Health Assembly of the results of the external audit in the first year of his assignment, which had begun after the Fifty-seventh World Health Assembly in May 2004.

WHO's complex and highly decentralized structure meant that the auditor had first to develop an understanding of how it functioned through audits at various levels. Hence visits had been made to two country offices and the regional offices for Africa, the Eastern Mediterranean and the Western Pacific, followed by an interim audit at headquarters at the beginning of 2005. The audits had been performed in accordance with the Common Auditing Standards of the Panel of External Auditors of the United Nations, taking a comprehensive approach covering key areas of WHO's activities. Other regional offices and some country offices were to be covered in the remaining portion of the financial period; management reviews would also be conducted on some specific aspects of the Organization's functioning. In addition, the separate accounts of certain trust funds had also had to be examined.

To date, audits had been performed at IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, the International Computing Centre and UNAIDS. The findings had been communicated to those bodies through separate management letters. Interaction with the Secretariat had been constructive, and a high level of cooperation had engendered an environment that optimized the value of the external audit process. The acceptance by the Director-General of the interim report and its recommendations was indicative of the consensus that had been reached.

Among the significant issues discussed in the interim report was the policy on fraud prevention, which had since been finalized and circulated, and work on the revision of the WHO Manual. In that context, it was essential to have formalized procedures in place when the Global Management System was introduced in 2006. Difficulties had been experienced in operating the budget control and financial accounting system in two locations in the Regional Office for Africa. A comprehensive study of that system had been undertaken and its recommendations reviewed, with a view to establishing a plan of action to implement the proposed changes.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.18.

Some weaknesses persisted in the area of inventory management, which had been addressed by the Secretariat. The current provisions in the WHO Manual relating to the custody and disposal of inventories were to be further refined, and the establishment of a complete set of inventory records should be a priority, if the transfer to the asset module of the Global Management System was to be facilitated. Local cost subsidies and the Fellowship Programme were critical components of the Organization's activities in countries and the submission of the required reports needed further attention. A revised policy laying down principles for funding support to countries was expected to be issued shortly, together with an evaluation of the Fellowship Programme carried out by the Office of Internal Oversight Services. Once management decisions had been taken improvements would follow.

The External Auditor had taken note of the recommendation made by PBAC, and the report for the biennium would contain a schedule on the status of implementation of significant recommendations made by the external audit. The accountability framework would also be significantly strengthened by a drafting mechanism for internal and external audit recommendations. Efforts would continue to be directed towards bringing greater value to the Organization and its stakeholders by means of the external audit process.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that it would be helpful if in future reports the External Auditor prioritized the issues raised. She would also like to see the Secretariat's response to the report, and clear timeframes for resolution of problems identified. The process could be improved by the tracking system for internal and external audit reports included in the appropriations resolution adopted earlier.[1]

She asked for an immediate reply about what action would be taken in response to the External Auditor's recommendations regarding the Regional Office for Africa, and why staff appraisals for 2003 had not yet been completed. On travel advances, she had noted the Secretariat's response to PBAC that processing would be improved by the Global Management System; when would that system become operational? She commended the Organization's work on the fraud-prevention policy and looked forward to its early completion.

Mr MCKERNAN (New Zealand) said that he was pleased to note the excellent relationship that had been established between the Secretariat and the External Auditor. Some recommendations concerned basic financial controls that should be customary practice in any large organization, and he supported the introduction of the systems needed to deal with those recommendations. He concurred with the previous speaker about the prioritization of recommendations. Given that an increase of 17% had been approved for the Programme budget 2006-2007, tight financial discipline must be accorded the highest priority to ensure that resources were not wasted.

New Zealand was particularly concerned by the External Auditor's comments regarding staff travel allowances, and urged the Director-General to resolve the matter forthwith. It was also concerned by the comments on the Budget and Finance Unit in the Regional Office for Africa, as that Region was receiving 30% of the total budget and had been allocated the largest budget increase in real terms for the 2006-2007 biennium. He requested an update on the situation and considered it imperative that the External Auditor's recommendations should be incorporated in an action plan to be implemented by the Director-General and the Regional Director.

Ms BLACKWOOD (United States of America) said that all the identified internal weaknesses in allotment and expenditure controls, staff advances, management of short-term staff contracts, local cost subsidies and management of non-expendable equipment needed prompt attention. She concurred with the previous two speakers regarding the importance of establishing a tracking system and timeframes for the resolution of problems. She encouraged the regional committees to look into issues affecting regional or country offices, and looked forward to future progress reports.

[1] Resolution WHA58.4.

Mr KOCHETKOV (Russian Federation) welcomed the practice of interim reporting and endorsed the requests for prioritizing recommendations and scheduling their follow-up. He drew attention to paragraph 27 of the External Auditor's report, which mentioned problems relating to the performance assessment report. He expressed considerable unhappiness that for a long time his delegation had expressed concern regarding those weaknesses which were the main obstacle to assessing the Organization's financial performance. They could only be resolved through cooperation with Member States. He welcomed the efforts by the Secretariat to remedy those weaknesses.

Mr MACPHEE (Canada) viewed the interim report as an essential tool in the implementation of results-based management, and endorsed the suggestions for prioritizing future recommendations and scheduling their implementation. The report recorded some progress in the area of policies and procedures: it would be helpful if the External Auditor could indicate the areas where guidelines would be useful, so that steps be taken to distribute them to all offices concerned. Noting the recommendations made concerning staff evaluations, he emphasized that such evaluations were an integral part of results-based management. The External Auditor should monitor the situation closely so that future reports could show the progress made in reducing the backlog.

Dr NABAE (Japan) agreed with previous speakers about the need for a tracking system, including timeframes, to follow up implementation of recommendations made by the Internal and External Auditors.

Mr MENON (representing the External Auditor) said that he had taken note of the comments made, especially the request that recommendations should be prioritized. They would be complied with in the next report.

Dr NORDSTRÖM (Assistant Director-General) said that a tracking system would be developed to follow up the recommendations of both the Internal Auditor and the Joint Inspection Unit. Some progress had already been made with staff appraisal; an electronic system for processing appraisal of individual performance was being developed, a different system of incorporating competencies was being applied, and training in leadership was being given to all the Secretariat's 380 managers, with special focus on human resources.

The Global Management System should facilitate the issuing of travel advances but, pending its introduction in 2006, the travel policy had been changed to enable staff members to obtain resources before travelling. Travel advances made would be strictly regulated. Efforts were also being made to improve manual handling of claims. An important step had been taken in the implementation of fraud policies: guidelines had been distributed and planning was in progress for training on risk situations.

In regard to the overall increase in the budget, the Secretariat recognized its responsibility to ensure the best possible management of financial resources and was instituting various improvements. On the matter of baselines and indicators in relation to the performance assessment report for 2002-2003, the Secretariat recognized that weaknesses existed. Some major improvements had already been made for the 2004-2005 biennium and further efforts would be made to provide useful input for managers when implementing programmes in the 2005-2006 biennium.

Mr BROMSON (Administration and Finance, Regional Office for Africa) pointed out that there had been a change of management in the Regional Office and that the new Regional Director was reviewing all outstanding audit recommendations relating to policies, procedures, financial monitoring and control, and was committed to tackling all issues in a timely manner. Ways were being considered with the Budget and Finance Unit to strengthen control systems.

Ms WILD (Comptroller), referring to compliance with policy, expressed appreciation for the attention drawn to the matter by both the External and Internal Auditors. Issues concerning allotment and expenditure control, unliquidated obligations and contracts for services arose fairly regularly; they

were not easy to deal with, but constant efforts were being made to encourage improvement. Policies and procedures on non-expendable inventory had been updated and the action recommended by the External Auditor was being taken. Compliance was always difficult for the Secretariat in the area of local costs and fellowships, but it depended on timely and reliable reporting by those to whom local cost payments were made and by participants in the Fellowship Programmes. She therefore welcomed the recommendation made in the report of the External Auditor for improved compliance. The Secretariat was striving to formulate a reporting mechanism on local costs that would be easy for Member States and that would enable the Secretariat better to account to States for the use of funds. Further efforts would be made to improve the situation.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) welcomed the opportunity for dialogue on issues of concern to her delegation. However, she had not received answers to two of her questions, namely, how many staff appraisals for 2002-2003 were still outstanding and, with reference to the issue of travel advances, when the Global Management System would be in operation. She also reiterated her request for specific timeframes for implementing the external and internal audit recommendations, including those relating to the Regional Office for Africa.

Dr NORDSTRÖM (Assistant Director-General) said that he regretted that he was unable to answer the first question. Because there should be no outstanding appraisals of staff performance, great efforts were being made to improve the appraisal system. Regarding the Global Management System, the aim was that some components would come into operation on 1 January 2006, and it was likely that the travel module might be in use towards the end of that year. The Secretariat was committed to working with the External Auditor to provide replies on the tracking system and the timeframe for completing implementation of recommendations by January 2006.

The Committee noted the report.

Assessments for 2006-2007: Item 17.4 of the Agenda (Resolution EB115.R8; Document A58/30)

Dr YOUNES (Secretary) read out a correction to the draft resolution contained in resolution EB115.R8. In the paragraph adopting the scale of assessments, a comma and the words “reflecting the latest available United Nations scale” should be inserted after “2006-2007”.

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that the Executive Board at its 115th session had considered the proposed scale of assessments for the financial period 2006-2007, and had agreed to recommend that the scale applied in the financial period 2004-2005 should continue to be used. If that scale were approved, there would be no change in the way in which the burden of payment of the regular budget was shared out among Member States compared to 2005.

The draft resolution, as amended, was approved.[1]

Amendments to the Financial Regulations and Financial Rules: Item 17.6 of the Agenda (Resolution EB115.R9; Document A58/32)

Dr YOOSUF (Maldives, Representative of the Executive Board) said that the Executive Board at its 115th session had considered the proposed amendments to the Financial Regulations and Financial Rules and had noted that those changes would make use of Organization’s financial

[1] Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA58.19.

resources more efficient and effective. Transparency in financial reporting of the achievement of the expected results would be improved. The Board had recommended that the Health Assembly should adopt the draft resolution contained in resolution EB115.R9.

The draft resolution was approved.[1]

3. REAL ESTATE FUND: Item 18 of the Agenda (Documents A58/33, A58/44 and A58/44 Corr.1)

Dr YOOSUF (Maldives, Representative of the Executive Board), speaking in his capacity as Chairman of PBAC, said that, at its second meeting, held on 14 May 2005, the Committee had reviewed the proposal for construction projects at locations in countries of the Eastern Mediterranean Region such as Iraq, Jordan and Tunisia, where difficulties were encountered in finding suitable accommodation for programme staff. It had noted that WHO did not intend to construct premises where its staff were housed in safe health-ministry premises, where a United Nations house was planned or available, or where accommodation could be rented at affordable prices and construction would not be cost-effective. PBAC had recommended that the Health Assembly should adopt the draft resolution contained in document A58/33, as amended in document A58/44 Corr.1.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) said that a wider strategy designed to pinpoint problems arising in particular offices in the regions, and any potential problems within the headquarters building, should ultimately be used in order to provide a comprehensive picture of the real estate situation and thus a more coherent basis for decision-making.

Dr ABDESSALEM (Tunisia) fully supported the proposal of the Regional Office for the Eastern Mediterranean concerning the construction of the WHO Representative's office in Tunisia; as early as 1997, it had offered 1700 square metres of land for that purpose. It also hoped that the premises of the WHO Mediterranean Centre for Vulnerability Reduction would be housed at that site and was ready to assist in that regard.

Mr KOCHETKOV (Russian Federation) asked how much funding would be allocated to guaranteeing the safety and security of staff in the locations concerned and whether the retrofitting of buildings included a component to ensure compliance with Minimum Operating Security Standards.

Mr MACPHEE (Canada) agreed that a long-term comprehensive strategy was needed in order to facilitate future decision-making in matters of real estate, not least in view of the trend towards greater decentralization of staff and the devolution of programme responsibility to the regions and country offices. In that connection, the security aspects represented a significant cost factor that should be given careful consideration.

Mr SUNDARAM (Infrastructure and Logistics Services), replying to the delegate of the United Kingdom, said that at its 117th session the Executive Board would receive a progress report on that strategy, including a location-by-location inventory of WHO's current real estate. That inventory would form part of the larger capital master plan in which various safety issues would be addressed. That plan would therefore answer in part the question raised by the delegate of the Russian Federation.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.20.

Dr NORDSTRÖM (Assistant Director-General) said that, as stated in the Programme budget 2006-2007, the overall cost estimate for spending on staff and infrastructure security was US$ 30 million, of which US$ 20 million were earmarked for payment into the common system of the United Nations and US$ 3 million primarily for WHO's headquarters and field security requirements. The remaining US$ 7 million were allocated to security-specific investments relating to real estate and infrastructure and logistic support functions, which involved improvements in the security of WHO's premises. New investments also comprised a security element, however, and it was therefore difficult to determine a clear-cut figure.

Mr MACPHEE (Canada) pointed out that the overall cost of rebuilding or expanding offices was increased by the security element, which was an integral part of the process. It was to be hoped that the capital master plan would convey a realistic appreciation of the inbuilt security cost as a separate item in order to facilitate the consideration of future work on premises that might be largely dictated by the need to meet Minimum Operating Security Standards.

Dr NORDSTRÖM (Assistant Director-General) confirmed that the security element would be clearly identified as a separate item in the 10-year capital master plan, which would provide a more precise picture of the present situation and of future costs.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A58/33, as amended in document A58/44 Corr.1.

The draft resolution, as amended, was approved.[1]

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

Cancer prevention and control: Item 13.12 of the Agenda (Resolution EB114.R2; Document A58/16) (continued from the fourth meeting)

The CHAIRMAN drew the Committee's attention to the revised text of the draft resolution contained in EB114.R2, which incorporated the amendments previously proposed by a number of delegations and which read:

> The Fifty-eighth World Health Assembly,
>
> Having examined the report on the prevention and control of cancer;
>
> Recalling resolutions WHA51.18 and WHA53.17 on the prevention and control of noncommunicable diseases, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA56.1 on tobacco control, and WHA57.12 on the reproductive health strategy, including control of cervical cancer, and WHA57.16 on health promotion and healthy lifestyles;
>
> Recognizing the suffering of cancer patients and their families and the extent to which cancer threatens development when it affects economically active members of society;
>
> Alarmed by the rising trends of cancer risk-factors, the number of new cancer cases, and cancer morbidity and mortality worldwide, in particular in developing countries;
>
> Recognizing that many of these cases of cancer and deaths could be prevented, and that the provision of palliative care for all individuals in need is an urgent, humanitarian responsibility;
>
> Recognizing that the technology for diagnosis and treatment of cancer is mature and that many cases of cancer may be cured, especially if detected earlier;

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.21.

Recognizing that tobacco use is the world's most avoidable cause of cancer and that control measures, such as legislation, education, promotion of smoke-free environments, and treatment of tobacco dependence, can be effectively applied in all resource settings;

Recognizing that among all cancer sites cervical cancer, causing 11% of all cancer deaths in women in developing countries, has one of the greatest potentials for early detection and cure, that cost-effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health;

Recognizing the value of multidisciplinary management and the importance of surgery, radiotherapy, chemotherapy**, palliative care** and other approaches in the treatment of cancer;

Recognizing the contribution of IARC, over 40 years, to research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the causes of cancer, mechanisms of carcinogenesis, and effective strategies for cancer prevention and early detection;

Mindful of the need for careful planning and priority-setting in the use of resources in order to undertake effective activities to reduce the cancer burden;

Recognizing the importance of adequate funding for cancer prevention**,** ~~and~~ control **and palliative-care** programmes, especially in developing countries;

Encouraged by the prospects offered by partnerships with international and national organizations within the Global Alliance for Cancer Control, and other bodies such as patient organizations;

Recognizing the support given by IAEA to combat cancer, and welcoming the initiative of the Agency to establish ~~a~~**the** ~~programme~~**Programme** of ~~action~~**Action** for ~~cancer~~**Cancer** ~~therapy~~**Therapy**, and research efforts of national cancer institutes in various Member States,

1. URGES Member States:

(1) to collaborate with the Organization in developing and reinforcing comprehensive cancer control programmes tailored to the socioeconomic context, and aimed at reducing cancer incidence and mortality and improving the quality of life of cancer patients and their families, specifically through the systematic, stepwise and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment rehabilitation and palliative care, and to evaluate the impact of implementing such programmes;

(1*bis*) to set priorities based on national burden of cancer, resource availability and health system capacity for cancer prevention, control and palliative-care programmes;

(2) to integrate national cancer-control programmes in existing health systems that set out outcome-oriented and measurable goals and objectives for the short-, medium- and long-term, as recommended in the Annex to the present resolution, to identify evidence-based, sustainable actions across the continuum of care, and to make the best use of resources to the benefit of the entire population by emphasizing the effective role of primary health care in promoting prevention strategies;

(3) to encourage and to frame policies for strengthening and maintaining technical equipment for diagnosis and treatment of cancer in hospitals providing oncology and other relevant services;

(4) to pay special attention to cancers for which avoidable exposure is a factor, particularly exposure to chemicals **and tobacco smoke** in the workplace and the environment, certain infectious agents, and ionizing and solar radiation;

(5) to encourage the scientific research necessary to increase knowledge about the burden and causes of human cancer, giving priority to tumours, such as cervical **and oral** cancer, that have a high incidence in low-resource settings and are amenable to cost-effective interventions;

(6) to give priority also to research on cancer prevention, early detection and management strategies, including, where appropriate, traditional **medicines and therapies, including for palliative care** ~~and herbal medicine~~;

(7) to consider an approach in the planning, implementation and evaluation phases of cancer control that involves all key stakeholders representing governmental, nongovernmental and community-based organizations, including those representing patients and their families;

(8) to ensure access to appropriate information in relation to preventive, diagnostic and treatment procedures and options**,** especially by cancer patients**, and to palliative care**;

(9) to develop appropriate information systems, including outcome and process indicators, that support planning, monitoring and evaluation of cancer prevention**,** ~~and~~ control **and palliative-care** programmes;

(10) to assess periodically the performance of cancer prevention and control programmes, allowing countries to improve the effectiveness and efficiency of their programmes;

(11) to participate actively in implementing WHO's integrated health promotion and prevention strategies targeting risk factors for noncommunicable diseases, including cancer, such as tobacco use, unhealthy diet, harmful use of alcohol and exposure to biological, chemical and physical agents known to cause cancer, and to consider signing, ratifying, accepting, approving, formally confirming or acceding to the WHO Framework Convention on Tobacco Control;

(11*bis*) to improve access to appropriate technologies, with support from WHO, for the diagnosis and treatment of cancer, in order to promote its early diagnosis and treatment, especially in developing countries;

(12) to determine cost-effective minimum standards, adapted to local situations, for cancer treatment and palliative care that use WHO's strategies for nationwide provision of essential drugs, technologies, diagnostics and vaccines**, taking into consideration in the case of palliative care the recommendations of the Second Global Summit of National Hospice and Palliative Care Associations (Seoul, 2005)**;

(13) to ensure the medical availability of opioid analgesics according to international treaties and recommendations of WHO and the International Narcotics Control Board and subject to an efficient monitoring and control system;

(14) to ensure, where appropriate, **the documented, scientific, evidence-based safety and efficacy of available traditional medicines and therapies** ~~availability of safe and efficacious traditional and herbal medicine~~;

(15) to develop and strengthen health system infrastructure, particularly related to human resources for health, in order to build adequate capacity for effective implementation of cancer prevention and control programmes, including a cancer registry system;

(16) to accord high priority to cancer control planning and implementation for high-risk groups, including relatives of patients and those having experienced long-duration and high-intensity carcinogen exposure;

2. REQUESTS the Director-General:

(1) to develop WHO's work and capacity in cancer prevention and control and to promote effective, comprehensive cancer prevention and control strategies in the context of the global strategy for the prevention and control of noncommunicable diseases, the Global Strategy on Diet, Physical Activity and Health, and resolution WHA57.16 on health promotion and healthy lifestyles, with special emphasis on less developed countries;

(1*bis*) to provide technical support to Member States in setting priorities for cancer prevention, control and palliative-care programmes;

(2) to strengthen WHO's involvement in international partnerships and collaboration with Member States, other bodies of the United Nations system and actors from a wide variety of related sectors and disciplines in order to advocate, mobilize resources, and build capacity for a comprehensive approach to cancer control;
(3) to continue developing WHO's strategy for the formulation and refinement of cancer prevention and control programmes by collecting, analysing and disseminating national experiences in that regard, and providing appropriate guidance, upon request, to Member States;
(4) to contribute to drawing up recommendations on early diagnosis of cancer, especially in order to define and reach the target populations that should benefit from such diagnosis;
(5) to consider allocating additional resources so that the knowledge provided by research is translated into effective and efficient public-health measures for cancer prevention and control;
(5*bis*) to support research on cost-effectiveness studies on different strategies for prevention and management of various cancers;
(6) to promote and support research that evaluates low-cost interventions that are affordable and sustainable in low-income countries;
(6*bis*) to support research on development of an effective vaccine against cervical cancer;
(7) to support the further development and expansion of a research agenda in IARC and other bodies that is appropriate to the framing of integrated policies and strategies for cancer control **and to promote and support technical and medical programmes in cancer treatment**;
(8) to promote ~~guidelines on the~~**guiding principles on palliative care for cancer patients, including** ethical **aspects**~~ care of patients with terminal cancer~~;
(9) to provide adequate resources and leadership support to the International Programme on Chemical Safety for its active role in international multisectoral mechanisms for chemical safety, including support for capacity building in chemical safety at country level;
(10) to support and strengthen mechanisms to transfer to developing countries technical expertise on cancer prevention and control, including surveillance, screening and research;
(11) to advise Member States, especially the developing countries, on development or maintenance of a national cancer registry containing the type, location of the cancer and its geographical distribution;
(12) to collaborate with Member States in their efforts to establish national cancer institutes;
(13) to explore appropriate mechanisms for adequately funding cancer prevention~~, and~~ control **and palliative-care** programmes, especially in developing countries;
(14) to initiate the development of a joint programme between WHO – Member States and Secretariat – and IAEA for cancer prevention, control, treatment and research;
(14*bis*) to examine jointly with the International Narcotics Control Board the feasibility of a possible assistance mechanism that would facilitate the adequate treatment of pain using opioid analgesics;
(14*ter*) to explore all opportunities to improve the accessibility, affordability and availability of chemotherapy drugs, particularly in developing countries, for the treatment of HIV/AIDS-related cancers;
(14*quarto*) to report regularly on the implementation of this resolution to the Health Assembly.

ANNEX

NATIONAL CANCER CONTROL PROGRAMMES: RECOMMENDATIONS FOR OUTCOME-ORIENTED OBJECTIVES

National health authorities may wish to consider the following outcome-oriented objectives for their cancer control programmes, according to type of cancer:

- preventable tumours (such as those of lung, colon, rectum, skin and liver): to avoid and reduce exposure to risk factors (such as tobacco use, unhealthy diets, harmful use of alcohol, sedentariness, excess exposure to sunlight, infectious agents, including hepatitis B virus and liver fluke, and occupational exposures), thus limiting cancer incidence;

- cancers amenable to early detection and treatment (such as oral, cervical, breast and prostate cancers): to reduce late presentation and ensure appropriate treatment, in order to increase survival, reduce mortality and improve quality of life;

- disseminated cancers that have potential of being cured or the patients' lives prolonged considerably (such as acute leukaemia in childhood): to provide appropriate care in order to increase survival, reduce mortality and improve quality of life;

- advanced cancers: to enhance relief from pain and other symptoms and improve quality of life of patients and their families.

Ms BLACKWOOD (United States of America) proposed the following additional amendments to the draft resolution: in subparagraphs 2(5*bis*) and 2(6*bis*), replace the word "support" with "promote", and in subparagraph 2(14) replace the word "initiate" with the phrase "explore the feasibility of initiating" and delete the phrase "Member States and Secretariat".

Dr YOUNES (Secretary) read out the proposed amendments.

The draft resolution, as amended, was approved.[1]

Disability, including prevention, management and rehabilitation: Item 13.13 of the Agenda (Resolution EB114.R3; Document A58/17) (continued from the fourth meeting)

The CHAIRMAN drew the Committee's attention to a revised version of the draft resolution contained in resolution EB114.R3, which incorporated the amendments proposed by several delegations, and which read:

The Fifty-eighth World Health Assembly,

Having considered the report on disability, including management and rehabilitation;[2]

Noting that about 600 million people live with ~~physical and mental~~ disabilities of various types;

Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

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[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.22.

[2] **Document A58/17.**

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, **growth of the ageing population** ~~ageing~~, chronic conditions, malnutrition, **those injured by landmines,** war, violence, **especially domestic violence, AIDS, environmental degradation,** road-traffic, domestic **injuries, injuries caused by games** and occupational injuries, and other causes often related to poverty;

Stressing that 80% of people with disabilities**, particularly in the child population,** live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment;

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure **equality of opportunities and** good quality of life **for persons with disabilities** ~~regardless of disability~~;

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;[1]

Recalling the International Classification of Functioning, Disability, and Health (ICF) officially endorsed at the Fifty-fourth World Health Assembly in 2001;

Recalling also the United Nations World Programme of Action concerning Disabled Persons,[2] indicating inter alia that the sphere of responsibility of WHO includes disability prevention and medical rehabilitation;

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012) and the European Year of People with Disabilities (2003);

Recalling the United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

Mindful that the internationally agreed upon development goals as contained in the United Nations Millennium Declaration would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities;

Recognizing the importance of the early conclusion of the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities,[3]

1. URGES Member States:

(1) to strengthen national programmes, policies and strategies for the implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

(1*bis*) to increase awareness of the public at large of the importance of the issue of disability and to coordinate efforts of all sectors of society to participate in disability prevention activities;

(2) to develop their knowledge base with a view to promoting **and protecting** the rights and dignity of persons with disabilities and ensure their full inclusion in society**, particularly by encouraging training and protecting employment**;

(2*bis*) to take all necessary steps for the reduction of risk factors conducive of disabilities during pregnancy and childhood;

(3) to promote early intervention and identification of disability**, especially during pregnancy and** ~~especially~~ for children, and full physical, informational, and economic

[1] Adopted by United Nations General Assembly resolution 48/96.

[2] United Nations General Assembly resolution 37/52.

[3] United Nations General Assembly resolution 56/168.

accessibility in all spheres of life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;

(3*bis*) to implement family counselling programmes including premarital confidential testing for diseases such as anaemia and thalassemia along with prevention counselling for intra-family marriages;

(4) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;

(5) to facilitate access to appropriate assistive technology and to promote its development and other means that encourage the inclusion of persons with disabilities in society;

(6) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;

(7) to coordinate policies and programmes on disability with those on ageing where appropriate;

(8) to ensure gender equality in all measures, with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;

(8*bis*) to ensure equality at work, on satisfactory terms, for persons with disabilities;

(9) to participate **actively and constructively** in the preparatory work for the United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities,[1] **in order that it may be adopted, as soon as possible, by the General Assembly as a matter of priority**;

(9*bis*) to investigate and put into practice, under their specific conditions, the most effective actions to prevent the appearance of disabilities, with the participation of other sectors of the community;

(10) to ensure provision of adequate and effective medical care to people with special needs and to facilitate their access to such care including to prostheses, wheelchairs, driving aids and other devices;

(11) to research and implement the most effective measures to prevent disabilities in collaboration with communities and other sectors;

2. REQUESTS the Director-General:

(1) to intensify collaboration within the Organization in order to work towards enhancing quality of life and promoting the rights and dignity of persons with disabilities inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;

(2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;

(3) to support Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;

(4) to further strengthen collaborative work within the United Nations system and with Member States, academia, private sector, and nongovernmental organizations, including organizations of people with disabilities;

[1] United Nations General Assembly resolution 56/168.

(4*bis*) to contribute to the work of the Ad Hoc Committee responsible for preparing a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities;

(5) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;

(5*bis*) to promote studies of incidence and prevalence of disabilities as a basis for the formulation of strategies for prevention, treatment and rehabilitation;

(6) to produce a world report on disability and rehabilitation based on the best available scientific evidence;

(7) to promote a clear understanding of the contributions that people with disabilities can make to society;

(8) to report on progress in implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board**;**~~.~~

(9) to support Member States in taking the necessary steps to reduce the risk factors that lead to disabilities.

Ms YUAN (United States of America) proposed that, in subparagraph 1(2*bis*), the words "conducive of" should be replaced with "contributing to". Subparagraph 1(8*bis*) should be deleted or combined with subparagraph 1(2) since it repeated the idea of protecting employment and quality of work, which was contained in the latter paragraph. In subparagraph 1(9*bis*), the phrase "the appearance of" should be deleted because its meaning was unclear. In subparagraph 2(4*bis*), "appropriately," should be inserted after "to contribute" and subparagraph 2(8) should be moved to become the last subparagraph.

Dr BLOOMFIELD (New Zealand) proposed that subparagraph 1(3*bis*) should be amended by the insertion of a comma and the words "as appropriate," after "to implement".

Dr YOUNES (Secretary) read out the paragraphs with the proposed amendments, noting the proposal to delete subparagraph 1(8*bis*).

Mr HILMERSON (Sweden) proposed that subparagraph 1(9) should be amended by the deletion of "as soon as possible", in order to keep to the wording of the Health Assembly's resolution on the work of the Ad Hoc Committee. Moreover, the phrase "as a matter of priority" conveyed the idea of urgency.

The CHAIRMAN took it that the Committee approved the draft resolution as amended.

The draft resolution, as amended, was approved.[1]

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued from the fifth meeting)

Mr GUNNARSSON (Iceland) explained that different countries viewed alcohol differently, according to their particular cultures. As delegates had expressed widely divergent views on the subject, he requested that more time should be allowed for informal discussions.

The CHAIRMAN proposed closing the meeting early for that purpose.

The meeting rose at 12:05.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA58.23.

SEVENTH MEETING

Monday, 23 May 2005, at 15:00

Chairman: Dr M.A. RAHMAN KHAN (Bangladesh)

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

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued)

The CHAIRMAN said that, before the Committee resumed its consideration of the draft resolution, the Secretariat would respond to delegates' comments.

Dr LE GALÈS-CAMUS (Assistant Director-General), referring to alcohol use and HIV infection, said that WHO had recently published a report on the link between alcohol consumption, substance abuse, high-risk behaviours (including unsafe sex) and HIV/AIDS. Training modules had also been prepared for primary health care professionals on management of the comorbidity caused by HIV/AIDS, depression and alcohol consumption. A programme on gender and alcohol consumption was being implemented in three countries which mainly involved the screening and treatment of young women for alcohol problems. The link between road accidents and the harmful use of alcohol was a priority area for all the United Nations organizations concerned, and the Secretariat would work in accordance with the mandate conferred on it by the United Nations General Assembly in April 2004.

The likely cost of drawing up an international convention on alcohol was estimated to be US$ 33 million, based on the example of the WHO Framework Convention on Tobacco Control and the discussions that had been held in the Executive Board and the current Health Assembly. However, the figure was conservative, as it seemed likely that an instrument to regulate alcohol use would require longer and more difficult negotiation than the Framework Convention.

Mr GUNNARSSON (Iceland) said that, in an attempt to reach a consensus on the draft resolution, he had volunteered to find a text that would be as broadly acceptable as possible. Some delegates had wanted the text to remain unchanged. Others had approved of the first of the two amendments proposed earlier by the delegate of Thailand, namely to replace the word "Recalling", at the start of the first preambular paragraph with "Reaffirming"; there had been less support, however, for adding a footnote to subparagraph 1(1) making reference to the 10 best practices as described in document A58/18. An important amendment to emerge from his consultations had been the addition of a new, last preambular paragraph, to read: "Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word 'harmful' in this resolution refers only to the public health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way". Further proposed amendments were to insert the word "particularly" after the phrase "in the context of" in the fourth preambular paragraph; to reword the start of subparagraph 2(2) so that it read: "to consider intensifying international cooperation ..."; to add a new subparagraph 2(2*bis*), to read: "to consider also conducting further scientific studies pertaining to different aspects of the possible impact of alcohol consumption on public health"; and to replace the word "distributors" in subparagraph 2(8) with the expression "trade sectors".

Dr YOUNES (Secretary) re-read the proposed amendments to the draft resolution.

Mr HOHMAN (United States of America) requested that the amendments should be distributed in writing, so that delegations could consult with their governments.

Mr RECINOS TREJO (El Salvador) said that the Group of the Americas, on whose behalf he was speaking, was not in favour of the amendments proposed, particularly the insertion of a reference to best practices, and wanted further discussion. He therefore endorsed the request by the previous speaker and asked for the discussion to be postponed until the following day.

Mr SHEIKH (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the request for the amendments to be distributed in writing. He asked delegates submitting to their respective governments the proposed amendment referring to religious and cultural sensitivities to recall the clear sensitivities about alcohol consumption in that Region and the fact that the amendment was designed to make it easier to reach a consensus on the draft resolution.

Ms MAFUBELU (South Africa) reiterated her support for the amendments proposed by the delegate of Thailand, in particular the reference to the 10 best practices. She endorsed the request for a written version of the amendments.

The CHAIRMAN said that a revised text would be issued the next morning. The agenda item would be left open.

(For approval of the draft resolution, see summary record of the eighth meeting, section 3.)

The meeting rose at 15:45.

EIGHTH MEETING

Tuesday, 24 May 2005, at 09:15

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

1. THIRD REPORT OF COMMITTEE B (Document A58/59)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft third report of Committee B.

The report was adopted.

(For correction of the report, see summary record of the tenth meeting, section 1.)

2. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 22 of the Agenda (Document A58/40)

The CHAIRMAN invited the Committee to consider the report by the Secretariat and the following draft resolution on the United Nations reform process and WHO's role in harmonization of operational development activities at country level proposed by Algeria, Argentina, Australia, Belgium, Denmark, Finland, France, Guatemala, Israel, Jordan, Monaco, Netherlands, Norway, Romania, San Marino, Senegal, South Africa, Sweden, Switzerland, and the United Kingdom of Great Britain and Northern Ireland which read:

> The Fifty-eighth World Health Assembly,
>
> Taking note of the report on collaboration within the United Nations system;[1]
>
> Recognizing the primacy of national planning and priorities and, in this respect, the leadership of national governments for coordination of development activities;
>
> Mindful of the crucial importance of the United Nations reform process related, inter alia, to operational activities for development launched by the United Nations Secretary-General and aimed at both ensuring a better coordination of field level activities and delivering services in a coherent and effective way;
>
> Recognizing the contributions that WHO makes to such development activities;
>
> Mindful also of the need to ensure that United Nations operational activities for development include focus on the achievement of the internationally agreed development goals, including those contained in the Millennium Declaration;
>
> Mindful in particular of the ongoing exchanges of views among Member States generated by the United Nations Secretary-General's report "In larger freedom: towards development, security and human rights for all", which outlines actions he believes would make the United Nations a more effective and efficient instrument for forging a united response to shared threats and shared needs, including the reforming, restructuring and revitalizing of its major organs and

[1] Document A58/40.

institutions where necessary, to enable them to respond effectively to the changed threats, needs and circumstances of the twenty-first century;[1]

Determined to reduce the transaction costs of international cooperation in the field of health for both recipients and providers, and to improve its efficiency, monitoring, and reporting;

Eager to realize the unused potential offered by effective collaboration between organizations of the United Nations system, bilateral donors, global initiatives, and other stakeholders in advancing health development;

Recalling the adoption of United Nations General Assembly resolution 59/250 on the Triennial comprehensive policy review of operational activities for development of the United Nations system (22 December 2004), which calls for better coherence and coordination between United Nations entities at country level and for the simplification and harmonization of their rules and procedures;

Taking note of the Rome Declaration on Harmonisation (2003) and of the Paris Declaration on aid effectiveness, ownership, harmonization, alignment, results and mutual accountability (2005);

Willing to ensure a more effective use of human and financial resources at country level, avoiding in particular duplication of activities within the United Nations development system and the Bretton Woods institutions;

Noting the preliminary work under way at WHO on ownership, alignment, harmonization and results, WHO's active role as a member of the United Nations Development Group, and its efforts to strengthen country-level response in accordance with its mandate and through its country focus policy;

Underlining the importance of applying the "Three Ones" principle launched by UNAIDS and approved in resolution WHA57.14,

1. URGES Member States to ensure that operational development activities are planned and implemented in dialogue with, and under the stewardship of, the national government and in conformity with its priorities, while being aware of the coordinated efforts of bodies of the United Nations system carried in the context of the United Nations Development Assistance Framework;

2. REQUESTS the Director General:

(1) to ensure that WHO continues to implement country-level activities in accordance with Member States' priorities, and to coordinate the activities of WHO with those of other organizations of the United Nations system and, where appropriate, with other relevant actors working to improve health outcomes;

(2) to ensure that WHO staff and programmes at headquarters, and regional and country offices adhere to the international harmonization and alignment agenda, as reflected inter alia in the Rome Declaration and Paris Declaration, and actively participate in the preparation and implementation of the United Nations Development Framework, working closely with other members of the United Nations country team and in close collaboration with the United Nations Resident Coordinator at country level, in order to ensure coherence and efficiency;

(3) to take into account the Triennial comprehensive policy review of operational activities for development of the United Nations system, including gender mainstreaming and the promotion of gender equality, in order to guide WHO actions at country level, and to participate actively in examination of the Triennial comprehensive policy review at the Economic and Social Council and at the United Nations General Assembly;

[1] Document A/59/2005.

(4) in particular, to examine ways and take specific steps to further rationalize procedures and reduce transaction costs as outlined in Chapter 4, paragraph 36, of United Nations General Assembly resolution 59/250;

(5) to submit to the Fifty-ninth World Health Assembly, through the Executive Board, an interim report on progress in implementing this resolution and, to the Sixty-first World Health Assembly, a comprehensive analysis of WHO's contribution to implementation of United Nations General Assembly resolution 59/250, in particular the alignment of WHO's operational development activities at country level with those of the United Nations system and the impact of such a coordination effort on aid effectiveness and its monitoring.

Dr AL KHARABSEH (Jordan) said that coordination with the United Nations system and with other intergovernmental organizations was necessary to avoid duplication in financing and activities. It should not, however, constitute an impediment for WHO or provide a bureaucratic obstacle to the flexibility needed by the Organization to carry out its mandate.

Mr MARTIN (Switzerland), speaking as the coordinator for drafting of the resolution, announced that Canada wished to be added to the list of sponsors and that Algeria wished, with regret, to withdraw from the list.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) proposed the addition of the words "as agreed by the governing bodies" after "Member States' priorities" in subparagraph 2(1).

Ms RISSANNEN (IAEA) said that the Agency contributed to sustainable development through several programmes and established safety standards, some cosponsored by WHO, for the protection of health against ionizing radiation. IAEA had cooperated since 1959 with WHO on human health activities, was designing its programme on nutrition with WHO assistance and had a long record of providing essential equipment and staff training to diagnose and treat cancer patients safely with radiation technology. In the previous 25 years, it had invested some US$ 150 million in developing, maintaining and upgrading cancer diagnostic and radiotherapy centres worldwide. It supported cancer-related research and elaborated guidelines for safe and effective use of radiotherapy equipment and all other radiation sources. Through technical cooperation, it supported Member States in meeting their priority needs concerning food and agriculture, human health, water resources and the environment.

IAEA emphasized that cancer treatment should be part of a comprehensive cancer-control programme in developing countries. In 2004, the Programme of Action for Cancer Therapy had been launched to enhance that work, in order to ensure access to radiotherapy. In alliance with Member States, WHO and other relevant bodies, the Programme would provide support to developing countries in needs assessment, planning, design and implementation of comprehensive cancer-control programmes; a core strategy was being formulated and funds raised. A multidisciplinary team was being set up, a core intervention package was being defined, and preliminary site-selection criteria and guidelines were being identified. In the coming year a specific strategy for resource mobilization would be formulated and the foundation laid for key partnerships for the Programme. IAEA looked forward to increased collaboration with WHO to enhance global cancer-care capacity and offered its full support for the implementation of the resolution.

Ms KONGSVIK (Norway) commented on WHO's participation in the United Nations Development Group and the broader United Nations reform agenda for operational activities, and on WHO's follow-up to the Paris Declaration on Aid Effectiveness (March 2005). She commended WHO's active involvement in collective endeavours to make the United Nations' operational work more relevant where it most mattered, at country level, and in particular WHO's key role in facilitating participation by United Nations agencies in national strategies for poverty reduction and sector-wide

approaches. The Organization should take bold steps in that direction, strengthening its role at country level, and must become more proactive on issues such as rationalization of country presence through the establishment of common premises, the joint office model, and shared services. Although disappointed that the report contained no reference to the Paris Declaration on Aid Effectiveness, she expressed satisfaction at WHO's participation in the preparation of that seminal document and at the Director-General's statement on the subject conveying an impression of a United Nations that was determined to apply the principles of ownership, harmonization, alignment, results and mutual accountability.

She had noted with great interest the agreement to amend any legislation, rules and procedures that inhibited the Development Group's agencies from participating in sector-wide approaches and direct budget funding arrangements; to increase support for the development of national capacities for the management of such aid; to simplify programme procedures and make greater use of national systems for sector reporting, monitoring and evaluation, annual performance reviews, progress reports and procurement procedures; and to review staffing and skill mix at country level with a view to strengthening capacity for the provision of high quality "upstream" policy advice in key sectors and across sectors.

She commended WHO's work on elaborating those important commitments and looked forward to a comprehensive report on their implementation for consideration by the Health Assembly in 2006.

Mr MARTIN (Switzerland) proposed a slight amendment to the French version of the draft resolution: the word "*consisteraient*" was unnecessary and should be deleted from the seventh preambular paragraph.

Dr BOUDIBA (Algeria) confirmed that Algeria wished to have its name removed from the list of sponsors as it considered that a reference to the report issued by the Secretary-General of the United Nations in March 2005 should not be included in the draft resolution as that report had not received the endorsement of the international community.

The draft resolution, as amended, was approved.[1]

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

Public health problems caused by harmful use of alcohol: Item 13.14 of the Agenda (Resolution EB115.R5; Document A58/18) (continued from the seventh meeting)

The CHAIRMAN invited the Committee to consider the revised draft resolution, which incorporated a number of proposed amendments:

> The Fifty-eighth World Health Assembly,
>
> ~~Recalling~~**Reaffirming** resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on the Global Strategy on Diet, Physical Activity and Health;

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA58.25.

Recalling *The world health report 2002,*[1] which indicated that 4% of the burden of disease and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries;

Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence – especially domestic violence against women and children – disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasizing the risk of harm due to alcohol consumption**, particularly** in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognizing the threats posed to public health by the factors that have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol**;**

Taking due consideration of the religious and cultural sensitivities of a considerable number of Member States with regard to consumption of alcohol, and emphasizing that use of the word "harmful" in this resolution refers only to public-health effects of alcohol consumption, without prejudice to religious beliefs and cultural norms in any way,

1. REQUESTS Member States:

   (1) to develop, implement and evaluate effective strategies[2] and programmes for reducing the negative health and social consequences of harmful use of alcohol;

   (2) to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;

   (3) to support the work requested of the Director-General below, including, if necessary, through voluntary contributions by interested Member States;

2. REQUESTS the Director-General:

   (1) to strengthen the Secretariat's capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;

   (2) to **consider** intensify**ing** international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at global and regional levels;

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[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

[2] **For example, the 10 "best practices" as described in document A58/18.**

(2*bis*) to consider also conducting further scientific studies pertaining to different aspects of possible impact of alcohol consumption on public health;

(3) to report to the Sixtieth World Health Assembly on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol;

(4) to draw up recommendations for effective policies and interventions to reduce alcohol-related harm and to develop technical tools that will support Member States in implementing and evaluating recommended strategies and programmes;

(5) to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States and promoting research where such data are not available;

(6) to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems of their patients associated with harmful patterns of alcohol consumption;

(7) to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;

(8) to organize open consultations with representatives of industry and agriculture and ~~distributors~~**trade sectors** of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;

(9) to report through the Executive Board to the Sixtieth World Health Assembly on progress made in implementation of this resolution.

Mr GUNNARSSON (Iceland) proposed, to promote consensus, deletion of the footnote in subparagraph 1(1) as a compromise designed to accommodate the persistently differing views on the sensitive issues addressed in the draft resolution.

Dr SUPACHAI KUNARATANAPRUK (Thailand) acknowledged the concerted efforts of Member States, in particular Iceland, to find a compromise. The inclusion of the footnote in question had been proposed by his delegation, with the support of 15 Member States. Thailand, however, was willing to be flexible by withdrawing its amendment, if that would further the possibility of consensus.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the acceding countries, stressed that the draft resolution should be approved by consensus. To that end, she was equally prepared to demonstrate flexibility by supporting the proposal to delete the footnote.

Mr RECINOS TREJO (El Salvador), speaking on behalf of the Group of the Americas, reiterated his preference that the draft resolution should retain the wording contained in resolution EB115.R5. He was, however, prepared to support the amended version, taking into account the new Icelandic proposal. He commended the flexibility shown by the Thai delegation.

Ms BLACKWOOD (United States of America) also expressed her appreciation of that flexibility and voiced her support for the Icelandic proposal.

Ms MAFUBELU (South Africa) agreed with the previous speaker but emphasized that deletion of the footnote concerning best practices did not preclude further work on the subject, the outcome of which should be reported at future sessions of WHO's governing bodies.

Mr SHEIKH (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, praised the spirit of compromise, and expressed particular gratitude to the delegate of Iceland.

Mr SMITH (Jamaica) said that, although he agreed with the comments of the delegate of El Salvador in support of the draft resolution, he wished to place on record his concern about the proposed amendments to the original text of the draft resolution, which had been adopted by the Executive Board after lengthy discussion. In particular, the proposed change to the fourth preambular paragraph was unhelpful and deeply regrettable; it fundamentally altered the substance of the paragraph, which lost its focus on the harm due to alcohol consumption in the context of the three important elements mentioned.

Dr SUPACHAI KUNARATANAPRUK (Thailand) pointed out that he had favoured consensus by withdrawing his proposed amendment. However, he wished to place on record his deep concern about the need for Member States to choose proven and effective core strategies and measures for reducing alcohol-related harm. He requested that further efforts should be made to explore the effectiveness of such policies and interventions in a broader context; the findings could then be exploited when the recommendations referred to in subparagraph 2(4) were drawn up.

The draft resolution, as amended, was approved.[1]

The meeting rose at 10:05.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA58.26.

NINTH MEETING

Tuesday, 24 May 2005, at 15:20

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

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

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5) (continued from the fifth meeting)

Dr CHITUWO (Zambia), speaking in his capacity as chairman of the working group, confirmed that agreement had been reached on the two draft resolutions: the achievement of health-related Millennium Development Goals, which was set out in the report, and working towards universal coverage of maternal, newborn and child health interventions. The revised texts would be circulated.

The CHAIRMAN invited delegates to make general comments, deferring discussion of the draft resolutions to a later meeting after the revised texts had been circulated.

It was so agreed.

Dr KAPP-JOEL (Luxembourg), speaking on behalf of the Member States of the European Union, the acceding countries Bulgaria and Romania, the candidate countries Croatia and Turkey, and the countries of the Stabilisation and Association Process and potential candidate countries, Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that sound health systems were a prerequisite for universal access to primary health care, in particular in respect of maternal, newborn, child, and reproductive health. They would also facilitate the fight against AIDS, tuberculosis and malaria. The slow rate of progress towards the attainment of the health-related Millennium Development Goals was a matter of serious concern. The provision of additional resources for health programmes, the improvement of the coordination of all stakeholders, and the integration of health strategies in policies to reduce poverty were needed in order to strengthen health systems and attain the Goals.

The European Union was committed to supporting Member States, especially fragile countries, whose specific needs had to be taken into account. It supported the view that health should be treated as an exception to the rule with regard to public sector reform programmes in developing countries; and that it should benefit from an increase in public spending. The European Union would continue its dialogue with Bretton Woods institutions on the budgetary flexibility required for the fight against HIV/AIDS, tuberculosis, malaria and other health priorities. It was unacceptable that every 30 seconds a child under five years of age died in Africa of an easily treatable disease and that every minute a woman died in pregnancy or childbirth. No region had so far attained the Target relating to infant mortality. The right to good sexual and reproductive health, including contraception, must be recognized, and women's empowerment should be encouraged. The United Nations International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995) had stated that realization of those rights was essential to development and the fight against poverty. Without continued efforts in those areas, progress towards the Millennium Development Goals would be limited; the United Nations General Assembly high-level plenary meeting on the outcome of the Millennium Summit (New York, 14-16 September 2005) was expected

to confirm that link. A technical process to examine the best way to take those objectives and the indicators related to the fifth Millennium Development Goal into account would be a positive step.

The joint European Commission/WHO international conference on Women, Children and Newborn Health (Brussels, 4 May 2005) had already placed reproductive health, related rights and the rights of children at the centre of European Community development policy. The provision of access to information on and services for reproductive health was a vital aim, as recognized by the international community; it would be crucial for achieving the Millennium Development Goals. Questions relating to reproductive health and related rights should therefore be given special attention at the forthcoming high-level plenary of the United Nations General Assembly.

Tobacco use was also an important obstacle to attainment of the Millennium Development Goals and the European Union was therefore pleased that the WHO Framework Convention on Tobacco Control had entered into force.

Professor AKOSA (Ghana), speaking on behalf of the Member States of the African Region, said that five years after the Millennium Summit and 10 years away from the target date for the attainment of the Millennium Development Goals, the picture in the Region was grim; progress towards attainment of the Goals, including those related to health, had been slow and, if current trends continued, the target would not be reached. Urgent action was required to accelerate progress. Existing health interventions must be expanded and investment in the social sector increased. He therefore endorsed the key strategic directions proposed in the report. The draft resolution should be strengthened to ensure that greater attention was given to the crisis in human resources, which had arisen from international migration, the active recruitment of health workers from developing countries and inadequate investment in training to fill the resulting shortages in such countries. Developed countries should strive towards self-sufficiency in human resources and should support developing countries in doing likewise. Health systems in the African Region continued to be under-funded; Member States should be encouraged to fulfil the pledge made in the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases to set a target of allocating 15% of the national budget to health. Moreover, developed countries should strive towards allocating 0.7% of their gross national product towards overseas development support. Member States should continue working towards the ideals of the New Partnership for Africa's Development, including the promotion of good governance, and effective stewardship and use of domestic and international resources. The continued denial to some countries of much-needed funds because of political reasons was worrying. Sufficient resources should be provided by the international community to ensure that the targets were met in 2015.

The concerns of the African Member States in relation to the draft resolutions had been properly taken into account by the working group.

Mrs HESSEL (Denmark) strongly supported the Millennium Declaration and the Millennium Development Goals as the common framework for poverty reduction and the driving force for international development. WHO had an important role to play in the attainment of those Goals, in particular Goals 4, 5 and 6. She expressed appreciation for the focus in *The world health report 2005* on the health of mothers and children and the challenges ahead, especially in sub-Saharan Africa.[1] The report underlined the continued need to place firmly on the health agenda the goals and programme of the United Nations International Conference on Population and Development (Cairo, 1994) and its follow-up conference (New York, 1999), and access to reproductive health services. The report also focused on safe abortion, the large unmet need for contraception, and the need to integrate sexual and reproductive health and HIV/AIDS interventions more vigorously at country level. The WHO strategy on accelerating progress towards the attainment of international development goals and targets related to reproductive health, endorsed in resolution WHA57.12, represented a crucial policy tool and

[1] *The world health report 2005: make every mother and child count.* Geneva, World Health Organization, 2005.

guidance for the Organization's work concerning the goals of the 1994 Cairo Conference and the Millennium Development Goals. She welcomed the strategy's focus on the role of the Organization at the global level, ensuring accountability through the report on progress towards sexual and reproductive health as part of achieving the Millennium Development Goals. Adequate resource allocation by WHO, including regular budget funding, was crucial for timely and full implementation of the strategy. Full implementation of the Programme of Action adopted in Cairo in 1994 was essential to reducing poverty and, therefore, to achieving the Millennium Development Goals. Unfortunately, the Millennium Declaration and the Millennium Development Goals had not adequately reflected the goals of the International Conference on Population and Development in relation to the achievement of good reproductive health and reproductive health rights for all by 2015. Denmark would work with like-minded partners to ensure that population and development matters were once again placed at the centre of poverty eradication efforts.

She supported the proposal made by the United Nations Millennium Project Task Force on Child Health and Maternal Health that a specific target and associated indicators concerning universal access to reproductive health services by 2015 through the primary health care system should be established under Millennium Development Goal 5.

Mr NESVÅG (Norway) welcomed the strategic directions outlined in the report, in particular in relation to human resources for health, equity and gender concerns. Urgent action was needed to engage a full range of health workers and to implement the Programme of Action adopted in Cairo in 1994 and the WHO strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health.

WHO had a crucial role to play with respect to the Millennium Development Goals. At country level, it must move away from vertical disease-specific programmes and strengthen its focus on system-wide issues, providing high-class technical support on more comprehensive approaches to health systems development. WHO could also contribute to the attainment of the cross-cutting Goals, in particular poverty reduction, the promotion of gender equality, the empowerment of women, and building global partnerships for development. To that end, it should be more active in the reform of the United Nations at the global and country levels. Activities concerning the achievement of those Goals in the areas of maternal, newborn and child health, and sexual and reproductive health were seriously behind schedule. All Member States had a responsibility to act on prior commitments in those areas, including those undertaken in connection with the Programme of Action and the International Conference on Financing for Development (Monterrey, Mexico, 2002). Norway supported the proposal by the United Nations Millennium Project Task Force on Child Health and Maternal Health to add the target of universal access to reproductive health services by 2015 to Millennium Development Goal 5. Norway continued to support WHO's work in leading the global health efforts to achieve the Millennium Development Goals.

Dr QI Qingdong (China) expressed appreciation for the efforts WHO had been making to achieve the Millennium Development Goals. Nevertheless, it did not currently seem likely that the health-related Goals would be achieved within the agreed timeframe; there were many challenges, especially concerning developing countries. WHO needed to intensify its policy guidance and support to enable poor countries to formulate guiding principles and action plans that matched their own strategic vision, and to support capacity-building, thus enabling Member States to assume greater responsibility for attaining the Goals. WHO should also take the lead in harmonizing and coordinating technical and financial support among international development partners in health, and should urge other United Nations organizations to honour their commitments. At the country level, the Organization should play a key role in coordinating health-related activities in order to avoid duplication. It was also important to encourage cooperation among the Member States themselves at the national and regional levels with a view to sharing their experiences and measuring progress.

Dr SHANGULA (Namibia) recalled that Namibia's Vision 2030 and the Second National Development Plan incorporated the aspirations of the Millennium Development Goals. The Safe Motherhood Initiative had been introduced in 1991 and improvements had been recorded in relation to Millennium Development Goals 4, 5 and 6. Despite those successes, the HIV/AIDS epidemic in Namibia was being compounded by such factors as poverty, alcohol and substance abuse, cultural practices and ignorance. The prevalence rate of tuberculosis had also increased, rising from 629 per 100 000 in 1996 to 712 per 1000 000 in 2002. Nevertheless, he expressed confidence that Namibia would be in a position to meet most, if not all, of the Goals by the target date, and he urged approval of the draft resolution as revised by the working group.

Ms TANHUA (Finland) stressed two crucial, strategic points that should be the focus of WHO's activities in support of Member States. First, an effective health-care system staffed by enough properly trained health workers was vital to progress in achieving the health-related Millennium Development Goals. Strengthening such systems and supporting Member States' capacity accordingly were central to WHO's responsibilities and mandate as the leading global intergovernmental organization for health. Secondly, commitment to the Goals implied commitment to improving women's rights, in accordance with the 1995 Beijing Platform for Action. Indeed, sexual and reproductive health and rights were critical elements in achieving the three health-related Goals, particularly in relation to maternal health, child mortality and HIV/AIDS; she was therefore concerned at the planned developments involving the core budget. Considered in a disaggregated manner, the Goals could serve as indicators of the health status and level of equity of a country or population, if both health-system aspects and reproductive health and rights were taken into account.

Mr PALU (Australia) supported the key strategic directions outlined in the report, calling in particular for health to be placed within a broad development framework, health strategies to be incorporated in overall public policy, and efforts to be made to improve governance. Health systems had to be strengthened and reformed in order to help countries to improve health outcomes for their populations, and improved policies and institutions – in the health sector and beyond – were needed if progress were to be made. Developing countries required a commitment to sustainable, broad-based economic growth resting on good governance for any significant progress towards the Goals. He welcomed the recognition that development policies should seek gender equality and women's empowerment. He strongly supported the call for more attention on the health needs of people living in fragile States, for declining health status was widely held to be indicative of a country's systemic weakness, and the failure of governments to provide effective basic health services could undermine public confidence in their legitimacy. With Australia committed to helping to achieve the Goals, he endorsed the international consensus that policies and actions were required of both developing and developed countries to achieve them. He further welcomed WHO's commitment to harmonizing its efforts towards achieving the Goals within the United Nations system and to working actively in the context of current United Nations reform to heighten that system's impact and effectiveness.

Ms PEDERSEN (Sweden) said that WHO had a particularly important role to play in achieving those health-related Millennium Development Goals on which the least progress had been made, notably in the areas of maternal health and HIV/AIDS. Implementation of the Programme of Action of the 1994 International Conference on Population and Development was essential for ensuring security of individuals, reducing poverty and achieving the Goals. Since it was more important than ever to safeguard sexual and reproductive health and rights, she regretted that the Millennium Declaration and its associated Goals had not sufficiently reflected those adopted by the 1994 Cairo International Conference. Sweden would therefore strive to ensure that linkages between sexual and reproductive health and rights and socioeconomic development were made central to the global consensus on how to achieve the Goals. She expressed support for the proposal by the United Nations Millennium Project Task Force on Child Health and Maternal Health to establish a specific target and indicators,

under Goal 5, on universal access to reproductive health services by 2015, and urged WHO to contribute to that work.

Dr AZENE (Ethiopia) concurred with the delegate of Luxembourg that, since the major Goals were health-related, greater focus on health was required. Echoing the call from the delegate of Ghana to strengthen the resolution, he said that working towards universal coverage of maternal, newborn and child health interventions was important for Africa as a whole and all developing countries.

Dr AKASHI (Japan) said that, given their purpose of providing appropriate health services and so improving people's health, the Millennium Development Goals must be met. WHO's emphasis on human resources and health system development was welcome, but development partners should also provide technical support for policy-making in that area. Japan had been and would continue supporting sustainable human resource development in maternal and child health and in infectious disease control in many countries.

The period until 2015 had to be used effectively by developing countries, which should draw up a road map for overcoming obstacles to the improvement of human resources and health systems, and should monitor progress. Such countries should therefore improve health administration systems and their capacity to use assistance from development partners to good effect. He stressed the importance of collecting appropriate data for monitoring and evaluating progress to the Goals, and of strengthening national health information systems. Since collaboration with related organizations was a necessity, he supported the idea and aim of the recently launched Health Metrics Network.

Mrs HOMANOVSKA (Ukraine) reiterated her country's commitment to achieving the Millennium Development Goals, particularly those relating to health. Improving health provision was a priority in Ukraine, especially for the poor, and key strategy areas were maternal, child and reproductive health and the fight against HIV/AIDS and tuberculosis. Progress in achieving the Goals depended on the effectiveness of the national health system, which was under reform, and on an organized approach to family health, and priority had been given to training for family doctors. She welcomed cooperation between WHO, UNAIDS and other international organizations on the Goals, and the assistance provided to Member States in that regard.

Mr FERRER RODRÍGUEZ (Cuba) said that, according to the *Human development report 2003*,[1] if global progress continued at the same pace as in the 1990s, only the Millennium Development Goals with targets of halving extreme poverty and the proportion of people without access to safe water stood a realistic chance of being met, although the trends for HIV/AIDS and hunger were in the right direction. Of the health-related Goals, that of reducing child mortality by two thirds was the furthest from being achieved, and under-five mortality would decrease by a quarter rather than two thirds; much the same was true of maternal mortality. There was an almost unbridgeable gap between industrialized and developing countries and between the different regions and countries of the South in meeting all the Goals, with Africa suffering terrible living conditions. Ten million children died each year in the world, almost 99% of them in developing countries, and more than half those deaths were from diseases that were often preventable with a cheap vaccine. More than half a million women died annually from pregnancy-related causes, 99% of them in countries of the South. In monetary terms, 91% of medicines were consumed by 15% of the world's population.

According to *The world health report 2003*,[2] the rich countries had so far failed to live up to all their responsibilities under the compact, which included establishing fairer international trade policies,

[1] UNDP. *Human development report 2003. Millennium Development Goals: a compact among nations to end human poverty.* New York, Oxford University Press, 2003.

[2] *The world health report 2003: shaping the future.* Geneva, World Health Organization, 2003.

increasing official development assistance, delivering debt relief and accelerating technology transfer. Ridding the world of its ills called for less selfishness and more solidarity. In one developed country alone, military expenditure was US$ 500 000 million a year.

Cuba had achieved most of the Millennium Development Goals, particularly those related to health, and was making progress towards achieving others. He noted, for example, that in 2004, the infant mortality rate (5.8 per 1000 live births) had been the lowest in its history, placing Cuba among the 36 countries highest ranked by UNICEF. All Cuban children were vaccinated against 13 diseases, with a coverage of 95%, and the country had eradicated poliomyelitis, diphtheria, measles, whooping cough, rubella, mumps and the severe clinical forms of tuberculous meningitis and neonatal tetanus; several of the vaccines were produced in Cuba. In addition, at 0.05%, the prevalence of HIV infection in the 15-49 age group was the lowest in the Americas and one of the lowest in the world. Nearly 1800 patients received free treatment, involving six generic antiretroviral agents produced in Cuba and seven provided under a cooperation programme financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr GRONDIN (International Organization for Migration) supported efforts to develop a global partnership for better health for all and to mobilize collective action to achieve the health-related Millennium Development Goals. That needed consideration of migration and its impact on individual health and health systems. Most public health policies and health system management strategies had failed migrants and mobile populations. Migration of health-care workers had indeed had an impact on health systems in developing countries; the aim should be not to stop migration, but to manage its health implications. Achieving WHO's goals of global partnership and collective action for health demanded a change in behaviour, responsibility, accountability, and a coherent, focused approach.

Well-managed migration had an enormous potential for development, contributing, for example, to reducing poverty by providing opportunities for employment and education. It could also help to promote gender equality: between 49% and 51% of all migrants were women, and although they were more vulnerable to exploitation and the health risks associated with the migration process, that process could empower them by providing opportunities for education, access to health care, work experience and economic independence. Migrants returning home could be an important source of investment, entrepreneurship and experience. Remittances could enable migrants' families to purchase health services and medicines.

Migration of health-care workers compromised the ability of countries, particularly those with a heavy burden of disease, to provide efficient health services and threatened their capacity to fight diseases and to combat malnutrition. That situation had a profound impact on health systems and access to health services, creating a need for a migration management strategy in the context of human resources for health. Her organization was ready not only to work with WHO to implement resolution WHA57.19 on international migration of health personnel, but also to put migration on the global health agenda; to that end, the two organizations had developed protocols as a follow-up to the Memorandum of Understanding they had signed in 1999. Those protocols covered such issues as avoidance of duplication, accountability and programme evaluation, and activities for the period 2005-2007 in the areas of migration of health-care workers, migration in emergency settings, and migration in the context of mental health, communicable diseases, and gender issues.

Mrs WIENKAMP-WEBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Confederation of Midwives, expressed concern that insufficient progress was being made towards achieving the Millennium Development Goals. Attaining any one Goal depended on progress made towards achieving others. She particularly welcomed the emphasis in *The world health report 2005* on the importance of maternal and neonatal care from pregnancy onwards,[1] with skilled professionals on hand to act immediately when

[1] *The world health report 2005: make every mother and child count.* Geneva, World Health Organization, 2005.

unpredictable complications occurred. Chapter 4 of that report reflected the key message in the joint statement by WHO, her Council and the International Federation of Gynecology and Obstetrics on the critical role of skilled attendants and the need for them to have an enabling environment in which to operate. Midwives and nurses were experienced in the provision of care in a variety of settings but they could not build roads and health facilities, supply clean water, or manufacture and transport necessary drugs and equipment. She called on governments and nongovernmental organizations to work with the Council and the Federation to integrate those elements into a single care package and to ensure that it reached women and their families everywhere; achievement of Millennium Development Goal 8, which highlighted the need for effective partnerships, might be the key to success in those efforts. Both organizations would work with their member associations and others to support national and global initiatives that reflected commitment to progress towards the Goals, and particularly to a broad approach that acknowledged that such efforts were interrelated.

Dr PIRMOAZEN (International Medical Parliamentarians Organization), speaking at the invitation of the CHAIRMAN, drew attention to the fact that in many developing countries one woman died every minute in childbirth or owing to complications in pregnancy. Those deaths could be prevented through appropriate care, treatment and information, and the babies of women who had received prenatal and antenatal care were more likely to survive. In order to save thousands of women dying from unsafe abortions, appropriate services should be made available so that the need for abortion could be avoided. In many developing countries, political decisions could make the difference between life and death: it was for parliamentarians to develop policies that would save lives by increasing access to education and health services. The first step would be to review and develop legislation relating to health and to monitor its implementation.

Medical parliamentarians should work to mobilize resources for health-related issues, either from allocations in the national budget or from official development assistance. Despite the urgent need for reproductive health services, international financial support for them had decreased. Further funding was also required to protect people in developing countries from HIV/AIDS. Most preventable deaths in developing countries resulted from poor reproductive health and that should be included in the Millennium Development Goals, since preventable deaths were socially unjust and impeded economic development.

The challenges demanded cooperation and collaboration, and he urged the international community to join forces in meeting them. Medical parliamentarians, for their part, would work to create the political will needed to improve health-related development, notably in reproductive health.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed WHO's work in the area of maternal and child health. She urged WHO to formulate standards and regulating principles for disease-selective programmes to ensure that their impact on national health systems could be monitored; financial and technical resources from donors would have to be assured in that connection and impact reports should be shared transparently with all stakeholders.

Well-trained, well-supported and well-motivated health workers were essential to a functioning health system, and her organization would support implementation of resolution WHA57.19. She urged WHO and donors to support developing countries in tackling the crisis by providing long-term predictable financial and technical resources. The Fund's experience, and its research in eastern and central Africa, had shown that paying for health care led the poorest people further into poverty. A Save the Children report had highlighted the impact of such regressive financing measures as user fees, and had called for countries to move towards more pro-poor financial protection measures. She urged national health and finance ministers, WHO and donors to help to ensure that essential health services were free at the point of access. Urgent solutions were needed to support health-service delivery in fragile environments, and her organization would assist in developing the necessary knowledge base, while asking WHO, donors and academics to work with nongovernmental organizations to document best practice in such situations.

Health information systems and reporting on health-related Millennium Development Goals had to be improved, and health-system indicators should be added to that monitoring. Data should be increasingly disaggregated so that other social determinants of health could be more accurately monitored and measured. She asked WHO to clarify the progress made with the equity lens it had agreed to develop at the Fifty-seventh World Health Assembly.

Ms WYKLE-ROSENBERG (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, emphasized the need for the Secretariat to support Member States in monitoring the impact of international trade agreements on public health. Public health policy must be protected from interference by vested commercial interests, since, on issues ranging from tobacco to water to food, the profit motive of transnational corporations could run counter to the human right to health. The WHO Framework Convention on Tobacco Control set a new standard for the global regulation of industries whose products and practices were harmful to public health. Member States had recognized that trade liberalization could contribute to the spread of tobacco addiction, in that trade agreements were used to pressure developing countries to accept tobacco products, and had sought to protect public health over the interests of the tobacco industry.

Access to safe and healthy food and water was essential for life and good health and to meet the Millennium Development Goals. By 2025, some 3000 million people, 80% of them in developing countries, would suffer from water shortage. Water was rapidly becoming a commodity, in some poor communities an unaffordable luxury, with the help of trade agreements, and that trend should be monitored closely for its negative impact on public health, particularly in poor regions that lacked adequate access to water.

For the first time in history, as many people had too much to eat as there were people who did not have enough. The global epidemics of hunger and obesity had led to the adoption of the Global Strategy on Diet, Physical Activity and Health. As global food corporations and their trade associations maintained a hold over the world's food resources and wielded influence over trade agreements and global financial institutions, however, transparency and proper management of conflicts of interest were vital to the strategy's successful implementation.

She urged WHO to monitor trade agreements and financial institutions vigorously to ensure their consistency with the Goals, and recommended that the Secretariat and Member States participate in the process under way in the United Nations Commission on Human Rights further to develop human rights norms for the conduct of transnational corporations as an essential element of healthy, equitable development in the twenty-first century.

Dr LEITNER (Assistant Director-General) said that WHO needed to find the right focus in order to have the greatest possible impact on health development in the context of overall development. It would also have to alternate between focusing on halting and reversing trends in major diseases and on ensuring the existence of robust health systems with well-qualified, motivated health personnel where they were most needed. The need for that focus had not been so clear five years earlier, but one positive outcome of the debate was perhaps that it had helped clarify what strategic interventions were needed to ensure better health conditions for people all over the world.

There had also been recognition of the need for closer coordination of national efforts and international support, and for more partnerships between the public and private sectors. There was clearly a need not only for more investment in health but also for cost-effectiveness in the planning and use of such investment. Implementation must be guided by such considerations as equity and gender equality, with emphasis on vulnerable groups in society.

Mrs PHUMAPHI (Assistant Director-General) said that WHO with its partners had been endeavouring to develop and implement effective policies that respected the regulatory framework of the countries concerned, guided by the Millennium Development Goals, the conclusions of the International Conference on Population and Development (Cairo 1994) and the commitments made at numerous other international conferences and the strategies and resolutions adopted by the Health

Assembly. WHO had sought to collaborate with countries, for example, in developing frameworks to guide its work on HIV/AIDS and reproductive health. It was also formulating strategies for working with major partner agencies to achieve the health-related targets, and for reporting to the global community on the progress made towards attaining Goals 4 and 5. In preparing *The world health report 2005,* the Secretariat had adopted a similar approach based on extensive consultations with Member States and partners, in order to formulate policy briefs that went beyond the technical aspects of countries' health programmes to look at critical components of health systems, such as community engagement, human resources and funding. It had sought to focus on integration and the continuum of care, and on bridging the gaps in areas such as access to reproductive health care and making good the lack of resources, which were largely responsible for the lack of progress towards Goals 4, 5 and 6. It was aware of the need for a shift in focus, to ensure that the people and communities in developing countries derived real benefit from the Organization's work.

Dr CASSELS (Millennium Development Goals, Health and Development Policy) said that many of the points raised would be reflected in the revised versions of the draft resolutions. The Millennium Development Goals touched on a wide range of WHO's activities, and delegates had helped to identify priority areas. Clearly, increased investment was critical, but investment alone, without well-constructed health systems, would not yield the desired results. With regard to the importance of tackling the widespread crisis in human resources, he recalled the draft resolution on the international migration of health personnel (already approved by the Committee), which testified to the importance WHO attached to the issue. Certain countries were lagging behind in terms of attaining the Goals and would require additional support. In order to effectively address the issues, many of the strategies in support of the Goals had to be embedded in a broader public policy. The importance of partnerships across the United Nations system, including the Bretton Woods institutions, and new global partnerships for health had also been emphasized in the context of their potential impact on human resources and health systems. Attention had been drawn to cooperation between countries as a crucial ingredient in achieving the Goals.

(For approval of the draft resolutions, see summary record of the tenth meeting, section 3.)

The meeting rose at 16:55.

TENTH MEETING

Wednesday, 25 May 2005, at 09:25

Chairman: Professor J. PEREIRA MIGUEL (Portugal)

1. THIRD REPORT OF COMMITTEE B (Documents A58/59 and A58/59 Corr.1) (continued from the eighth meeting, section 1)

The CHAIRMAN drew attention to the third report of Committee B, which had been approved at the eighth meeting of the Committee. A typographical error, however, had subsequently been identified in the English version of the draft resolution entitled "Assessments for 2006-2007", contained in that report. The error had been rectified and the corrected text of the draft resolution was contained in document A58/59 Corr.1.

Ms WILD (Comptroller) apologized for the typographical error, which had arisen between the Board's 115th session and the Health Assembly. The figures in the document A58/59 Corr.1 corresponded to those in the document[1] submitted to the Board at its 115th session and thus reflected the Board's recommendations.

The report, as corrected, was adopted.[2]

2. FOURTH REPORT OF COMMITTEE B (Document A58/61)

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.[3]

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

Achievement of health-related Millennium Development Goals: Item 13.2 of the Agenda (Document A58/5) (continued from the ninth meeting)

The CHAIRMAN invited the Committee to consider the revised text of the draft resolution contained in document A58/5,[4] which read:

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[1] Document EB115/17.

[2] See page 356.

[3] See page 357.

[4] The Annex on "Health in the Millennium Development Goals" in document A58/5 is not reproduced here.

The Fifty-eighth World Health Assembly,

Having considered the report on achievement of the health-related Millennium Development Goals;[1]

Recalling the commitments made in the United Nations Millennium Declaration adopted by the United Nations General Assembly in September 2000[2] and the United Nations Secretary-General's road map towards its implementation;[3]

Recognizing that the internationally agreed development goals including all those contained in the United Nations Millennium Declaration, especially the health-related goals, mark a turning point in international development, represent a powerful consensus and commitment between rich and poor nations, and set clear priorities for action and benchmarks against which to measure progress;

Recognizing that health is central to achievement of the internationally agreed development goals, including all those contained in the United Nations Millennium Declaration, and that such goals create an opportunity to position health as a core part of the development agenda and to raise political commitment and financial resources for the sector;

Noting with concern that current trends suggest that many low-income countries will not reach the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, that many countries may achieve them only among their richer population groups, broadening the inequalities, and that urgent action is needed;

Recognizing the importance of using applicable human-rights instruments in efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Acknowledging that rapid progress will require political commitment and a scaling-up of more efficient and effective strategies and actions, greater investment of financial resources, adequately staffed and effective health systems, capacity-building in the public and private sectors, a clear focus on equity in access and outcomes, and collective action within and between countries;

Recognizing that internationally agreed development goals, including those contained in the United Nations Millennium Declaration, are complementary and synergistic and cannot be achieved in isolation as health is central to the achievement of non-health goals and their attainment will affect health targets, including those for HIV/AIDS, tuberculosis and malaria, and other targets set by the Health Assembly;

Recalling that at its Thirty-eighth session (April 2005) the Commission on Population and Development emphasized: "the importance of integrating the goal of universal access to reproductive health by 2015 set at the International Conference on Population and Development into strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, in particular those related to improving maternal health, reducing infant and child mortality, promoting gender equality, combating HIV/AIDS, eradicating poverty and achieving universal access to primary education";[4]

Recognizing WHO's leadership with the World Bank on the High-Level Forum on the Health MDGs (Abuja, 2004) and the impact this has had in catalysing action and progress on the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration;

Recalling resolution WHA55.19 which calls on the international donor community to increase its assistance to developing countries in the health sector; and which encourages

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[1] Document A58/5.

[2] United Nations General Assembly resolution 55/2.

[3] Document A/56/326.

[4] Draft resolution E/CN.9/2005/L.5, 11 April 2005, paragraph 3.

developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development assistance to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Development Countries (Brussels, 2001), and encourages developing countries to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

Noting that the Heads of State and Government of the Organization of African Unity at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) pledged to set a target of allocating at least 15% of their annual budget to the improvement of the health sector;[1]

Noting that many countries have cooperation and partnership mechanisms with civil-society, the broader community, religious organizations and the private sector which cover all levels of the administration (national, regional and district);

Recognizing the importance of action and empowerment for gender equality in bringing about more equitable and effective approaches to national development,

1. REQUESTS Member States:

(1) to reaffirm the internationally agreed health-related development goals, including those for health development contained in the United Nations Millennium Declaration;

(2) to develop and implement in the context of existing policy and planning processes nationally relevant "road-maps" on the achievement of the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, which incorporate the following actions to accelerate progress:

(a) prioritizing the internationally agreed health-related development goals, including those contained in the United Nations Millennium Declaration, within national development and health plans, including where appropriate Poverty Reduction Strategy Papers, plans that are led by national governments with support from development partners and civil society, and take into account the overall health priorities of the countries concerned; and ensuring that priorities for health and poverty reduction are reflected in associated budgets and expenditure frameworks;

(b) raising the level of funding for effective interventions that address health conditions relevant to the achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(c) implementing related Health Assembly resolutions, including resolution WHA56.21 on child and adolescent health, resolution WHA57.12 on reproductive health and resolution WHA57.14 on HIV/AIDS, which are components of a global partnership for development and crucial for attainment of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and the goal of universal access to reproductive health by 2015 set at the United Nations International Conference on Population and Development (Cairo, 1994); and establishing or sustaining national monitoring mechanisms for measuring progress towards achievement of the agreed goals;

(d) strengthening collaboration and partnership among relevant sectors, including ministries of finance, and with the international financial institutions, on investments in the health sector with a view to increasing the share of overall government resources allocated to health and, where appropriate, to revise ceilings on public-sector spending to allow for increases in health spending financed from development assistance;

[1] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

(e) strengthening the core functions of public or private components of the health system, as appropriate, in line with the Declaration of Alma Ata (1978) so that they contribute to the delivery of better and more equitable health outcomes in areas relevant to the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(f) improving health and nutrition information systems, including strengthening of vital registration systems, supported by critical health-systems research, in order to inform policy-making, while avoiding an increase in the reporting burden and emphasizing the need for data disaggregated by age, socioeconomic quintile, sex and ethnicity; and to strengthen monitoring and evaluation systems that promote accountability, empowerment and participation;

(g) to ensure that health and development policies are underpinned by a gender analysis and to strive for gender equality and women's empowerment;

(h) to strengthen equity and nondiscrimination in development efforts and to facilitate the empowerment and participation of the population in decision-making processes;

2. CALLS on developed and developing countries to address with shared responsibility the growing crisis of human resources for health; and on developed countries to strive towards self-sufficiency without adversely impacting on the human resource situation in developing countries and to provide support to developing countries to achieve self-sufficiency through planning, training, recruitment and retention of all categories of health professionals;

3. URGES developed countries that have not done so to make concrete efforts towards the target of 0.7% of gross national product (GNP) as official development association to developing countries, and 0.15% to 0.2% of GNP of developed countries to least developed countries, as reconfirmed at the Third United Nations Conference on the Least Development Countries (Brussels, 2001);

4. URGES developing countries to continue to build on progress made in ensuring that official development assistance is used effectively to help achieve development goals and targets;

5. URGES those countries which are Members of the African Union to fulfil the commitment made at the African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (Abuja, 2001) to set a target of allocating at least 15% of annual budget to the improvement of the health sector;[1]

6. REQUESTS the Director-General:

(1) to ensure that priority actions to support Member States in accelerating progress towards the internationally agreed health-related goals, including those contained in the Millennium Declaration, are reflected in the Programme budget 2006-2007, in future budgets, and in the Eleventh General Programme of Work; and to develop a coherent and adequately resourced strategy, with clear goals and deliverable products, for advancing work in the areas mentioned below, and to report to the Health Assembly on progress;

(2) to provide support to Member States, at their request:

(a) to develop outcome-oriented and adequately resourced policies and strategies for health development;

[1] Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, paragraph 26.

(b) to strengthen the capacity of public and private health systems, as appropriate, to deliver equitable outcomes on a national scale, through measures that require interdepartmental collaboration, and to convene and support nationally led teams that work with all local actors in order to facilitate access to all sources of financing; develop the education, recruitment and retention of health professionals; integrate community health workers into overall systems; and implement resolution WHA57.19 on international migration of health personnel;

(c) to identify vulnerable groups with specific health needs and to devise appropriate programmes that deliver equitable outcomes;

(d) to strengthen intersectoral linkages to address the social and environmental determinants of health;

(e) to engage in technical and policy dialogue with international financial institutions, including on the impact of their policies on health-related needs; to lead harmonization and coordination processes among development partners in health; and to ensure alignment of support around country priorities;

(f) to use appropriate monitoring and evaluation frameworks, including those related to universal access to reproductive health, that measure progress towards the internationally agreed health-related development goals, including those contained in the Millennium Declaration, in order to determine cost-effective programmes that achieve better health and nutrition outcomes without adding to the reporting burden in countries;

(g) to promote research that guides successful implementation of activities to achieve internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(3) to ensure that due attention is devoted to the particular health problems of countries emerging from conflict and other forms of crisis;

(4) to support actively and contribute to, in the context of reform of the United Nations system, heightening the impact and effectiveness of the United Nations Country Teams; to simplify further, harmonize and coordinate procedures within the United Nations system and with other partners; and to improve alignment of the United Nations inputs with national priorities;[1]

(5) to promote efforts that increase coherence and coordination in development assistance for health so that resources effectively strengthen broad-based health systems;

(6) to participate appropriately in the high-level plenary of the United Nations General Assembly on the outcome of the Millennium Summit (September 2005).

Dr CHITUWO (Zambia) proposed that, in the penultimate preambular paragraph, the words "including NGOs," should be inserted after "civil-society".

The draft resolution, as amended, was approved.[2]

The CHAIRMAN invited the Committee to consider the revised version of the draft resolution on working towards universal coverage of maternal, newborn and child health interventions, which incorporated amendments proposed by a working group and read:

The Fifty-eighth World Health Assembly,

Concerned by the high level of maternal, newborn and child morbidity and mortality in the world, by the fact that the maternal mortality ratio worldwide has not changed substantially

[1] See also resolution WHA58.25.

[2] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA58.30.

over the past decade, by the slow pace of progress in improving maternal, newborn and child health, by the growing inequalities between and within Member States, and by the continuing need to address gender inequalities;

Alarmed by the inadequate resources for maternal, newborn and child health and by the lack of appreciation of the great impact of maternal, newborn and child health in sustaining socioeconomic development;

Concerned by the inadequacy of vital registration and other data required to produce accurate information on maternal, infant and under-five mortality, on their breakdown by socioeconomic groups, on income quintiles, and on urban rural differentials;

Mindful that cost-effective interventions exist to meet the health needs of women, newborns and children;

Aware that care needs to be provided as a seamless continuum both throughout the life-cycle and spanning individuals, families, communities and the various levels of the health system, including reproductive health care, thus creating an integrated approach to maternal, newborn and child health;

Convinced that only through coordinated and concerted action and unprecedented resource mobilization at international and national levels will it be possible to deal with the global crisis that currently affects the health workforce and strengthen health systems in order to end the exclusion of the poor, the marginalized and the underserved;

Welcoming the increased commitment of the international community and WHO to the health of women, newborns and children, and to meeting the internationally agreed development goals, including those contained in the Millennium Declaration;

Recalling resolution WHA56.21 welcoming the strategic directions for child and adolescent health and development, resolution WHA57.12 adopting the strategy to accelerate progress towards the attainment of international development goals and targets related to reproductive health and aware of the need for stepping up efforts to achieve international goals for reproductive, maternal, newborn and child health and development, and resolution WHA55.19 which calls for an increase in investment in health in developing countries;

Recalling the goals and objectives of the World Summit for Children (New York, 1990), the Programme of Action of the International Conference on Population and Development (Cairo, 1994), and the Beijing Platform for Action of the Fourth World Conference on Women (Beijing, 1995) and their respective follow-ups; the United Nations General Assembly special session on HIV/AIDS (New York, 2001); the United Nations special session on children (New York, 2002);

Recalling also the Delhi Declaration on Maternal, Newborn and Child Health (April 2005);

Welcoming *The world health report 2005: Making every mother and child count* and the guidance offered by the associated policy briefs,

1. URGES Member States:

   (1) to commit resources and to accelerate national action towards universal access and coverage with maternal, newborn and child health interventions, through reproductive health care;

   (2) to establish or sustain national and international targets, and to establish monitoring mechanisms for measuring progress towards the achievement of agreed goals, particularly the target on universal access to reproductive health care by 2015;

   (3) to involve all key stakeholders, including civil-society organizations and communities, in setting priorities, developing plans and programmes, measuring progress and evaluating impact;

   (4) to improve the quality and completeness of vital registration and other relevant household-survey data, where appropriate, to reflect mortality differentials among mothers, infants and under-fives;

(5) to adopt and implement, in line with international agreements, the legal and regulatory frameworks to promote gender equality and protect the rights of women and children, including equal access to health care, with special attention for those thus far excluded, particularly the poor, the marginalized and the underserved;

(6) to ensure that national strategic-planning and budgetary processes include interventions at political and programme level to strengthen health-care delivery systems for effective and rapid advance towards universal coverage, including:

(a) realigning the content of programmes for maternal, newborn and child health and nutrition, incorporating their management structures and services, and embedding them in core development processes for health systems in order to ensure that reproductive health care is fully integrated;

(b) addressing the workforce crisis by drawing up national plans for development of human resources for health that include financial incentives and mechanisms for equitable deployment and retention, especially for rural primary care, so as to give the poor better access to care;

(c) building realistic scenarios, with their costing and budget implications, for scaling up the health systems required for delivering maternal, newborn and child health care;

(d) building the institutional capacity to manage appropriate financing reform, inter alia a move from user fees to prepayment mechanisms and pooling systems, including tax-based and insurance systems, in order to achieve the goal of universal access and financial and social protection;

(e) building a national consensus around the need for moving towards universal coverage, with mechanisms for predictable, sustained and increased funding; around maternal, newborn and child health at the core of the citizen's health care, including entitlements where appropriate; and around the human-resources-for-health crisis as a national priority;

(f) creating partnerships between government, civil-society organizations, private sector entities and development agencies to maintain the political momentum, overcome resistance to change, and mobilize resources;

(g) establishing participation mechanisms for not-for-profit civil-society organizations and religious organizations in order to strengthen accountability mechanisms and systems of checks and balances;

2. REQUESTS the Director-General:

(1) to strengthen the coordination, collaboration and synergies of WHO's programmes on reproductive, maternal, newborn and child health, its programmes on malaria, HIV/AIDS, tuberculosis and health promotion, and its programme on health systems development, in support of countries;

(2) to ensure that WHO fully participates in harmonization efforts within the United Nations system, supports efforts of Member States to establish policy coherence and synergies between and within national and international initiatives in maternal, newborn and child health, particularly between those taken by partners within the United Nations system and others;

(3) to support the efforts of national health authorities to ensure that reproductive, maternal, newborn and child health are systematically included in frameworks for socioeconomic development and plans to ensure sustainability;

(4) to further collaborate with relevant partners to produce information on health status inequalities, such as through UNICEF's Multiple Indicator Cluster Surveys or Demographic and Health Surveys, in order to inform appropriate and specific policy actions by all concerned partners;

(5) to intensify technical support to Member States for developing their institutional capacity for achieving international goals and targets through universal access to, and coverage of, reproductive, maternal, newborn and child health programmes, in the context of strengthening health systems;
(6) to mobilize the international community so that it commits the additional resources required to achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care;
(7) to declare an annual world maternal, newborn, and child health day in order to ensure continued global visibility of the reproductive, maternal, newborn and child health agenda and to provide an opportunity for countries and the international community to reassert their commitment to this issue;
(8) to report biennially to the Health Assembly on progress towards reducing exclusion and achieving universal access to, and coverage of, reproductive, maternal, newborn and child health care, and on the support provided by WHO to Member States to attain this goal.

Dr YOUNES (Secretary) drew attention to two typographical errors: the final part of the third from last preambular paragraph should read "the United Nations General Assembly special session on children" and the final part of subparagraph 1(2) should read "reproductive health by 2015".

Mr WIERINGA (Canada), observing that his country continued to support WHO and its partners strongly in their promotion of maternal and child health, commended their initiatives and the focus on the area through *The world health report 2005* and World Health Day 2005. The draft resolution, however, included no recognition of sexual and reproductive health or reproductive rights and failed to reaffirm strongly the goals of the International Conference on Population and Development. As such, it did not appropriately reflect the continuum of care that existed between reproductive health and maternal and child health. While not wishing to block consensus, Canada had therefore decided, with regret, to withdraw its sponsorship of the draft resolution.

The draft resolution, as corrected, was approved.[1]

4. FIFTH REPORT OF COMMITTEE B

Mr YEE Ping Yi (Singapore), Rapporteur, read out the draft fifth report of Committee B.

The report was adopted.[2]

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 09:40.

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[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA58.31.

[2] See page 357.