COMMITTEE A

FIRST MEETING

Tuesday, 23 May 2006, at 09:15

Chairman: Dr A. RAMADOSS (India)
later: Dr K. LEPPO (Finland)

1. OPENING OF THE COMMITTEE: Item 10 of the Agenda

The CHAIRMAN welcomed participants and introduced Mr M.N. Khan and Dr Hansen-Koenig, who would attend the Committee's meetings in their capacity as representatives of the Executive Board.[1] Any views they expressed would therefore be those of the Board, not of their national governments.

He drew the Committee's attention to the proposals by the Committee on Nominations for the posts of Vice-Chairmen and Rapporteur.[2]

Decision: Committee A elected Dr K. Leppo (Finland) and Dr P. Mazzetti Soler (Peru) as Vice-Chairmen and Dr A. Cissé (Guinea) as Rapporteur.[3]

2. ORGANIZATION OF WORK

The CHAIRMAN encouraged delegates to participate in the debate but to limit the length of their interventions to three minutes. He suggested bringing forward agenda item 11.11, on Intellectual property rights, for consideration after agenda item 11.3, and beginning the discussion of agenda item 11.17 with the subitem on strengthening nursing and midwifery, so that Her Royal Highness Princess Muna Al-Hussein of Jordan, the WHO patron for nursing and midwifery, could address the Committee at that meeting.

It was so agreed.

DR GREGORICH-SCHEGA (Austria), speaking on behalf of the Member States of the European Union, said that the acceding countries Bulgaria and Romania, aligned themselves with her statement. Competences within the European Union were shared between Member States and the European Community, represented by the European Commission. Although the Commission had observer status with WHO, its observers were not authorized to participate in the work of subcommittees or other subdivisions such as drafting or working groups, unless invited to do so under Rule 48 of the Rules of Procedure of the World Health Assembly. According to Rule 86, that also

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[1] By virtue of Rules 44 and 45 of the Rules of Procedure of the World Health Assembly.

[2] See page 254.

[3] Decision WHA59(4).

applied to committees of the Health Assembly. She therefore requested the Committee to invite the European Commission to attend any drafting or working groups it might establish.

Mr BURCI (Legal Counsel) recalled that a similar request had been put to the Executive Board at its 117th session. The Board had agreed to invite the Commission to participate in working and drafting groups on items falling within the competence of the European Community.[1]

Mr HOHMAN (United States of America) said that he had no difficulty with the request, but would like the European Union to state for which items competence was shared, and to explain which items were specific to either the European Union or the European Community.

Dr GREGORICH-SCHEGA (Austria) proposed that, whenever a working or drafting group was convened, her delegation, representing the Member State holding the Presidency of the Council of the European Union, would provide that information.

The CHAIRMAN said that he took it that the Committee agreed to the request on that understanding.

It was so agreed.

3. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda

Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005): Item 11.1 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R7 and Annex 4, A59/4 and A59/5)

Mr M.N. KHAN (representative of the Executive Board) said that at its 117th session the Board had recognized the threat of an influenza pandemic to all countries.[2] The Board, commending the high level of global collaboration to combat the shared threat, had called for continuing action by WHO in order to maintain the present spirit of cooperation. Preparedness activities must also be initiated and led at the national level.

The Board had identified priority needs, major problems facing countries and strategies for dealing with them. Surveillance and early warning systems, epidemiological and laboratory capacities needed improvements in order to strengthen global defences against all epidemic-prone diseases. Many countries lacked the information technology needed for rapid reporting within the time frames set out in the International Health Regulations (2005). The current early warning system could not be fully reliable until more countries had the capacity to detect, diagnose and report human cases immediately. Rapid intervention soon after the start of a pandemic, involving mass prophylactic treatment with antiviral medicines, was a challenging but important opportunity to avert a pandemic or at least slow its initial spread. WHO's prompt efforts to prepare an operational protocol for such intervention was appreciated, although that in turn depended on national detection and reporting capacities. The Board had asked WHO to continue to coordinate relevant research. It had expressed its strong support for the draft resolution contained in resolution EB117.R7 calling for the immediate voluntary implementation of relevant provisions in the Regulations.

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[1] See document EB117/2006/REC/2, summary record of the first meeting, section 1.

[2] See document EB117/2006/REC/2, summary record of the second meeting.

Dr SOMSAK AKKSILP (Thailand) welcomed the draft resolution. However, paragraph 2(4) would be difficult to implement, because it involved multisectoral intervention and might need changes to national laws and regulations. In paragraph 4(4) the phrase "for non-commercial purposes only" should be inserted after "other novel influenza strains". The words "or pandemic influenza" should be added at the end of paragraph 4(7). In paragraph 5(4), the word "temporary" should be deleted; it was not clear why the influenza pandemic task force should be a temporary mechanism. In order to clarify the meaning of the words "affected countries", the description "avian influenza or pandemic influenza" should be inserted before those words in paragraph 5(5(b)). Paragraph 5(5(d)) should be deleted; the International Health Regulations (2005) would enter into force in June 2007, and voluntary compliance would be monitored for only one year.

Dr HOSSAIN (Bangladesh) expressed support for the draft resolution. No case of avian influenza or human infection with H5N1 virus had yet been reported in his country, but a national pandemic-influenza preparedness and response plan, drawn up with the support of WHO and FAO, had been approved in April 2006. It provided a strategic framework for coordinating the action of various sectors and stakeholders and would facilitate the mobilization of resources for immediate and long-term capacity building in the health sector in order to implement the International Health Regulations (2005). The numerous actions already taken or under preparation, many with the support of WHO, included the mobilization and allocation of funds, setting up a technical committee and a rapid response team, the planning of national strategic guidelines, the development of a surveillance and early detection system, provision for the procurement of equipment and medicines, and training and capacity building in research, detection and response, including building infrastructure.

Dr GREGORICH-SCHEGA (Austria), speaking on behalf of the European Union and its Member States, said that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia, and Turkey, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina and Serbia and Montenegro aligned themselves with her statement. Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005), was central to the agenda of the Health Assembly. WHO, FAO and OIE were the primary international organizations for standard setting and dealing with health issues relating to avian and human pandemic influenza. She endorsed those organizations' global strategic framework for avian influenza control and pandemic influenza preparedness. At the 117th session of the Executive Board the European Union had explained its position concerning the efforts of the international community to combat avian influenza and to increase preparedness for a possible human influenza pandemic. She also emphasized WHO's role in vaccine research.

The European Union placed emphasis on a common information policy, in order to avoid conflicting or confusing media messages in the event of an outbreak of pandemic human influenza. An informal meeting of European health ministers had been held (Vienna, 24 February 2006) in order to identify possible mechanisms for coordinating communications in a time of crisis. A European-wide network of ministerial press officers had been set up in order to facilitate coordination in crises. She emphasized rapid information sharing and making available biological specimens from suspected and confirmed cases in humans or animals.

On 6 and 7 June 2006, a Senior Officials Meeting on Avian and Human Pandemic Influenza would be held in Vienna in order to review current developments in different regions of the world, and discuss policies for the future. It would also examine the status of pledges made at the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006) in support of country, regional and global programmes, and improved coordination between the various mechanisms available. Those pledges should be rapidly honoured, so that WHO and other international organizations could play their part in combating influenza.

In its statement to the Executive Board, the European Union had underlined the importance of the Regulations as the key global instrument for protection against the international spread of disease. It therefore supported the draft resolution recommended in resolution EB117.R7.

Mr HAGE CARMO (Brazil) expressed support for the proposals to strengthen preparedness and response, and especially those arising from the joint WHO, FAO, World Bank and OIE meeting on avian influenza and human pandemic influenza (Geneva, 7-9 November 2005). Special attention should be given to Latin America and to other subregions in order to improve vaccine development and viral, laboratory and medical assistance. His country was improving standardization, transparency and exchange of information in order to establish a cooperation mechanism to deal with epidemiological emergencies. He supported the draft resolution.

Dr MELNIKOVA (Russian Federation) emphasized that every State should be focusing on early detection and control of the avian influenza virus. National epidemiological surveillance systems for influenza should be strengthened and systems set up in order to give an early warning of disease outbreaks and respond to them. Scientific research should be expanded and new methods of prevention, diagnosis and treatment developed. Close cooperation among countries was necessary in order to ensure rapid and transparent exchange of information, including sharing samples of new strains of influenza capable of leading to a pandemic.

Based on its experience of preparing to combat the threat posed by avian influenza and a possible pandemic, the Russian Federation was willing to engage in scientific and technical cooperation with countries that needed to strengthen their public health systems, including staff training and clinical diagnosis. With a view to enhancing regional cooperation, it had assumed responsibility for capacity building in health systems in central Asian and eastern European countries including influenza surveillance, staff training and information sharing. Using the Vector State Research Centre of Virology and Biotechnology as a base, the Russian Federation was planning to establish an influenza reference laboratory to serve as a WHO collaborating centre for countries belonging to the Commonwealth of Independent States; that would help coordinate regional research and prevention measures.

She endorsed the measures being taken by WHO against a possible influenza pandemic and WHO's coordinating role. She welcomed the draft resolution, an important basis for exchanging epidemiological information and ensuring prompt response in the event of a pandemic. She requested information on the establishment and functioning of the Avian and Human Influenza Trust Fund established at the Beijing Conference in January 2006, including information on donor countries, the size of the Fund, the sums donated, and the payments made. Would the Trust Fund be discussed at the meeting of senior officials on avian and human pandemic influenza (Vienna, 6-7 June 2006)?

Ms RASMENI (South Africa) said that she favoured voluntary implementation of certain sections of the International Health Regulations (2005), and commended the draft resolution. The adoption of the Regulations was opportune because the world was at risk of a human influenza pandemic. Their implementation would ensure maximum security against the international spread of disease, and minimize interference with the movement of people and goods. Although they would strengthen defence against infectious diseases, they did not exempt Member States from individual responsibility to increase their domestic preparedness and capacity to manage any public emergency effectively. She urged all Member States to support the draft resolution.

Dr BLOOMFIELD (New Zealand) said that his country had taken a government-wide approach to pandemic-influenza preparedness and response. Early compliance with the relevant articles of the International Health Regulations (2005) would contribute to pandemic preparedness within and between countries. In general, New Zealand would be able to comply with most of the articles. It encouraged Member States to ensure voluntary compliance with all the articles of the Regulations relevant to pandemic preparedness as speedily as possible, and to move towards full and formal compliance with the regulations by June 2007. He approved the broad thrust of the draft resolution.

Mr RODRÍGUEZ SUÁREZ (Mexico), supporting the draft resolution, emphasized the need to ensure equitable access by all countries to the resources available in order to deal with a pandemic once it had begun. Stocks of antiviral medicines and vaccines were currently insufficient to provide

access for all who might be affected. Ways must be explored of producing vaccine outside the countries that had the necessary technology and especially in other countries at an intermediate level of economic development. Mexico was one of those countries, and would be glad to benefit from the relevant technology while respecting intellectual property requirements. Impetus must also be given to research into new forms of vaccine production, since the current supply of vaccines was inadequate for timely coverage of all the population at risk.

Access to antiviral medicines was also crucial. Mexico was strongly in favour of WHO possessing a reserve stock, but three million treatments did not seem enough to cope with a global crisis. All governments were responsible for establishing their own stocks, but without a guaranteed international reserve little could be done to reduce the impact of a pandemic. In view of those risks, non-pharmacological control measures were also a vital necessity, and that called for a clear, internationally accepted policy, based on sound science and the available evidence.

Mr VALAŠEK (Slovakia) welcomed the new WHO initiative. The revised Slovak pandemic-preparedness plan, based on WHO guidelines, had been in effect since November 2005 and was in line with European Union and WHO recommendations. In November 2005 the Slovak Republic had participated in Common Ground, an exercise simulating a pandemic influenza outbreak, which had resulted in a review of preparedness measures. A mission in April 2006 by the European Centre for Control and Prevention had written a highly favourable report on Slovakia's performance, but highlighted the need to increase influenza vaccination coverage and to improve communication strategy. His country was working intensively on implementing the International Health Regulations (2005). WHO should organize a meeting for country IHR focal points in order to enable countries to share their problems and achievements.

Dr SELUKA (Tuvalu) said that the Regulations encouraged all countries to work together in a global partnership in the event of an epidemic. They were also a stimulus to the revision of national health regulations. Tuvalu was developing a national influenza pandemic preparedness plan. He emphasized the critical role of all countries, including Chinese Taiwan, in preparing for a pandemic.

Dr JACKLICK (Marshall Islands) said that his country had drafted a plan for pandemic influenza preparedness. With the threat of emerging diseases, however, it was important to implement the International Health Regulations (2005) at both country and global levels, and he supported the draft resolution. He drew attention to the burdens of other diseases.

His country was committed to working with other Member States to accomplish the mission of WHO and the vision of a free, safe and healthy world. It fully supported Taiwan's partnership in the Global Outbreak Alert and Response Network and its participation in WHO technical meetings as an observer.

Professor LAMBO (Nigeria), speaking on behalf of the Member States of the African Region, pledged full support for the strengthening of pandemic-influenza preparedness and response, including implementation of the International Health Regulations (2005). Confirmation of the presence of H5N1 influenza virus in the African Region was of great concern for both human and animal health; States were not yet adequately prepared for an influenza epidemic. It would be difficult to track the incidence of sickness among the many households and smallholdings which kept flocks of birds, especially in rural areas. Such households traditionally slaughtered and ate birds when signs of sickness appeared. It would be difficult to kill all the affected birds, compensate the owners, and prevent the spread of disease to humans. Concerted action was required, under government leadership, by all sectors, stakeholders and development partners. Even sporadic human cases would create enormous challenges for national health systems, which were already fragile and overburdened. Only a few countries had national surveillance systems sensitive enough to pick up clusters of human cases, and laboratory confirmation was expensive and very demanding of scarce skilled manpower. Implementation of the Regulations within the framework of a regional strategy of integrated disease surveillance would strengthen core capacities to cope with a possible human pandemic.

The Region's key achievements to date included: (1) the establishment of an ad hoc expert panel on avian influenza in order to guide Member States in preparing their response, including collaboration between national animal health and human health authorities; (2) preparation of a regional preparedness and response plan for 2006-2007 by the Regional Office for Africa and its adoption at the regional meeting on avian influenza held at Brazzaville in January 2006; (3) holding a regional United Nations conference in Libreville in March 2006, at which a declaration on avian influenza had been adopted; (4) the development by more than two thirds of Member States of national integrated multisectoral preparedness and response plans, including components on communication and social mobilization; (5) the establishment of a regional network of influenza laboratories; and (6) the provision of technical and logistical support to affected countries, in order to strengthen their national capacities.

Many challenges remained. Collaboration and coordination among the various sectors were weak, as were the health systems. Health-care services were fragile and laboratory capacity to confirm diagnoses was small. High-risk traditional and cultural practices prevailed, encouraging transmission of infection. Rural people feared becoming poorer, because poultry breeding made a significant contribution to their income and nutrition. Maximum commitment and political will were required on the part of governments, especially in mobilizing the relevant sectors and stakeholders. The Region was proposing an ongoing role in that respect for the African Union and subregional bodies, so as to secure proper collaboration and coordination among countries. Much as the countries in one Region appreciated the donations and pledges recorded at the Beijing conference on avian and human influenza, no African country had been earmarked to benefit from the roughly US$ 1900 million pledged at that forum. He pleaded for a fair share for African countries, and suggested that funds provided for applicant countries should take the form of grants and subsidies, not loans. It would also be appropriate to assist African countries with technical expertise in the light of individual country needs. He supported the draft resolution.

Dr SANOU (Burkina Faso) welcomed the proposals for early implementation of the International Health Regulations (2005). In February 2006, his country had adopted a national multisectoral prevention and response plan for avian influenza which involved action in the sphere of human and animal health, the environment and communications and had drawn on technical and financial assistance from all his country's partners, including Taiwan. The planning had been timely, because on 3 April 2006, the presence of the H5N1 virus among poultry had been confirmed, although no human case had been suspected or detected to date. Burkina Faso had already notified WHO of its IHR focal point. The same agency was responsible for tracking human influenza of avian origin and complementing the Regulations, so creating a link between the two functions. He welcomed the draft resolution, which would prove to be a test-bed for some articles of the Regulations.

Dr AKIZUKI (Japan) said that there was a growing risk of a new pathogenic avian influenza virus with the capacity, through mutation, of human to human transmission. No nation could ignore the threat. Since October 2005, numerous international conferences had been held on the subject, and various countries and regions had begun to prepare action plans, following international guidelines and protocols. The International Health Regulations (2005) were a crucial element in that process, providing timely information while ensuring transparency. She endorsed the draft resolution as a major international commitment to shared responsibility.

In order to assist in implementing the Regulations, particularly in affected countries, Japan had announced an assistance package of about US$ 155 million. It would cover strengthening surveillance, a communications campaign, human resources development, the stockpiling of 500 000 courses of antiviral agents and the provision of influenza test kits and personal protection equipment for 700 000 people. Japan's assistance for measures against avian and pandemic influenza would be further expanded.

The thorough implementation of the Regulations called for greater efforts by all countries. They should review progress and resolve impediments to compliance with the Regulations.

Dr Leppo took the chair.

Dr CUYPERS (Belgium) said that his country had already begun to implement the International Health Regulations (2005), especially with regard to capacity-building. A supplementary budget had been introduced to strengthen capacity at airports, together with a surveillance system for early detection, pursuant to Annex 2 of the Regulations. In the context of its preparedness for a possible influenza pandemic, Belgium emphasized an intersectoral approach, involving planning, training and exercises. The Government had established a committee in order to coordinate the work of all its ministries and federal agencies; it was developing a plan of action against the propagation of avian influenza, and studying the likely socioeconomic impact of a pandemic. Its approach was similar to that of United Nations organizations. In its public health measures, Belgium was guided by WHO. International travel had considerable implications for the spread of epidemics and called for measures beyond the scope of individual Member States. WHO should ensure coordination among various parties involved in passenger flights, especially the airlines. Measures to trace contacts and inform passengers would enable Member States to take rapid and effective action. Effective and accessible vaccines must be developed in sufficient quantities, being the second line of defence if initial control measures failed to cope. WHO should assign a high priority to the development of vaccines. It should also tackle the global shortfall in production and its over-concentration in certain regions, together with the problem of timely provision and accessibility of vaccines. WHO should be working with scientists and industry to solve those problems. His Government was fully behind its efforts.

Dr BOR (Turkey) said that 2006 was proving to be a challenging year for many countries in combating the threat of avian influenza. Turkey had so far succeeded in overcoming it. Some cases had been observed in eastern Turkey at the end of 2005, the first human cases being confirmed on 4 January 2006. Observing the principle of transparency and rapid communication, Turkey had informed the international community the very same day. Owing to the effective measures it had taken, there had not been one human case in Turkey since 13 January 2006. During the 2005 outbreak Turkey had cooperated closely with international institutions such as WHO, FAO, OIE, the European Union, the Centers for Disease Control and Prevention in the United States of America and the European Centre for Disease Prevention and Control.

For the first time in history, a disease was under discussion before the pandemic had occurred. The entire world had to be vigilant. International organizations, especially WHO, were striving to ensure that all countries were prepared. Most of them already had national pandemic-preparedness plans.

Several practical lessons could be learnt from the hard work done with the help of international experts, including the gains to be made by training and equipping health workers, veterinary staff, cull teams and local authorities in order to recognize human cases in time and so reduce mortality rates. Health institutions in areas at risk must have sufficient equipment and personnel. Samples must be transported safely and quickly; delays might arise during national and international holidays and because of biosafety problems. National laboratories must be adequately prepared, and shared experience would be valuable in that respect. Rapid cooperation with WHO collaborating centres was important, and that necessitated a common language in terms of data analysis, calibration, interpretation of results and terminology. Transparency and speedy communication were crucial. Failure by any country to commit to those standards would be putting short-term interests before global health. In order to ensure adequate collaboration among government agencies, there should be a coordinating authority acting as a national focal point, using a common language and supplying the media with reliable information while managing resources rationally. She was pleased that the draft resolution reflected the same approach. In addition to cooperation between countries and relevant international organizations, the various institutions must harmonize their efforts. In the case of Turkey, WHO had successfully led the cooperative effort required.

The role of the press in creating public awareness was unquestionable. Accurate information was a key tool in crisis management. The media should create awareness without causing panic. In a

crisis, problems could arise from the concern to ensure safety of travel, resulting in complicated and frantic procedures, further exacerbated by fears for the economy.

She was grateful to the Director-General and the Regional Director for Europe for their support in dealing with Turkey's avian influenza cases.

Dr MEZA (Honduras) endorsed the draft resolution. Her Government's national pandemic-influenza preparedness plan provided for keeping local officials informed, strengthening epidemiological and laboratory vigilance, enhancing the capacity to respond to outbreaks and epidemics, vaccinating vulnerable groups against common influenza, providing basic medicines, strengthening radio communication networks in the areas most at risk, and setting up a national fund in order to cover the cost of epidemic control. Her Government was also planning a national committee with its own chain of command in order to deal with any influenza pandemic and a legal framework for the national plan. It would expand epidemiological and laboratory surveillance to cover the monitoring of animals, comply with the International Health Regulations (2005), and educate and inform the public. Within its national network of services, it would endeavour to improve intensive care units and isolation wards in hospitals, expand hospital and primary care provision, and standardize patient management procedures.

Taiwan was a partner in health, because its geographical location made it susceptible to the spread of avian influenza. That was also a gap in the Global Outbreak Alert and Response Network, and a risk for all. Her country therefore favoured the participation of Taiwan, through its Center for Disease Control, in the work of WHO.

Dr LI Jianguo (China), speaking in exercise of the right of reply under Rule 59 of the Rules of Procedure of the World Health Assembly, said that in the course of the discussion delegates had referred repeatedly to Taiwan. It was a fundamental principle of WHO that Taiwan was part of China, and no Member State could use the discussion as a pretext for challenging that principle. References to Taiwan as an observer and as a participant in the proceedings posed an unacceptable challenge to China, and he therefore requested that such references be removed from the record.

The CHAIRMAN said that the concerns expressed by the Chinese delegate had been noted.

Mr HOHMAN (United States of America), on a point of order, requested clarification from the Legal Counsel as to whether a Member State could request changes to statements made by other Member States in the official records of committees.

Mr BURCI (Legal Counsel) explained that the summary records of committees accurately reflected the statements made by delegates. The Secretariat could not censor such records in any way, nor could it delete parts of statements at the request of a Member State.

Professor TLOU (Botswana) commended WHO's support to countries affected by the avian influenza epidemic, and its guidance to other countries on raising awareness of the challenges of human influenza epidemics. In the absence of prompt control measures backed by good surveillance, the disease could spread worldwide and epidemics could last for years, and the fact that the virus had the potential to undergo multiple genetic variations could reduce the effectiveness of long-term stockpiling of vaccines and antiviral agents. The rapid spread of the disease among birds in Asia, Europe, the Middle East and Africa posed a threat to the socioeconomic stability of all countries, and occurrences of avian influenza virus infection in humans caused even greater concern. Her Government, including the Ministry of Agriculture, and with guidance and support from WHO, FAO and OIE, had made progress in raising awareness about avian influenza. A national multisectoral pandemic-influenza preparedness and response plan had been drawn up in accordance with the International Health Regulations (2005), and a multisectoral task force and technical working group had been established in order to strengthen surveillance, planning and response in line with the draft resolution, which she fully supported. Her Government looked forward to further assistance in

strengthening its response capacity, including laboratory capacity to detect human cases of the virus. It commended WHO's efforts in the area of control activities.

Dr THOMAS (Saint Vincent and the Grenadines) expressed full support for the draft resolution. Epidemics and other health hazards did not recognize political borders, and he supported all initiatives taken in order to combat influenza pandemics, including those taken by Taiwan. He urged Taiwan's meaningful preparation in the WHO process.

Dr SADRIZADEH (Islamic Republic of Iran) said that the spread of the H5N1 virus to new areas increased the risk of human infection. Although vaccines were considered the first line of defence during a pandemic, the development of a vaccine and increased manufacturing capacity would pose a challenge for both WHO and the international community. The same applied to antiviral agents, which were costly and in limited supply. He therefore agreed that, pending the availability of vaccines, they should be used at the start of a pandemic for the treatment of patients and the protection of workers in essential services. As supplies of oseltamivir and zanamivir were also limited, WHO should play a catalytic role in accelerating and expanding the transfer of manufacturing technology to other production facilities, particularly those in developing countries.

He fully supported the draft resolution concerning immediate voluntary compliance with the relevant provisions of the International Health Regulations (2005).

Mr ABDOO (United States of America), recognizing that H5N1 and other novel strains of influenza virus posed serious threats to world health, said that immediate voluntary implementation of the relevant provisions of the Regulations would facilitate early intervention, thereby preventing or delaying a pandemic, as well as the most effective management possible of a pandemic should one occur. The prompt generation of reliable and complete epidemiological data in support of rapid intervention at the beginning of a pandemic would be difficult or impossible without adequate capacity to detect human cases of avian influenza in affected countries; surveillance systems and laboratory capacities worldwide had to be improved. Member States should notify the Secretariat as soon as possible of suspected or confirmed novel influenza virus infections and respond quickly, fully and transparently to formal requests for information.

His Government had already informed the Secretariat about its national IHR focal point and nominated its candidate for the pandemic influenza task force, and he urged other countries to take similar action as soon as possible. In that connection, he applauded the announcement by Taiwan's Centre for Disease Control that it would comply voluntarily with the Regulations, and urged the Secretariat to facilitate the Centre's participation in the global health framework.

He supported the draft resolution, and his country would be prepared to sponsor it subject to the incorporation of certain amendments. He proposed that in paragraph 3 the concluding words "after their entry into force" should be deleted, so that Member States could end voluntary compliance before, as well as after, that date.

Mr ROSENBERG (Canada) said that Canada continued to support the pivotal role of WHO in coordinating efforts to strengthen global pandemic-influenza preparedness and response, and commended the work done on surveillance, vaccines, antiviral agents and rapid containment strategies. It fully supported the draft resolution. Immediate voluntary compliance with the International Health Regulations (2005) would enhance global health security. Canada welcomed the announcement by the Taiwanese Centre for Disease Control that it would comply voluntarily, and supported the strengthening of the Global Outbreak Alert and Response Network. It commended China's energetic implementation of the WHO Memorandum of Understanding to facilitate universal application of the Regulations.

Mr GUNDALAI (Mongolia) said that the whole world had learnt from the outbreak of severe acute respiratory syndrome in 2003 that the threat of transmission of avian influenza to humans posed a global challenge. Birds did not respect national borders, which made closer cooperation in global

disease prevention vitally important. As the late Director-General had said, there should not be any gap in the Global Outbreak Alert and Response Network, and universal access to that Network was central to efforts to combat disease.

Mongolia, a large, scarcely-populated country, was host to many migrant birds, especially in summer. It was difficult to reach the population of remote rural areas, especially herdsmen and children, who were unaware of the dangers of avian influenza. Mongolia's infrastructure would have to be strengthened in order to overcome that problem and to ensure that it was prepared for an outbreak of the disease.

Dr GEORGE (Portugal) said that in his country a plan for dealing with an influenza pandemic had been drawn up, comprising an effective system of epidemiological surveillance, prevention and control measures to be taken by health centres and hospitals, a risk communication strategy, and internal and external evaluation. The plan would be financed by resources mobilized within the health and education sectors and the private sector. He fully supported the draft resolution.

Professor HORVATH (Australia) expressed support in principle for the draft resolution. Australia's existing legislation and administrative practices provided a strong foundation for compliance with the relevant provisions of the Regulations, and the necessary steps were being taken to that end. He encouraged all Member States, where possible, to do likewise.

His Government was committed to working with regional and global organizations and partners to build capacity in the Asia and Pacific region for prevention and control of emerging diseases, and would be donating Aus$ 100 million over four years to initiatives designed to improve the capabilities of countries in the region in detection and surveillance and in emergency preparedness and response.

Ms BELLO DE KEMPER (Dominican Republic) said that the recent outbreak of avian influenza in five members of the same family in one Asian country should serve as a reminder that progress had to be made in applying the provisions of the International Health Regulations (2005). Although the Region of the Americas was as yet unaffected, support was nevertheless needed for building and enhancing capacity for pandemic prevention and response. Her country was committed to complying with the Regulations. If human health was to be safeguarded, no population or territory in which outbreaks of disease occurred, or which could be affected by diseases in other populations or territories, should be exempted from the requirements of the Regulations.

Dr LI Jianguo (China) welcomed the draft resolution. His Government had undertaken to harmonize national rules in order to promote intersectoral cooperation, and to provide training in order to improve surveillance and response capacities. It had also made a great effort to respond to H5N1 influenza and to prevent transmission of the virus to humans by developing an emergency response plan, a diagnosis and treatment plan and a plan for country-wide surveillance.

His Government had also cooperated actively with WHO and other intergovernmental and international organizations. At the international pledging conference on avian and human influenza in January 2006, it had pledged US$ 10 million, US$ 500 000 of which had been handed over to WHO on 19 May 2006, thus demonstrating that despite its own heavy disease burden China was prepared to contribute to the health of peoples worldwide.

International communication and cooperation were essential for increasing preparedness and response to avian influenza. His Government donated more than 300 influenza virus strains annually to the WHO influenza collaborating centres, and 80% of the influenza vaccine strains recommended by WHO came from China. He urged the Organization to step up its efforts to help developing countries to implement the Regulations by assisting them with capacity-building in information and public response. China was ready to cooperate and to share its experience with other countries in that regard.

The issue of Taiwan referred to by some delegates was irrelevant to the Committee's agenda and should not be allowed to interfere with its work. It was to be hoped that that problem would eventually be resolved. Meanwhile, Member States should focus on the item under consideration.

Dr LEVENTHAL (Israel) said that the threat of avian influenza offered an opportunity for building bridges between countries. Thus, Israel had cooperated on the issue with Jordan and the Palestinian Authority, and exchanged information with Egypt. National IHR focal points had been appointed in each of those countries. At a recent WHO symposium on the International Health Regulations (2005), delegates had taken the view that the Regulations should be implemented immediately, even if they had not yet entered into force. He therefore supported the draft resolution and urged its early implementation.

Dr AL-JUNAID (Yemen) pointed out that in order to implement the draft resolution Member States would have to allocate financial resources for certain specific activities. Thus, paragraph 4(7) urged Member States to strengthen and maintain the capacity for surveillance and response, but all health sectors would need to be bolstered in order to deal with influenza outbreaks, with exchanges of updated information.

He agreed with China that Member States should concentrate on the item under consideration and not digress into points of no relevance.

Dr HARPER (United Kingdom of Great Britain and Northern Ireland) said that, at the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006), his Government had undertaken to provide £20 million through multilateral channels over three years in order to strengthen preparedness in developing countries against avian influenza and a possible human pandemic. It was awaiting clarification from the World Bank regarding outstanding priorities before advising on how the money might be spent. Work on avian and human pandemic influenza was continuing in the United Kingdom, and an additional £10 million had recently been allocated for research aimed to enhance understanding of the molecular biology of the virus in order to develop novel vaccines. Assistance to organizations of the United Nations system was also being considered, provided that they could demonstrate effective reprioritization and ability to deliver on the ground. His Government was prepared to augment capacity where necessary, as was indicated by its recent decision to provide funding for the continued running of the Office of the United Nations System Senior Coordinator for Avian and Human Influenza.

The United Kingdom welcomed the draft resolution and strongly supported the call for voluntary early compliance with the International Health Regulations (2005). It expected to be able to respond to that call in regard to pandemic and avian influenza. He requested more information regarding the influenza pandemic task force, since greater clarity would ensure that its operation was transparent and in keeping with the provisions of the Regulations relating to the Emergency Committee. Any recommendations made by the task force would have to be considered on their individual merits. He suggested that the draft resolution be clarified by certain amendments, which he would submit to the Secretariat.

Dr AL FANNA (Oman) said that implementation of the draft resolution would have a significant impact worldwide. The epidemic constituted a serious danger, and screening of cases was important so that precautionary measures could be taken. WHO had played an important role in that area. She thanked the Secretariat for the support given to Members in the Eastern Mediterranean Region, and supported all endeavours to incorporate the Regulations into national legislation.

Professor WYSOCKI (Poland) expressed support for the draft resolution. The report contained in document A59/4 was most useful and informative, particularly with regard to work on pandemic vaccine. Developing rules and criteria for the use and distribution of such a vaccine would be a formidable task for the Secretariat and for Member States.

Poland had strengthened its surveillance systems and streamlined and tested its emergency preparedness plans, in accordance with WHO and European Union recommendations, and believed that those plans fulfilled the requirements for “generic” emergency preparedness.

Dr OTTO (Palau) said that Palau was building capacity and developing plans and infrastructure for preparedness and response to avian influenza or an influenza pandemic. Palau belonged to a region at risk from avian influenza, and because the country had such a small population a single case could have catastrophic consequences. It also had limited resources and, without outside assistance, would find it difficult to prepare and respond appropriately. He was grateful to the Regional Office for the Western Pacific for technical assistance, and to partners for their assistance to Pacific island countries through the Pacific Community's Public Health Surveillance Network. He supported the draft resolution as amended by the delegate of the United States of America.

Dr DE ASSUNÇÃO CARVALHO (Sao Tome and Principe) said that the serious threat to public health posed by avian influenza obliged all countries to comply with the International Health Regulations (2005). He noted that Taiwan had declared that it would immediately comply voluntarily with the relevant provisions of the Regulations. His country had drawn up a national action plan in order to prevent and combat avian influenza. He suggested that Taiwan's collaboration should be taken into account by inviting it to participate in WHO's work in that area. He supported the draft resolution.

Dr KAGGWA (Uganda) expressed concern at the risks posed by avian influenza and a possible human influenza pandemic. Although no case of the disease had been reported in Uganda, a national plan had been drawn up, preparedness and response strategies were being implemented, and a national IHR focal point had been designated. Those actions had been taken because some countries in the vicinity were already affected.

Although he fully supported the draft resolution, he called on the international community to mobilize appropriate financial and logistical support, especially for less developed countries, in order to help them deal with any new outbreaks.

Dr PADILLA (Bolivarian Republic of Venezuela) said that his country was strengthening pandemic-influenza preparedness and response, and had developed a national plan designed to reduce vulnerability and avoid excessive morbidity and mortality in the event of a pandemic. Six ministries were participating and national legislation was being brought into line with the Regulations. Diagnostic facilities at ports and airports were being enhanced, and acute respiratory diseases were being closely monitored in 24 hospitals throughout the country in order to track the possible spread of the influenza virus. Out of 198 suspect cases examined, 12 positive cases had been identified. Large stocks of antiviral agents were being made available, and as from the fourth quarter of 2006 influenza immunization would be provided for infants, the elderly and other vulnerable persons.

He supported the draft resolution.

Mr CHO Do-yeon (Republic of Korea) acknowledged all the condolences that had been offered on the death of the Director-General.

His Government had made pandemic influenza preparedness a national priority and had been stockpiling essential supplies, including antiviral agents. Influenza surveillance had been enhanced. Efforts were being made in partnership with the private sector in order to develop a preparedness plan that would mitigate the economic and social effects of pandemic influenza. His Government had shared information on avian influenza outbreaks promptly with the international community. It sought to provide technical assistance to other countries, and would be inviting some 10 countries as observers to its next preparedness exercise, scheduled for October 2006.

International collaboration was essential in tackling avian and pandemic influenza. His Government was committed to implementing the relevant provisions of the Regulations, including voluntary reporting of human cases of influenza, before they came into force in June 2007, and strongly endorsed immediate voluntary compliance.

Mr PAK Jong Min (Democratic People's Republic of Korea) emphasized the strengthening of national surveillance systems. WHO should support capacity building in the developing countries, and

should promote new information technologies that would reinforce health-care systems. In his country a system for the surveillance of avian influenza had been established, and preventive and response activities were being conducted on a national scale. Recently, his Government had developed an influenza preparedness strategy and was working closely with WHO and FAO in order to strengthen surveillance, preparedness and response to outbreaks in both birds and humans. WHO should provide effective support for that strategy.

Mrs TOELUPE (Samoa) agreed on the importance of proper preparation and stronger collaboration in the practical application of the Regulations. Samoa depended on the financial and technical support of international, regional and bilateral partners in dealing with the global threat of avian influenza. Her Government's response to that threat had been positive, so as not to repeat the experience of the 1918 influenza pandemic which had killed 25% of the population. Samoa was very concerned about its currently insufficient capacity to coordinate the necessary assistance for its people. She therefore reaffirmed her support in principle for the draft resolution.

Dr TIBAN (Kiribati) said that his Government understood the threat of avian influenza and, in compliance with the International Health Regulations (2005), was formulating a preparedness plan. Lack of human capacity in a number of key sectors had been identified, and resources to implement some of the activities consistent with the framework developed by WHO were also lacking. His Government had already received support from WHO and partner countries. He urged agencies and donors to provide assistance, in the exchange of technical expertise and provision of material assistance, so that Kiribati could play its part in preventing the spread of avian influenza.

Dr AHMED (Pakistan) said that, although the spread of the H5N1 virus in poultry in Pakistan since February 2006 was a matter of grave concern, no human case had been reported so far. Pakistan had adopted all necessary preventive measures and hoped that it would be able to contain the virus. He expressed gratitude for WHO's support in strengthening the surveillance system, conducting field investigations of avian influenza cases, and providing laboratory services. He acknowledged the serious threat to human health posed by outbreaks in poultry, and stressed the need for all countries to collaborate with WHO and the international community in order to reduce the risk of the avian influenza virus. He therefore fully supported the draft resolution.

Dr CHAOUKI (Morocco) fully supported the draft resolution, and the immediate implementation of the relevant provisions of the Regulations pending their entry into force in 2007. The threat of a pandemic and its possible consequences meant that the international community had to be fully prepared, and international and regional cooperation were essential if the disease was to be contained. The role of WHO and other international organizations was crucial in any joint response to a possible pandemic. Compensation of poultry raisers was needed in order to ensure their full cooperation, and collaboration among countries was also essential for those with scarcer resources to counter the threat. Morocco had opted for immunization as the best way to counter influenza, although the affordability of such a programme presented a major challenge, and had formulated a national plan for preparedness and response activities.

Mrs LE THI THU HA (Viet Nam) said that with support from WHO and other international organizations her country had developed an integrated national programme for avian influenza control and human pandemic influenza preparedness and response, and looked forward to working with international partners and donors in its implementation. During the past six months, the country had conducted four simulation exercises on preparedness. In line with the International Health Regulations (2005), Viet Nam had drafted a government decree on border health quarantine. She pointed out that financial and technical assistance as well as international cooperation and support would be needed to enable developing countries to implement the Regulations.

She supported the draft resolution, with the amendment to paragraph 4(4) proposed by Thailand.

Mr ALLAH KOUADIO (Côte d'Ivoire) supported the draft resolution. In order to confront the threat of avian influenza, his country had developed a national response plan, and he thanked WHO for its assistance. Difficulties persisted, especially in diagnosis of human influenza, and health systems and laboratory capacities must be strengthened in order to ensure early detection. Effective monitoring of the bird population was also needed, together with compensation for poultry producers in order to encourage them to report deaths among their flocks. All those measures required considerable resources. It was therefore essential to create a fund that was easily accessible so that the response by affected countries to restrict the avian pandemic and avoid human cases could be speedy. He emphasized efficient communication so that people could take appropriate action with regard to poultry consumption, thus reducing the economic and nutritional impact of the disease.

The meeting rose at 12:30.

THIRD MEETING

Friday, 26 May 2006, at 14:30

Chairman: Professor P.I. GARRIDO (Mozambique)
President of the Health Assembly

1. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

The General Committee heard reports from Dr RAMADOSS (India), Chairman of Committee A, and Dr MOHAMMAD (Oman), Chairman of Committee B, on the progress of work in their committees.

In view of the rate of progress, Dr RAMADOSS (India) proposed that agenda items 11.13, WHO's role and responsibilities in health research, 11.14, Emergency preparedness and response, 11.15, Health promotion in a globalized world, and 11.16, Patient safety should be transferred from Committee A to Committee B for consideration.

Dr MOHAMMAD (Oman) said that he expected that consideration of those agenda items could begin at the end of its work later that day.

It was so agreed.

The CHAIRMAN proposed to review the progress of work with the chairmen of the committees later in the day and to revise the programme accordingly, if necessary.

After a discussion of various options, **the General Committee drew up the programme of work** until Saturday, 27 May.

2. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee closed.

The meeting rose at 14:50.

SECOND MEETING

Wednesday, 24 May 2006, at 18:15

Chairman: Professor P.I. GARRIDO (Mozambique)
President of the Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A59/GC/4)

The CHAIRMAN reminded members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the World Health Assembly.

He drew attention to the fact that the coming into force of the amendments to Articles 24 and 25 of the Constitution[1] on 15 September 2005 meant that the Executive Board consisted of 34 rather than 32 persons designated by as many Members. The increase of two designating Members would affect the European Region and the Western Pacific Region. Accordingly, 12 new Member States needed to be nominated.

To help the General Committee in its task, three documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 10 Members whose term of office would expire at the end of the Fifty-ninth World Health Assembly and which had to be replaced. The second (document A59/GC/4) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. The third document tabulated, by region, Members of the Organization that were or had been entitled to designate persons to serve on the Executive Board. Vacancies, by region, were: Africa, 1; the Americas, 2; South-East Asia, 1; Europe, 4; the Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion was made by the General Committee, he noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 80 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 102 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly, for the annual election of Members entitled to designate a person to serve on the Executive Board: Afghanistan, China, Denmark, Djibouti, El Salvador, Latvia, Mali, Singapore, Slovenia, Sri Lanka, Turkey and the United States of America.

It was so agreed.

[1] Adopted by resolution WHA51.23.

2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr RAMADOSS (India), Chairman of Committee A, reported that progress of work in that committee was behind schedule. The Committee had agreed to hold night meetings but even so transfer of agenda items to Committee B might be necessary.

The CHAIRMAN proposed to review progress of work with the Chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Thursday, 25 May and Friday, 26 May.

The CHAIRMAN reminded the Committee that it would next meet on Friday, 26 May, but proposed advancing the time of the meeting to 14:30.

It was so agreed.

The meeting rose at 18:30.

SECOND MEETING

Tuesday, 23 May 2006, at 16:00

Chairman: Dr K. LEPPO (Finland)
later: Dr A. RAMADOSS (India)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005): Item 11.1 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R7 and Annex 4, A59/4 and A59/5) (continued)

Ms OSMAN ADEN (Djibouti) expressed support for the draft resolution concerning voluntary compliance with the relevant provisions of the International Health Regulations (2005) before entry into force. She urged the international community to show solidarity, leaving aside the financial considerations that could incite some countries not to declare cases of epidemic-prone infectious disease. In May 2006 a human case of avian influenza had been detected in Djibouti, of which the entire international community had been notified, in accordance with the voluntary provisions recommended in the draft resolution contained in resolution EB117.R7. A strategic plan was being implemented, with all possible preventive measures being taken, including stricter health controls at borders, slaughtering of poultry, raising of public awareness, and closer epidemiological surveillance. Despite the support received from WHO and other bilateral partners, real needs were not being met. It would be impossible to combat the spread of the H5N1 virus without the concerted effort of the international community, and speed was vital since the virus might mutate at any time. She called upon WHO to exercise fully its leadership role, including mobilization of resources to implement the resolution.

Mr DAVIDYAN (Armenia) said that, given the epidemic situation in the world regarding avian influenza, Armenia was taking a series of preventive and anti-epidemic measures. National and regional centres had been established, involving all ministries and departments. A national action plan against a possible pandemic had been agreed; quarantine measures were being set in place in order to prevent the virus crossing borders, including via the international airport; steps were being taken to increase the preparedness of health personnel; and seminars were being held throughout Armenia on the epidemiology, diagnosis and treatment of the disease. There was ongoing exchange of information between the health ministry and the Secretariat, and between the agriculture and health ministries, inter alia regarding cases of the viral infection of birds and associated laboratory tests. Work was being done to raise public awareness of measures to prevent the spread of the disease including the circulation of a health bulletin. The laboratory base for first-line medical and veterinary diagnosis was being strengthened. Armenia had requested financial assistance from the World Bank for preventive measures. Problems had been encountered in respect of joint programmes, however, specifically in setting up laboratories for polymerase chain reaction viral analysis, and obtaining vaccines and antiviral agents. Reporting forms were being developed. Training courses were being conducted and various other preventive measures were ongoing, including the use of disinfectants. No case had been registered of avian influenza among birds or in the population of Armenia.

Dr BALAGUER CABRERA (Cuba) said that the H5N1 virus had not as yet been identified in Cuba, but the country was at risk of infection from migratory birds arriving from North America, and

from trade and tourism. A joint plan had been signed by the public health and agriculture ministers, covering the necessary measures to be implemented in each of the phases established by WHO. Cuba's national veterinary institute had operated a surveillance system for avian influenza for more than 20 years. Monitoring had been stepped up in 2004 and 2005, with health personnel throughout the country being informed of the international avian influenza situation through the national commission for serious epidemics, which had been set up to deal with severe acute respiratory syndrome. Extensive dissemination of information and training were also being carried out, and dedicated web sites set up. Laboratory staff were being trained in animal and human disease surveillance. Resources, including financial support, were needed to cover the country's needs regarding diagnosis, quarantine, treatment and prevention among health staff. Work was being done on a possible vaccine and it had been decided, as a preventive measure, to vaccinate all people over the age of 60 and others at high risk against human influenza. Agreements on intellectual property should not obstruct plans to produce vaccines or new antiretroviral agents. Greater international coordination was required in order to improve the use of early warning systems, as was definition of the relevant standards and protocols for exchanging information.

Dr NYAMONGO (Kenya) said that, following confirmation of avian influenza among birds in five African countries, Kenya faced a real threat of infection. In accordance with Article 4 of the International Health Regulations (2005) Kenya had set up a multisectoral task force and designated national IHR focal points at the ministries of health and of livestock and fisheries development. The task force had six committees, responsible for: surveillance; laboratories and research; information, education and communication; coordination and resource mobilization; infection prevention and control; and case management. It had drawn up a national action plan for prevention, control and response to avian influenza and had started implementing activities under Article 4 of the Regulations. The task force was cooperating with all stakeholders, including WHO, the World Bank and large-scale poultry farmers, and information was exchanged monthly. Kenya was currently on alert phase 1, with a budget of US$ 38 million to deal with the problem of avian influenza. He expressed concern that most of the funding received as a result of the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006) would be in the form of loans and not grants; the latter would be the most appropriate form of support, especially given the heavy debt burden of many African countries. He supported the draft resolution.

Dr PALIHAWADENA (Sri Lanka) said that, although it was currently free of avian influenza, Sri Lanka risked infection from neighbouring countries. The Minister of Health had drawn up a joint national pandemic preparedness plan with the help of the Department of Animal Production and Health. Health staff had been trained, and referral hospitals and laboratories identified. More had to be done regarding animal and human disease surveillance in the country, for which better laboratory diagnostic facilities and human resource development were needed. Isolation facilities at the referral hospitals also needed to be expanded in order to meet demand in the event of a pandemic. She thanked WHO for its support in preparing the national plan and guidelines and in improving laboratory capacity. She endorsed Thailand's amendments and observations with regard to the draft resolution on the subject of affordability for developing countries.

Mr FORAU (Solomon Islands) thanked WHO for its support in terms of the technology, facilities and structure required to implement the International Health Regulations (2005). Progress in improving national preparedness and response was slow, but valuable assistance had been received from partners for epidemic disaster preparedness and response. Cooperation with all key stakeholders was continuing in the areas of surveillance, investigation, verification and response, both nationally and internationally, in the event of a public health emergency. One challenge his country faced was budgeting for an unpredictable event such as the outbreak of avian influenza, in which connection he pledged his support for the draft resolution.

Sir Peter BARTER (Papua New Guinea) acknowledged the positive support received from WHO, but expressed concern at the scant collaboration between some neighbouring countries in the Western Pacific Region. To date, there had been no recorded case of avian influenza in Papua New Guinea. A draft response plan would be ready in the weeks ahead, when attention would be given to: the uncontrolled movement of infected fighting cocks; lack of surveillance and information sharing; poor laboratory diagnostic standards; and slow release of information. Until all Member States took measures to ensure effective communication and surveillance, viral diseases such as avian influenza would continue to spread. His country shared a border with Indonesia, where he had been alarmed to see the recorded incidence of avian influenza. He also drew attention to other life-threatening but preventable diseases, such as diabetes, and expressed shock that smoking was permitted in the United Nations premises.

Dr NTABA (Malawi) said that, in view of the serious risk of an avian influenza pandemic, he fully supported immediate voluntary compliance with the relevant provisions of the International Health Regulations (2005), as called for in the draft resolution. Malawi was already implementing the Regulations. Drawing attention to paragraph 2(4) of the draft resolution, on public health measures and special provisions for travellers, he noted that 22 million air travellers moved in and out of Taiwan each year. The health authorities in Taiwan had already complied voluntarily with the Regulations and the Organization should acknowledge that 23 million people who were being denied any formal status in WHO and barred from meaningful participation were among the first to comply voluntarily with the Regulations. Having noted the views of some delegates in that respect, he affirmed that Malawi would not be bullied into silence on the matter.

Dr REN Minghui (China), rising to a point of order, said that the comments of the delegate of Malawi had nothing to do with the topic under discussion and wasted time.

Dr NTABA (Malawi) said that attempts were being made to censor the views of some delegates in the official records, including harassment by telephone day and night. Those developments were unbecoming of a civilized organization such as WHO and should not be allowed to continue. He requested WHO to acknowledge the immediate voluntary compliance with the Regulations by 23 million people who were being denied a voice in the Organization. That constituted a serious moral challenge. He expressed his country's full support for the draft resolution.

Professor AKOSA (Ghana) welcomed WHO's support in increasing preparedness for avian and pandemic influenza. Ghana also commended development partners for their assistance and held itself in readiness, having gone through all the stages of preparedness with the establishment of national task forces on veterinary and human aspects and a heightened surveillance system. The level of multisectoral cooperation to that end had been unprecedented in Ghana. Information management had nevertheless been a big problem, with the local media creating a phobia about eating chicken even though Ghana had decided to ban the import of chicken from affected countries. To date, no case of avian influenza had been identified in Ghana; the presence of the virus in neighbouring countries, however, caused concern. Ghana might perhaps be seen as a test case and given support to avoid the disease through the further strengthening of country surveillance, laboratory processes and task force activities, and the stockpiling of medicines. Were the disease to spread to humans in Ghana, the current workforce would certainly be unable to cope. Preparedness must include providing the necessary human resources with an appropriate skills mix. The prevention of avian and pandemic influenza and limiting their spread were a health-care priority in Ghana, which supported the draft resolution.

Dr MBOWE (Gambia) fully endorsed the statement made by Malawi. Avian influenza had the potential to become a global pandemic, and any individual, organization or government able to facilitate preparedness should be commended. The Gambia was therefore grateful to partners for the unprecedented support rendered in that regard. He fully supported the draft resolution.

Dr VILLAVERDE (Philippines) strongly supported the call for immediate voluntary compliance with the relevant provisions of the International Health Regulations (2005). The Philippines therefore urged WHO and other international development agencies to mobilize and coordinate external funding and other support for national influenza pandemic preparedness. National and local capacities should be assessed and gaps in the implementation of the Regulations identified.

Member States should intensify collaboration on case definition and investigation during outbreaks, besides regularly updating laboratory, epidemiological, food safety and public health information. They should also inform each other in due time of avian influenza cases that had crossed between countries in order for precautionary measures to be taken. Common guidelines should be formulated for health screening of travellers. Affected countries should develop an effective communication strategy to deal with the consequences of avian influenza. In addition, the principle of country-owned programmes should be considered as a basis for country-level intervention. A balanced view on concerns over sovereignty should be taken, particularly regarding consistency of measures for travellers and clarification of exit and entry screening measures.

Dr SRIVASTAVA (India) welcomed the comprehensive reports and the draft resolution, which India supported. The call for immediate voluntary compliance with provisions of the International Health Regulations (2005) would be heeded only if Member States were given necessary support in implementing the Regulations. WHO should take the lead in the mobilization and coordination of financial, technical and logistical assistance, including the reasonable stockpiling of medicines, and capacity-building. He therefore suggested that paragraph 5(5) of the draft resolution should include reference to "reasonable stockpiling of necessary drugs in advance" and to "facilitating, in collaboration with international partners, the development and commercial production of the influenza vaccine". Reference to "regional networking of laboratories" should be added in paragraph 5(7). An additional subparagraph along the following lines should also be added to paragraph 4: "to initiate a process of identifying and addressing the constraints – administrative and legal – for the timely adoption and implementation of the Regulations to promote intersectoral participation".

Influenza was a priority disease for his Government. Although outbreaks of avian influenza had been reported in three states, no human case had yet been reported in India. A national contingency plan for the management of human cases of avian influenza, in addition to a national plan for avian influenza, had been prepared; those plans included active surveillance for the early detection of suspected cases and rapid diagnostic confirmation, personal protective measures, reasonable stockpiling of proven and safe antiviral agents, and other general measures for epidemic control. As part of the implementation of the Regulations, a national IHR focal point had already been designated. Intercountry and interregional cooperation were being strengthened for the timely sharing of information and early diagnosis. Definite cooperation was required for primary source tracking, for national, local and focal source tracking, and for scanning and mapping of listed and unlisted water bodies.

Dr GARBOUJ (Tunisia) said that the draft resolution was further proof of WHO's readiness to deal with the threat of pandemic influenza, and provided an opportunity of evaluating measures to date. Member States should increase their cooperation in order to combat avian influenza.

Dr REN Minghui (China), in exercise of the right to reply, said that China was very concerned with the health of the 23 million people in Taiwan, China, and would be considering how their health could best be protected. The International Health Regulations (2005) were for sovereign States: Taiwan, however, was a part of China, and he trusted that the point could be resolved through negotiation. The Regulations provided for four equally important principles of implementation: respect for human rights, respect for national sovereignty, compliance with the Charter of the United Nations and WHO's Constitution, and universal application. The Regulations were to enter into force in 2007, and his authorities would make proper arrangements for their implementation in both China and Taiwan, China.

Dr NABARRO (Senior United Nations System Coordinator for Avian and Human Influenza) said that the previous six months had seen extraordinary action and progress within countries; crucial activities had been identified. Many countries had implemented major programmes, particularly in response to the threats posed by avian influenza, and many countries had put in place pandemic preparedness plans. However, challenges remained: all countries had to work together in a common cause; all parts of government should be engaged in pandemic preparedness and response; and WHO had a key role to play as the organization that would help to ensure rapid containment and response.

At the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006), countries had pledged to provide assistance for influenza action. However, the requests from the United Nations system at that meeting had not been funded to the full. WHO and other bodies in the United Nations system remained significantly underfunded. The efficiency with which it could provide support to Member States was therefore restricted at a time when support requirements were rising sharply as more and more Member States were experiencing cases of both avian and human influenza. The situation would be reviewed at the Senior Officials Meeting on Avian and Human Pandemic Influenza in Vienna in June. He endorsed the calls made for the prompt realization of pledges and adequate financial assistance for countries in need and for the United Nations system, in particular WHO.

Dr DUPLESSIS (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that since the end of 2004, the International Federation had been helping its member national Red Cross and Red Crescent societies to prepare against the increasing risk of pandemic influenza. The national societies placed emphasis on work at the community level, including awareness raising, training and planning in order to ensure continuity of work. At its General Assembly in November 2005, the International Federation had adopted a resolution on cooperation between national societies and health ministries in order to tackle the pandemic threat. Experience over the previous 18 months had shown a key factor for success had been the involvement of Red Cross and Red Crescent societies in national planning against the pandemic threat. However, some societies were apparently still not included in their national planning. In order to be successful, preparations for avian and human influenza must include such a level of community involvement. All governments should therefore consider the inclusion of their national Red Cross or Red Crescent Society as a matter of urgency.

In remembrance of the excellent work done by the late Director-General, Dr Lee, in leading the international community's response to avian influenza, the International Federation dedicated its future work to his memory and in support of his contribution.

Mr HOEK (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, the FDI World Dental Federation and the World Medical Association, said that massive investment in emergency preparedness and response was essential in order to stem the potentially devastating effects of pandemic influenza. To that end, all governments should comply with the International Health Regulations (2005) before their entry into force in 2007. Effective deployment of health-care professionals was a key element of successful preparedness and response. Health professionals had ethical and professional obligations to provide care, including during an outbreak of pandemic influenza, but at the same time, being at the forefront of disease prevention and control strategies, were entitled to occupational safety and protection, particularly from infections. Governments and the Secretariat were therefore urged to take the necessary steps to ensure that health professionals had the necessary protection and were given priority in respect of preventive measures, care and treatment.

Dr CHAN (Assistant Director-General), responding to a question from the delegate of the Russian Federation, said that the International Pledging Conference on Avian and Human Influenza (Beijing, 17-18 January 2006) had raised a total of US$ 1900 million, some US$ 1000 million of which were in the form of grants and US$ 900 million in the form of bank loans. The World Bank was requested to provide details to the Senior Officials Meeting on Avian and Human Pandemic Influenza

(Vienna, 6-7 June 2006) of the amounts pledged by various countries and the way in which the funds would be disbursed.

With regard to the proposal by the delegate of Thailand for the insertion of the words "for noncommercial purposes only" after "novel influenza strains" in paragraph 4(4), WHO needed the information and the biological material referred to in order to track the evolution of the avian influenza virus and detect early signs of mutation and for the development of a prototype vaccine, which would be distributed to vaccine manufacturers in both developed and developing countries. It would be impossible to develop influenza vaccine without the involvement of the pharmaceutical industry. The views of other Member States on that proposed amendment would therefore be important.

In paragraph 5(4), the word "temporary" had been used because a temporary mechanism would be needed in order to advise the Director-General until the Emergency Committee, provided for in Article 48 of the International Health Regulations (2005), took over in June 2007 when those Regulations entered into force. So far only 42 Member States had nominated members for the roster of experts referred to in Article 47 of the Regulations; and she called on all other Member States to do so as soon as possible.

With regard to the implications of the word "immediate" in paragraph 1 of the draft resolution, the legal advice was that, three months after the adoption of the resolution, Member States and the Director-General would be expected to begin the action stipulated therein. The word did not affect the five-year capacity-building time frame laid down in the Regulations. The countries concerned would still be able to apply to the Review Committee for extra time to build their capacity, and could have a total of nine years in which to do so. The phrase "mechanisms and procedures" in paragraph 4(2) referred only to the mechanisms and procedures laid down in Articles 6 to 10 of the Regulations.

The functions of the influenza pandemic task force were laid down in paragraph 5(4). The membership of the task force would be proposed by the six WHO regional offices in order to ensure regional balance and expertise. Headquarters would propose additional members in order to ensure that there were no gaps in terms of expertise. The task force would comprise some 20 experts who would meet at short notice if necessary. WHO would continue to make use of their expertise when the task force was replaced by the Emergency Committee in 2007.

Dr Ramadoss took the Chair.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that he had proposed amending paragraph 4(4) because the influenza pandemic was a global threat, not a business opportunity. Type-specific monovalent vaccines were too expensive for developing countries. An influenza vaccine was a global public good, and should be affordable for everyone. The price of vaccines was the main obstacle in all immunization programmes, despite the activities of the Global Alliance for Vaccines and Immunization and other initiatives. Global manufacturing capacity currently amounted to some 300 million doses of influenza vaccine per year. In the event of a pandemic, it would be impossible for vaccine manufacturers in the developing countries to produce enough vaccine for their populations; if manufacturers in the developed countries had a monopoly on production, the developing countries would not be able to afford the vaccine, and the money pledged in Beijing might not be sufficient in the event of a crisis. Member States should consider how best to solve the problem.

Mr AITKEN (Adviser to the Director-General) said that a new version of the draft resolution, incorporating delegates' amendments, would be ready for the Committee's consideration at its next meeting. However, some points, such as Thailand's proposal to add the phrase "for noncommercial purposes only" in paragraph 4(4), were likely to remain controversial. Delegates might wish to meet informally before the next meeting in order to find a way forward.

The CHAIRMAN said that, if there was no objection, he would take it that the Committee wished to defer consideration of the draft resolution until a subsequent meeting.

It was so agreed.

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

Eradication of poliomyelitis: Item 11.2 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R1 and Annex 4, and A59/6)

Mr M.N. KHAN (representative of the Executive Board), introducing the item, said that the Board, in reviewing the report on the eradication of poliomyelitis had noted that only four countries remained endemic for wild-type poliovirus and that all 23 countries reinfected with imported polioviruses in the period 2003-2005 were either completely or almost poliomyelitis-free. The report had, however, warned that flexible and multi-year financing commitments would be needed to cover the unmet funding requirements of the programme.

The Board's discussion had focused on the risk of further spread of poliovirus from northern Nigeria. The draft resolution contained in resolution EB117.R1 provided guidance for poliomyelitis-free Member States to respond to the circulation of polioviruses. The Board had amended the original draft resolution by adding a new paragraph (paragraph 1) in order to highlight the primary importance of interrupting transmission of poliovirus in the four countries where that had not yet been achieved; by emphasizing the importance of using the newly developed type-specific monovalent oral poliomyelitis vaccines in order to interrupt poliovirus transmission; and by calling upon the Director-General to report to the Board in January 2007 on the progress made.

Dr DUQUE III (Philippines) said that the Philippines endorsed the administration of appropriate monovalent oral poliomyelitis vaccines in countries where the disease was still endemic as an additional tool for supplementary immunization. Trivalent and oral poliomyelitis vaccines should continue to be used in most campaigns and in routine immunization in order to protect children against all poliovirus types that might be imported from other areas. Although the monovalent vaccines produced a stronger response than trivalent vaccines in children immunized for the first time, it was important to reach every child with readily available and potent vaccines if transmission was to be interrupted. Despite the apparent success in eradicating the disease, it was important that technical expertise and financial support for emergency response and type-specific monovalent oral poliomyelitis vaccines should be kept readily available in case of need.

Dr LASSMANN (Austria), speaking on behalf of the European Union and its Member States, said that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia, and Turkey, and the countries of the Stabilisation and Association Process and potential candidates, Bosnia and Herzegovina and Serbia and Montenegro, aligned themselves with his statement. He congratulated WHO on its efforts to combat poliomyelitis which, despite some high profile outbreaks, were setting the stage for a poliomyelitis-free world. Member States of the European Union reaffirmed their full support for the eradication of poliomyelitis and acknowledged the important role played by poliomyelitis eradication networks in providing structures for other health interventions. Developments in India and Pakistan had shown that concentrated interventions had reduced the number of cases considerably in recent years and the region might well be declared poliomyelitis-free in the near future. However, the incidence of poliomyelitis in some northern states of Nigeria significantly increased the risk that the wild-type poliovirus might spread. He therefore urged WHO to reinforce activities in that region through sufficient additional rounds of poliomyelitis immunization in order to interrupt transmission of the virus, and to ensure close monitoring of immunization coverage.

Dr HOSSAIN (Bangladesh) strongly supported the draft resolution. Many countries were still vulnerable to poliomyelitis, and concerted efforts were needed in order to prevent transmission of wild-type poliovirus and halt its importation. After five years free of poliomyelitis, Bangladesh had

responded rapidly to a case of imported poliovirus at the beginning of 2006, in keeping with the requirements of the draft resolution.

Mrs LE THI THU HA (Viet Nam) welcomed the considerable progress made towards the eradication of poliomyelitis but expressed concern that the number of cases in countries newly affected by imported poliovirus was higher than in those in which the disease was endemic. WHO and its international partners should redouble their efforts to interrupt transmission of wild-type poliovirus.

Ms MATA (Bolivarian Republic of Venezuela) said that more should be done by countries and organizations to assist countries newly affected by imported poliovirus and those endemic for the disease in order to ensure that immunization coverage was maintained, particularly among children. A major problem was the lack of financial support for the eradication process. Venezuela sought a more equitable distribution of resources and an end to financial speculation linked to the sale of medicines. It expressed solidarity with all countries not yet free of the disease and urged them to continue their elimination efforts as poliomyelitis anywhere was a risk for all. It supported the draft resolution.

Dr PECORARO (Italy) said that, despite the commendable efforts made over the previous five years, eradication of poliomyelitis had proved much more difficult than that of smallpox for three main reasons: the high proportion of subclinical cases; the existence of vaccine-derived poliomyelitis; and population and political changes. Italy had supported elimination efforts both financially and technically for some years and would continue to do so.

Dr ABEBE (Nigeria) said that Nigeria was making every effort to interrupt wild-type poliovirus transmission, especially in the northern part of the country through its new Immunization Plus strategy and increased routine immunization coverage, including targeted house-to-house activities. The country urgently needed support in order to meet the funding shortfall for its 2006 activities and the provision of Immunization Plus commodities. Nigeria endorsed the draft resolution and assured Member States of its commitment to interrupt the transmission of wild-type poliovirus.

Dr ZOMBRE (Burkina Faso) said that, despite the enormous progress worldwide, pockets of the disease remained. Although Burkina Faso had not detected a single case of infection with wild-type poliovirus since September 2004 and surveillance of acute flaccid paralysis was regarded as satisfactory, the various recommended eradication strategies were being rigorously pursued. Burkina Faso supported the recommendations that States in which the virus was endemic should strengthen their commitment to interrupt its transmission. The international community should continue its efforts to mobilize the funds required in order to implement the necessary activities both in countries endemic for the disease and in countries at risk of importing the virus.

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

The meeting rose at 17:50.

THIRD MEETING

Wednesday, 24 May 2006, at 09:40

Chairman: Dr A. RAMADOSS (India)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Implementation of resolutions: progress reports: Item 11.17 of the Agenda (Document A59/23)

- **Strengthening nursing and midwifery (resolution WHA54.12)**

Her Royal Highness Princess Muna AL-HUSSEIN (Jordan), the WHO patron for nursing and midwifery, speaking at the invitation of the CHAIRMAN, expressed condolences on the death of the Director-General.

The challenge posed by the current lack of human resources for health was enormous. WHO estimated that 57 countries suffered shortages of health workers, hindering the achievement of the Millennium Development Goals. The estimated global deficit of 2.4 million doctors, nurses and midwives was exacerbated by the uneven distribution of such workers in almost all countries, characterized by urban concentration and shortages in the rural areas. Constraints to nursing and midwifery included lack of training and essential skills, difficult working environments, weak professional and career development, inappropriate salary structures and lack of social recognition. Meeting these challenges needed strong political commitment, effective strategies and wide-ranging alliances.

The needs of the health workforce should be much higher on the agenda of health ministers, leaders of health professions and other policy-makers. At the Fifty-second session of the WHO Regional Committee for the Eastern Mediterranean in October 2005 she had highlighted the urgent need to review human resources in nursing. Integrated planning of the health-care workforce was required in order to monitor supply and demand, to improve recruitment, retention and deployment, and to study work patterns. She welcomed the recent launch of *The world health report*, which included an action plan that dealt with some of those needs.

Improved nursing and midwifery services were essential for attaining health targets. Jordan recognized the importance of nursing and midwifery, had strengthened their role in national health development, and had established many nursing schools and colleges. Jordan collaborated closely with other countries of the Eastern Mediterranean Region in strategic development, training and capacity building. Action was needed to plan human resources; involve the nursing profession in health policy-making; upgrade nursing education; continue professional development; enhance management and leadership skills for nurses; and establish quality assurance systems and a regulatory framework for nursing and midwifery practice. Such action was consistent with the strategic directions for nursing and midwifery services developed by the Secretariat. Member States could begin to assess their follow-up to resolution WHA54.12 on strengthening nursing and midwifery and discuss ways to accelerate national initiatives. She encouraged them to sustain investment in nursing and midwifery services, and urged the Secretariat to support, resource and promote those services in Member States. Health service systems could not improve without educated, valued and properly rewarded nurses and midwives, and all stakeholders should work together to meet that challenge.

(For adoption of the draft resolution, see summary record of the eleventh meeting, section 2.)

Eradication of poliomyelitis: Item 11.2 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R1 and Annex 4, and A59/6) (continued from the second meeting)

Mr HAGE CARMO (Brazil) said that his country had eliminated transmission of poliovirus through a successful campaign of immunization and surveillance carried out since the 1980s. However, there was need for continued research and maintenance of high levels of immunization and surveillance in order to achieve the goal of worldwide eradication. WHO needed to formulate a plan for the post-eradication phase, particularly with regard to the introduction of intramuscular vaccine in countries that still used oral vaccine and in countries where indigenous poliomyelitis had been eliminated for more than two decades. The risk of vaccine-associated poliomyelitis, which ranged from 1 case per 750 000 doses to 1 case per 4 million doses, as registered in Brazil, had to be dealt with.

Brazil supported the aim of eliminating indigenous poliovirus worldwide, and was making every effort not only to maintain those achievements but to help other countries. He suggested that, in paragraph 2(1) of the draft resolution contained in resolution EB117.R1, the words "when necessary", between commas, should be inserted before "requesting".

Dr BALAGUER CABRERA (Cuba) said that poliomyelitis had been eradicated in his country since 1962. WHO's eradication strategy had been a success. The report showed that adequate progress was being made in Asia, but not in sub-Saharan Africa, especially in northern Nigeria, which seemed to be the only world reservoir of types 1 and 3 poliovirus. A new strategic plan had been launched for the period 2004-2008, with the four major objectives of interrupting transmission, registering worldwide eradication, formulating a policy for the post-eradication period and integrating the poliomyelitis eradication infrastructure in general health activities. The replacement of oral vaccine by inactivated vaccine, which was about 10 times more expensive, called for a high level of funding in order to guarantee 95% coverage in the poorest countries. Cuba, in collaboration with WHO and PAHO, had conducted research with inactivated poliomyelitis vaccines. Those had shown high seroconversion rates for the three types of poliovirus, in programmes of immunization at 6-10 and 14 weeks or at 2 and 4 months: that finding was significant for those developing countries that still had to convert from oral to inactivated vaccine. There would have to be high-security laboratories in order to ensure that wild-type polioviruses could not escape, since that would have catastrophic consequences, bearing in mind that inactivated vaccine provided no protection with regard to contact with orally-vaccinated persons.

He supported the draft resolution, but pointed out that the poorest States would have to be given sufficient technical and financial help to ensure that the requisite biocontainment action could be taken should polioviruses be detected circulating in poliomyelitis-free areas.

Professor MWAKYUSA (United Republic of Tanzania), speaking on behalf of Member States in the African Region, said that, in 2004, 12 African countries had reported and confirmed wild-type poliovirus transmission. By the end of 2005, pandemic transmissions had been halted in Niger, but four previously poliomyelitis-free countries, Angola, Cameroon, Eritrea and Ethiopia, had experienced the importation of wild-type poliovirus. The Region's strong political commitment to poliomyelitis eradication had been reaffirmed at the African Union Summit of Heads of State and Government (Abuja, 30-31 January 2005). National immunization days had been conducted in many African countries, during which 100 million children had received repeat doses of oral poliomyelitis vaccine. Certification of standard acute flaccid paralysis surveillance had been sustained in 41 of the Region's 46 countries, and the African Certification Commission had reviewed and accepted poliomyelitis-free documentation from nine countries that had been disease-free for three years. Countries were continuing to strengthen routine immunization through the "reach every district" approach, in keeping with the original poliomyelitis-eradication strategy's target of at least 80% routine immunization coverage. Many countries had applied that approach successfully including his own, where there had been no case of wild-type poliovirus transmission since 1996. Although northern Nigeria remained a

reservoir of poliovirus types 1 and 3, cases were restricted to small foci. The Nigerian Government was making efforts to curb poliovirus transmission through its "Immunization Plus" initiative.

Despite those achievements, several factors could have a negative impact on eradication activities, such as wild-type poliovirus transmission, low routine immunization coverage, low surveillance capacity, cross-border population movements, ignorance and misconceptions, insufficient financial resources and restricted global vaccine availability. The presence of large numbers of refugees could also undermine the successes achieved.

The African countries were grateful to partners that had provided them with vaccines. However, they would continue to need the international community's support for poliomyelitis eradication activities in order to implement the new strategy of significantly reducing wild-type poliovirus transmission by the end of 2006 and improving routine immunization. Otherwise, the global, regional and national gains achieved thus far might be undermined. He supported the draft resolution.

Dr CHEW Suok Kai (Singapore) commended WHO's endeavours to achieve global eradication of poliomyelitis and the tremendous efforts made by countries endemic for the disease to halt wild-type poliovirus transmission. Over the years, Singapore had become a regional and international focus for medical treatment, attracting many foreign patients. Thus, in April 2006, a child from an African country who had apparently received a complete course of poliomyelitis immunization had travelled to Singapore for treatment of lower limb weakness. The case had been detected rapidly by Singapore's acute flaccid paralysis surveillance system and wild-type poliovirus had been identified. The child, who had been infected outside Singapore, had been treated and returned to its country of origin. The risk of poliovirus transmission in that instance had been minimized, as Singapore had very high routine childhood immunization coverage and a very high standard of environmental hygiene and sanitation. However, the situation might be different in other countries where there was a risk of the importation and transmission of wild-type poliovirus. No country would be safe from that devastating disease until all countries had eliminated poliomyelitis. He therefore strongly supported the draft resolution, but after paragraph 3(3) an additional subparagraph should be inserted requesting the Director-General to continue to prepare for other potential risks to poliomyelitis eradication in the short and long term, and to propose a mechanism for risk management to the Executive Board at its session in January 2007.

Dr BOTROS SHOKAI (Sudan) attributed the tremendous progress to cooperation. With the goal of global eradication within reach, however, the suspension of immunization in some parts of Africa and the cessation of immunization campaigns in countries with no new cases had led to an epidemic reemergence in countries that had already started the certification process. The remaining disease pockets posed a real threat to everything that had been achieved so far. Securing the necessary funds to complete poliomyelitis eradication required commitment on the part of the international community and donor countries.

In 2004, poliovirus had been imported into her country from west Africa and had spread to many states following the known historical route for epidemics in the country, that taken by migrant labourers and pilgrims. Her Government's response had been prompt and successful. Surveillance had been strengthened, national immunization days had been held with almost 100% coverage, mop-up immunizations had been conducted and routine Expanded Programmes on Immunization had been improved. She fully supported the draft resolution.

Mr SHARMA (India) expressed support for the draft resolution and pledged his country's full commitment to a poliomyelitis eradication programme which had achieved encouraging results in the past five years through strategically planned supplementary immunization activities and sensitive surveillance of acute flaccid paralysis. More than 20 000 cases had been reported at the beginning of the programme, but that number had declined to 66 in 2005. In terms of geographical spread, the number of affected districts had declined from 159 to 14, with pockets in western Uttar Pradesh and Bihar. Type 2 poliovirus had not been reported since 1999 and type 3 had been found in only one district; that distribution had permitted the use of highly immunogenic monovalent vaccine. Several

national and subnational immunization days had been held over the past few years. The two most recent national days had covered 170 million children in each round. Five million children in transit had also been immunized in 2005. Routine immunization had been stepped up, especially in the states of Uttar Pradesh and Bihar, and monthly health camps were being held in the country's 700 000 villages. Four subnational immunization rounds would be conducted between June and November 2006. All the indicators encouraged his Government's belief that India would be able to halve the transmission of poliovirus.

Dr IMAMECIOGLU (Turkey) emphasized that the Global Polio Eradication Initiative had brought a poliomyelitis-free world within reach, but much remained to be done. His Government would continue to support the Initiative within the Organization of the Islamic Conference and was continuing its poliomyelitis eradication activities in Afghanistan.

Dr TSHABALALA-MSIMANG (South Africa) noted the tremendous progress made since resolution WHA41.28. Significant challenges remained, however. The initial target of global eradication by 2000 had not been met, nor had the target for 2005 set out in the Global Polio Eradication Initiative Strategic Plan, 2000. The current pattern of wild-type poliovirus transmission and importations of the virus into previously poliomyelitis-free countries also put the 2008 target beyond reach. The Health Assembly, in consultation with the Advisory Committee on Poliomyelitis Eradication, should set a new date for global poliomyelitis eradication. The international health community should shift away from any perception that poliomyelitis eradication was a challenge only for poliomyelitis-endemic countries. The Advisory Committee had recommended that use of oral poliomyelitis vaccines should end once global certification of poliomyelitis eradication was achieved, after which point policy guidance was lacking. WHO should draw up such guidelines soon. The Health Assembly should also consider whether countries using oral poliomyelitis vaccines would need financial support so that they too could acquire injectable vaccine. A fund-raising process for purchase of injectable poliomyelitis vaccine by countries using oral vaccine should be launched in order that immunization policy choices after certification should be based on perceived risk rather than affordability. Indeed, it was the recently endemic, under-resourced developing countries using oral poliomyelitis vaccine that would be most at risk of poliovirus infection in the post-global certification era. She supported the call to scale up poliomyelitis-eradication activities and believed that all Member States should recommit themselves to the goal of poliomyelitis eradication worldwide.

Dr NAKASHIMA (Japan) expressed his appreciation of the continuing hard work of WHO and its partners in order to eradicate poliomyelitis. The Japanese Government had responded to the reintroduction of wild-type poliovirus into Indonesia and the emergence of a vaccine-derived poliovirus in Cambodia, countries which had both previously been poliomyelitis-free, by supporting rapid-response and supplementary immunization activities. Japan was committed to long-term eradication, and was working to ensure that the Western Pacific Region remained poliomyelitis-free. WHO could establish a new target year and prepare a new road map, as suggested by the delegate of South Africa. A new target was also needed for laboratory containment of the virus. Although the use of monovalent oral poliomyelitis vaccine had been effective in interrupting transmission of the virus, it was not always feasible for poliomyelitis-free countries to administer the vaccine as a rapid response to poliovirus re-circulation events. When selecting a vaccine formula, various factors should be taken into account, including the epidemiology of the event, the availability of the vaccine, the capacity to respond, and regulatory problems in the affected countries. His Government was committed to the global eradication of poliomyelitis, as outlined in the draft resolution. However, in paragraph 2(2) he suggested inserting the words "or another composition of vaccine, if appropriate", following "oral poliomyelitis vaccine".

Dr MOHAMMAD (Oman) thanked WHO for its timely provision of monovalent oral poliomyelitis vaccine stocks which had significantly contributed to his country's successful eradication of the disease. He urged the Organization to strengthen its efforts in countries where

poliovirus remained endemic, especially Afghanistan and Pakistan. Although millions of dollars had been spent on stemming the outbreaks and striving to eradicate poliovirus, a solution was needed in order to prevent its re-emergence. In the preparation of prevention strategies, the experience of other WHO regions should be taken into account, including the effectiveness of immunization campaigns for children. He endorsed the draft resolution.

Dr AHMED (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, as a result of the eradication programme in the Region, Egypt had been declared poliomyelitis-free two years after the last case was confirmed in May 2004. In the two remaining countries where the disease was endemic, Afghanistan and Pakistan, virus transmission was geographically and genotypically limited. However, the Region had suffered a serious setback during the past two years as a result of the importation of poliovirus from other countries. Epidemics had occurred in Somalia, Sudan and Yemen, which had been free of the disease for many years. With the support of their partners, Sudan and Yemen had managed to halt the epidemics, through great effort and expense. Somalia was also striving to control its own epidemic and to regain its poliomyelitis-free status. There was considerable anxiety through the Region about the high risk of reinfection by wild-type poliovirus re-imported from other countries. The risk would continue as long as the situation in Nigeria remained unchanged. The Regional Office was carefully monitoring the reservoir that had been the source of previous importations. The large number of reported cases of poliomyelitis during the first quarter of 2006 was a cause for grave concern, being over three times the number reported in 2005 and a substantial increase over the number in 2004, when the importation had occurred. As a result, the affected countries had conducted many rounds of national immunization days at a cost of millions of dollars, but more importantly a thousand children had been left disabled. He urged the countries where poliomyelitis was still endemic to strengthen their efforts to achieve 95% countrywide vaccination coverage. WHO should assist them in achieving global eradication of poliomyelitis by the end of 2006. The Member States of the Region fully supported the draft resolution.

Dr CAMARA (Guinea) acknowledged that poliomyelitis has been transformed from a once virulent and deadly disease into a comparatively rare one. However, polioviruses were continuing to circulate and the risk of transmission persisted in countries endemic for poliomyelitis. Since 2004, no new case of poliomyelitis had been reported in Guinea, but the country remained at risk of reinfection from its neighbours. With general support from donors, the disease could be eradicated. Guinea itself aimed to maintain an 80% vaccination coverage rate. It also intended to comply with the relevant performance indicators in surveillance of acute flaccid paralysis, and to improve its epidemiological capacity and mop-up new cases of wild-type poliovirus. He supported the draft resolution.

Dr YUSHARMEN (Indonesia) supported the draft resolution. The eradication of poliomyelitis had remained a top Indonesian health priority, following the declaration in 1995 of the country's poliomyelitis-free status. However, Indonesia was facing the risk of reinfection as a result of the importation of poliovirus into West Java in 2005 and the spread of the disease to other areas. Following an initial outbreak response immunization programme, two "mop-up" immunization rounds had been conducted in the neighbouring provinces. On the recommendation of the technical consultative group on poliomyelitis eradication, three rounds of national immunization days had been organized in 2005 and a further two in 2006, achieving a vaccine coverage rate of nearly 100%. Since 1 January 2006, two cases of poliomyelitis had been reported, with the onset of paralysis in the second case in mid-February. Indonesia planned to conduct "mop-up" operations, if required, during 2006 in order to achieve and maintain eradication status. During the current outbreak, acute flaccid paralysis surveillance had been significantly increased. He expressed appreciation to the countries, international agencies and other donors that had offered support during Indonesia's most recent outbreak.

Mr ABOUBAKER (Djibouti) recalled that Djibouti had been declared poliomyelitis-free in 1999. However, the re-emergence of wild-type poliovirus transmission in several neighbouring countries had prompted a series of immunization campaigns. Priority should be given to assisting

countries endemic for poliomyelitis, especially war-affected countries where health systems had been disrupted or destroyed, in order to meet the objective of immunizing every child. Strengthening epidemiological surveillance systems for early identification of new cases of acute flaccid paralysis should involve the community. Routine immunization should be made more widely available by improving primary health care systems, and thus the post-eradication phase could be managed with the very limited resources available.

Dr SADRIZADEH (Islamic Republic of Iran) said that the transmission of indigenous poliovirus had been significantly decreased in most of the countries endemic for poliomyelitis in the affected regions. The frequent importation of wild-type poliovirus into the poliomyelitis-free countries of Africa and Asia was a matter of concern. All countries must remain alert, however close the target of poliomyelitis eradication might be. High-level political commitment, community action and close intersectoral collaboration, as well as global solidarity and international cooperation, were needed. In his country, the circulation of indigenous poliovirus had been interrupted in 1997 and no wild-type poliovirus had been imported since December 2000. However, despite very high rates of routine and supplementary immunization with oral poliomyelitis vaccine and a sensitive surveillance system for acute flaccid paralysis, the country was alert to the risks of importation of wild-type poliovirus from those neighbouring countries endemic for poliomyelitis. The problem of importation could be tackled rapidly and efficiently, but the danger remained of losing the trust and confidence of communities.

Dr MELNIKOVA (Russian Federation) expressed appreciation of the efforts of WHO to eradicate poliomyelitis, which remained endemic in only four countries. Given the possibility of importation of wild-type poliovirus from those countries, the poliomyelitis-free countries must continue routine and supplementary immunization against the disease, organize high-quality epidemiological surveillance, and improve laboratory networks until the goal of eradication was achieved. She supported the draft resolution.

Mr HEIBY (United States of America) acknowledged the tremendous progress made by several affected countries, but recognized the continuing risk of wild-type poliovirus importations from northern Nigeria into Niger and the need to sustain the highest level of immunization coverage in Niger. Efforts to achieve eradication needed to continue. He commended the response by countries and international organizations to outbreaks of poliomyelitis originating in Nigeria. Extraordinary efforts had also been made by the governments of Egypt and India, along with WHO and UNICEF, to enable rapid development, licensing and deployment of monovalent oral poliomyelitis vaccines which had terminated or significantly reduced virus transmission in key endemic areas. In the final stages of poliomyelitis eradication, all countries should reduce the risk of importation and ensure that they could detect rapidly the circulating poliomyelitis virus and respond effectively. Political leadership was essential in order to improve the quality of supplementary immunization campaigns, increase routine immunization coverage and enhance surveillance. The new threat posed by the spread of wild-type poliovirus demanded constant monitoring of the situation. Once poliomyelitis was eradicated, it would appear in the list of diseases for which immediate notification was required under the International Health Regulations (2005). He urged all countries to adhere to the reporting requirement forthwith on a voluntary basis, and to cooperate fully in the final stages of the international campaign to eradicate the disease.

His country fully supported the draft resolution and wished to be listed as a sponsor. He suggested that, in paragraph 2(3), the words “all children” be replaced by “two to five million children”.

Dr XIAO Donglou (China) supported the proposals and strategies proposed in the report. The Chinese Government set great store on the expanded programme on immunization for children, which would be free. Funding for that purpose had increased and, for many years, the immunization rate for children had been more than 85%. Since 2000, there had been no wild-type poliovirus epidemic in China in spite of the continuing threat from neighbouring countries and territories. China intended to

step up poliomyelitis immunization programmes and to improve its monitoring of acute flaccid paralysis, particularly as poliomyelitis was still endemic in a small number of countries. He appealed to all countries to introduce effective joint prevention, control and reporting mechanisms. WHO should increase its technical guidance and support for countries and territories where poliomyelitis existed. A system for risk assessment of transmission of the disease should be established.

Dr KAGGWA (Uganda) said that his country was wholly committed to the Global Polio Eradication Initiative and no case had been reported there for nine years. Over the past 10 years, the Government had increased routine and supplementary immunization campaigns. Immunization coverage for infants had increased from 57% in 2000 to 84% in 2005. Supplementary immunization programmes had been carried out annually in the period from 1996 to 1999. They had since focused on high-risk districts bordering the Democratic Republic of Congo, Kenya and Sudan. In eight rounds of immunization days, coverage of over 90% had been achieved.

In its nationwide surveillance of acute flaccid paralysis, Uganda had attained the WHO indicators over three years previously, and was preparing documentation for submission to the African Regional Certification Commission in October 2006. The threat of poliovirus importation was real, and the country had a plan for preparedness and response. The prevailing insecurity in some parts of the country undermined the maintenance of high coverage with oral poliomyelitis vaccine and effective surveillance. Other constraints arose from the sharp fall in funding for poliomyelitis-related activities, and global fluctuations in the availability of poliomyelitis vaccine. Uganda was recommending one round of the national poliomyelitis immunization campaign in 2006, and requested support in order to finance it. He endorsed the draft resolution.

Professor HORVATH (Australia) supported the draft resolution. Although global eradication of poliomyelitis was attainable, the report made clear that greater political commitment and resources would be needed over the period 2006 to 2008 in order to achieve it. He urged Nigeria to take the stated action, in order to interrupt transmission of the virus. Australia had made a substantial financial contribution to eradication, giving Aus$ 500 million in 2006 to WHO for the global programme, Aus$ 7.6 million to Rotary International under the Global Polio Eradication Initiative, and a total of Aus$ 3.45 million since April 2005 towards halting the spread of poliomyelitis in Indonesia. Imported live poliovirus in that country had highlighted the need for vigilance and high immunization levels. The Western Pacific Region had been declared poliomyelitis-free, but the Pacific region as a whole remained vulnerable to vaccine-preventable diseases. Some countries in that region might need support in order to implement immunization campaigns if imported poliovirus was detected.

Professor BELLA ASSUMPTA (Cameroon) said that the circulation of wild-type poliovirus in her country had been halted for three years. Unfortunately, however, since 2003 imported cases had been recorded. National immunization campaigns had resumed, in conjunction with those in other west African countries. Cameroon had tightened up its surveillance system, and was conducting immunization campaigns along its borders.

She supported the draft resolution, but was concerned at the absence of any recommendation on long-term policy options for immunization (paragraph 7 of the report). The Secretariat should make proposals to countries on the matter of eventually ceasing the use of oral poliomyelitis vaccine.

Dr EL SAYED (Egypt) commended WHO's continuing efforts at eradicating poliomyelitis. The last notified case of poliomyelitis in Egypt had occurred in May 2004. Subsequently, countrywide immunization campaigns had been conducted, including a series of house-to-house visits. Routine immunization campaigns, using monovalent oral poliomyelitis vaccines, covered 95% of the territory. Further support was needed in order to combat poliomyelitis in Africa, the continent most affected. Political, community and religious leaders should be induced to lend their authority to the campaigns.

Mr CHO Do-yeon (Republic of Korea) said that maintaining the poliomyelitis-free status of the Western Pacific Region was the key priority for health policy in his country. It had been playing an

active part in WHO's quality control programmes for poliovirus laboratories, including acute flaccid paralysis surveillance and laboratory accreditation. It was also active in global joint research on polioviruses and other enteroviruses, with Government funding for improving early detection and research capabilities. Since 2005 it had been using inactivated poliomyelitis vaccine in order to avoid adverse effects caused by live attenuated poliomyelitis vaccines. In future, the wild-type poliovirus and vaccine strains would be promptly destroyed, as recommended by WHO. His country was active in global eradication efforts, and sought the support and assistance of WHO for continued implementation of its poliomyelitis eradication programmes.

Mr ANUTIN CHARNVIRAKUL (Thailand) drew attention to the risk of international spread of wild-type poliovirus. Its further spread had been averted by the measures taken by WHO and other development partners, notably UNICEF, at a cost of more than US$ 300 million. He proposed several amendments to the draft resolution. In the fifth preambular paragraph, the words "in 2005" should be inserted after "most of the new cases", followed by a new preambular paragraph which should read: "Noting with concern that there is a substantial unmet funding requirement of US$ 485 million for planned activities during the mop-up and certification phase between 2006 and 2008". A new subparagraph 2(5) should be added, to read: "sustaining high coverage of routine oral poliomyelitis vaccine immunization of at least 80% and highly sensitive disease surveillance".

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), expressing his support for the draft resolution, said that two major challenges to eradicating poliomyelitis remained. Funds were urgently needed. The United Kingdom had recently committed US$ 70 million to the eradication initiative for the current two-year period, bringing its total contribution up to US$ 600 million. He called on other countries to increase their own contributions to the initiative. The second and greatest challenge was the situation in northern Nigeria. The Nigerian authorities needed support in implementing their revised strategy; progress ought to be reviewed once the pilot phase was completed later in the year.

Dr CAMPBELL (New Zealand) also supported the draft resolution. In paragraph 1, he proposed replacing the verb "foster" by "act on".

Dr MOETI (Botswana) congratulated WHO and its partners for their support to African countries in their fight against poliomyelitis. Having experienced import of poliovirus in 2003 (and subsequently eliminated it), Botswana valued WHO's technical support. In spite of an importation in 2004, Botswana had met the required criteria for poliomyelitis-free status, and its documentation report to the African Regional Certification Commission in October 2005 had been accepted. It needed to maintain that status for the goal of poliomyelitis-free certification for the entire Region to be attained. Botswana looked forward to continued support from WHO and from other partners in order to combat indigenous wild-type poliovirus transmission and strengthen the surveillance and control activities in Member States that were currently poliomyelitis-free.

Mr ASLANYAN (Canada) concurred with the actions proposed in the report. Eradication should be predicated on a dual strategy of sufficient funding and strong political will by both donor and affected countries. Overall progress was encouraging but the international spread of the virus in zones previously free of poliomyelitis and the increasing incidence in Nigeria were causes for concern. Canada endorsed the proposed resolution, and encouraged the Secretariat to continue to work closely with Member States on its implementation.

Dr OTTO (Palau) said that his country's last case of poliomyelitis had occurred in 1968. Its current immunization rate for all vaccine-preventable diseases among children ranged from 95% to 98%. He commended the role played by Rotary International and UNICEF in poliomyelitis eradication efforts worldwide, and the Regional Office for the Western Pacific for its continued assistance to

Member States so that the Region remained poliomyelitis-free. Palau supported the draft resolution, with the amendments proposed by the delegates of Japan and New Zealand.

Mr RUÍZ MATUS (Mexico), commending WHO's efforts to interrupt poliovirus transmission, explained that Mexico was preparing for poliomyelitis eradication certification and was ceasing the use of oral poliomyelitis vaccine, which would be replaced in 2007 by a pentavalent acellular inactivated vaccine. It would continue to use oral poliomyelitis vaccine in the mass vaccination campaigns conducted during national health weeks. Mexico was committed to maintaining a high level of immunization coverage and surveillance and to containing and destroying wild-type poliovirus samples, which were stored in its central laboratory under high security. He welcomed the draft resolution.

Mr AL-QUTAMI (United Arab Emirates) said that his country continued to contribute to global poliomyelitis eradication efforts even though it had been free of poliomyelitis since 1974 and that status had been certificated. It was committed to maintaining that status in the post-certification phase through surveillance and prevention, for which laboratory support would be important. Quarterly and annual reports would be submitted to the Regional Office for the Eastern Mediterranean. A new preventive campaign had been launched in May-June 2005, together with an emergency plan for responding to any fresh outbreak of poliomyelitis. He commended the contribution of the Regional Office to poliomyelitis eradication efforts, and expressed support for the draft resolution.

The meeting rose at 11:30.

FOURTH MEETING

Wednesday, 24 May 2006, at 15:15

Chairman: Dr A. RAMADOSS (India)

1. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Eradication of poliomyelitis: Item 11.2 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R1 and Annex 4, and A59/6) (continued)

Dr VIOLAKI-PARASKEVA (Greece) emphasized the constant need for high-quality surveillance and suggested adding a new penultimate preambular paragraph to the draft resolution that would read: "Noting the importance of high-quality surveillance systems in countries where polio has been eradicated".

Dr ST JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, said that, although the Region of the Americas had been certified poliomyelitis-free in 1991, the countries in the Caribbean region would continue to be vigilant. They therefore urged that an adequate supply of trivalent oral poliomyelitis vaccine should be made available through the revolving fund. In the view of the large numbers of travellers to and from the Caribbean region, and the region's hosting of the Cricket World Cup in 2007, monovalent and oral poliomyelitis vaccines types 1 and 3 should be made available at an affordable price in order to prevent outbreaks of vaccine-derived poliomyelitis. Barbados fully supported the draft resolution as amended by New Zealand.

Dr AZIZ (Polio Eradication Initiative), speaking at the invitation of the CHAIRMAN on behalf of Rotary International, praised the dedication of the world's health leaders to achieve a poliomyelitis-free world. Rotary International supported efforts to ensure that every child was protected from that scourge and had already devoted almost US$ 600 million to that end, responding with grants in order to ensure immediate availability of funds wherever outbreaks had occurred. Other donors should do likewise. Its members had spent countless hours helping to immunize children in many countries, and would continue to do so. Governments had cooperated by synchronizing immunization campaigns in order to prevent the virus from spreading across borders. With only four countries still endemic for poliomyelitis, Rotary International called upon the leaders of Afghanistan, India, Nigeria and Pakistan to commit fully to eradicating the virus. As long as transmission continued in those countries, the threat of the spread to all poliomyelitis-free countries would remain.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that Members' comments and the continued strong support of the G8 countries, the Organization of the Islamic Conference, the African Union, and countries where poliomyelitis was still present confirmed the collective will stay on course until the goal of eradication had been achieved. As long as the disease remained in one country, all countries were at risk; the Director-General's Circular Letter of 27 April 2006 had advised all countries of the continued risk and of the need to maintain high poliomyelitis vaccination coverage. The draft resolution had been strengthened by the proposed amendments.

Monovalent oral poliomyelitis vaccines had been in use for one year and had proved their effectiveness; a recent comparative trial had shown that it was possible to double the number of children protected after a first dose. Monovalent vaccines were currently being used in all countries

with poliomyelitis and a stockpile was being established in order to support countries in the event of an outbreak. The Secretariat continued to work with Member States in exploring new ways to use inactivated poliomyelitis vaccines, including intradermal use, that could decrease the dose required and therefore reduce the cost. New guidelines for inactivated poliomyelitis vaccine use had recently been published in the *Weekly Epidemiological Record*, and work was in progress on the oral poliomyelitis vaccine cessation strategy in order to ensure maintenance of a poliomyelitis-free world.

The Advisory Committee on Poliomyelitis Eradication, at its meeting in October 2006, would be making recommendations to the Director-General regarding eradication targets. Government commitment in the four countries in which poliomyelitis was still endemic remained high and progress was being made. The 24 countries in which poliovirus had been reintroduced since 2003 had also demonstrated strong commitment and proved that imported poliovirus could be dealt with rapidly and outbreaks contained. Nine of those countries continued to fight the disease.

WHO and the poliomyelitis partners, Rotary International, UNICEF, and Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America), would continue to support countries in poliomyelitis eradication in whatever capacity was required. They looked forward to working with Nigeria in pursuing its new Immunization Plus strategy, involving, inter alia, house-to-house vaccination. They would also continue to work with countries on the "reaching every district" strategy to ensure that the resources invested in poliomyelitis eradication benefited routine immunization activities, and would support countries that continued to broaden poliomyelitis surveillance networks to other infectious diseases, such as measles, yellow fever and avian influenza.

Mr AITKEN (Adviser to the Director-General) read out the proposed amendments. In the fifth preambular paragraph, Thailand had proposed that "in 2005" should be added after "new cases", and the addition of a new sixth preambular paragraph to read: "Noting with concern that there is a substantial unmet funding requirement of US$ 485 million for planned activities during the mop-up and certification phase between 2006 and 2008". Greece had proposed the addition of a new penultimate preambular paragraph to read "Noting the importance of high-quality surveillance systems in countries where polio has been eradicated". In paragraph 1, New Zealand had proposed that "foster" should be replaced by "act on". Brazil had proposed that the words "when necessary" should be inserted after "responses and" in paragraph 2(1). In paragraph 2(2), Japan had proposed the addition of "or another composition of vaccine, if appropriate," after "oral poliomyelitis vaccine". The United States of America had suggested that at the beginning of paragraph 2(3) the words "all children" should be replaced by "two to five million children". The Philippines had proposed new paragraph 2(5) that would read "enhancing surveillance for acute flaccid paralysis to a level of greater than two cases per 100 000 children aged less than 15 years for the duration of the outbreak and at least 12 months immediately thereafter". Thailand had suggested a new paragraph 2(6) that would read "sustaining high coverage of routine oral poliomyelitis vaccines immunization of at least 80% and highly sensitive disease surveillance". Singapore had suggested that a new paragraph should be added after paragraph 3(3) that would read "to continue to assess other potential risks to polio eradication and a polio-free world in the short- and long-term, and propose a mechanism for their management to the 119th session of the Executive Board".

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

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA59.1.

Intellectual property rights: Item 11.11 of the Agenda

- **Commission on Intellectual Property Rights, Innovation and Public Health: report** (Documents A59/16, A59/16 Add.1, A59/16 Add.1 Corr.1 and A59/16 Add.2)

- **[Global framework on]essential health research and development** (Documents EB117/2006/REC/1, resolution EB117.R13 and Annex 4, and A59/17)

Dr ANTEZANA ARANÍBAR (Bolivia), supported by Mr DE CASTRO SALDANHA (Brazil), suggested that, as two draft resolutions had been submitted for the Committee's consideration, a drafting group should be formed to consider whether they could be combined into one. In view of the time constraints facing the Committee, the group should begin its work straight away.

Following a procedural discussion on the mandate and membership of a drafting group, and whether the draft resolutions should be first discussed by the Committee, in which Dr NYIKAL (Kenya), Dr TSHABALALA-MSIMANG (South Africa), Dr ANTEZANA ARANÍBAR (Bolivia), Dr AHMED (Pakistan), Mr SHARMA (India), Dr STEIGER (United States of America), Dr LEVENTHAL (Israel) and Mr AITKEN (Adviser to the Director-General) took part, the CHAIRMAN, on the suggestion of Dr NYIKAL (Kenya), proposed that the Committee should take up the item at its fifth meeting, after which a drafting group would meet to work further on the draft resolutions in the light of the Committee's discussion.

It was so agreed.

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

Strengthening pandemic-influenza preparedness and response, including application of the International Health Regulations (2005): Item 11.1 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R7 and Annex 4, A59/4 and A59/5) (continued from the second meeting)

The CHAIRMAN drew attention to the following revised draft resolution, which read:

The Fifty-ninth World Health Assembly,

Having considered the report on application of the International Health Regulations (2005);

Recalling resolutions WHA58.3 on revision of the International Health Regulations and WHA58.5 on strengthening pandemic-influenza preparedness and response;

Reaffirming the serious risk to human health, including the possible emergence of a pandemic virus, arising from ongoing outbreaks in poultry of highly pathogenic avian influenza, caused by the H5N1 strain of *Influenzavirus A*, in parts of Asia and elsewhere;

Noting with concern the persistence of outbreaks in poultry, the continuing occurrence of sporadic cases of severe human disease associated with these outbreaks, the endemicity of the virus in several countries, the spread of the virus through the migration of wild waterfowl to new areas, and its predicted further spread;

Aware that these and other developments have increased the probability that a pandemic may occur;

Highlighting the importance of WHO's global influenza preparedness plan and the control measures recommended therein;[1]

Mindful that rapid detection of human cases, supported by adequate national capacity, and rapid and transparent reporting of findings underpin WHO's ability to issue a reliable risk

[1] Document WHO/CDS/CSR/GIP/2005.5.

assessment and declare an appropriate phase of pandemic alert, and are further needed to ensure that the earliest epidemiological signals of increased transmissibility of the virus among humans are not missed;

Aware that several provisions in the International Health Regulations (2005) would be useful in ensuring a strengthened and coordinated response on the part of the international community to both the present situation and a possible pandemic;

Further aware that strengthened capacity to respond to human cases of avian influenza and the corresponding pandemic threat will strengthen the capacity to respond to many other emerging and epidemic-prone infectious diseases, and thus increase global public-health security against the threat of infectious diseases;

Noting that the International Health Regulations (2005) will not enter into force until 15 June 2007;

Recalling the main conclusions reached, and recommended actions agreed on, during a joint meeting convened by WHO, FAO, OIE and the World Bank on avian influenza and human pandemic influenza (Geneva, 7-9 November 2005);

Responding to the specific request made during that meeting to put forward proposals to the Fifty-ninth World Health Assembly through the Executive Board at its 117th session for immediate voluntary compliance with relevant provisions of the International Health Regulations (2005),

1. CALLS UPON Member States to comply immediately, on a voluntary basis, with provisions of the International Health Regulations (2005) considered relevant to the risk posed by avian influenza and pandemic influenza;

2. DECIDES that relevant provisions of the International Health Regulations (2005) shall include the following:

(1) Annex 2, in so far as it requires prompt notification to WHO of human influenza caused by a new virus subtype;

(2) Article 4 pertaining to the designation or establishment of a National IHR Focal Point within countries and the designation of WHO IHR Contact Points, and the definition of their functions and responsibilities;

(3) Articles in Part II, pertaining to [surveillance, (UK)] information-sharing, consultation, verification and public health response;

(4) Articles 23 and 30-32 in Part V pertaining to general provisions for public health measures for travellers on arrival or departure and special provisions for travellers;

(5) Articles 45 and 46 in Part VIII pertaining to the treatment of personal data and the transport and handling of biological substances, reagents and materials for diagnostic purposes;

3. NOTES that such voluntary compliance is without prejudice to the position of any Member State with regard to the International Health Regulations (2005) [~~after their entry into force~~ (USA)];

4. URGES Member States:

(1) to designate or establish immediately a National IHR Focal Point, as provided for in Article 4 of the Regulations, and inform WHO accordingly within 90 days, the said Focal Point having the authority to communicate official information and [to provide support for participate in (UK)] collaborative risk assessment with WHO;

(2) to follow, in matters pertaining to human cases of avian influenza, mechanisms and procedures set out in the Regulations for a disease that may constitute a public health emergency of international concern;

(3) to provide transparent and urgent notification and subsequent continued communication to WHO of any probable or confirmed human cases of avian influenza, including exported or imported cases;
(4) to disseminate to WHO collaborating centres information and relevant biological materials related to highly pathogenic avian influenza and other novel influenza strains [, for non-commercial purposes only, (Thailand)] in a timely and consistent manner;
(5) to strengthen collaboration on human and zoonotic influenzas among national organizations responsible for human and animal health in order to strengthen surveillance and implement immediate measures to control outbreaks of avian influenza in humans and animals;
(6) to respect time frames stipulated in the Regulations for undertaking and completing urgent activities and communications, particularly for the reporting of human cases of avian influenza, verification of events, and response to requests for further information from WHO;
(7) to collaborate, including through the mobilization of financial support, to build, strengthen, and maintain the capacity for influenza surveillance and response in countries affected by avian influenza [or pandemic influenza (Thailand)];
(8) to follow recommendations issued by the Director-General, with technical advice from the influenza pandemic task force, considered necessary for the international response to avian influenza or pandemic influenza;
(9) to inform the Director-General of the measures that they have taken in voluntary compliance with the International Health Regulations (2005);
[(10) to initiate a process of identifying and addressing the constraints - administrative and legal - for timely implementation of the Regulations with a view to promoting intersectoral participation; (India)]

5. REQUESTS the Director-General:
(1) to designate immediately WHO IHR Contact Points, as provided for in Article 4 of the Regulations;
(2) to implement, in so far as feasible and relevant for the purpose of this resolution, measures in Parts II and III of the Regulations falling under the responsibility of WHO;
(3) to further accelerate steps to establish a roster of experts and to invite proposals for its membership, pursuant to Article 47;
(4) to use the influenza pandemic task force as a temporary mechanism [until entry into force of the International Health Regulations (2005) (Thailand) in order] to advise the Organization on the response to avian influenza, the appropriate phase of pandemic alert and the corresponding recommended response measures, the declaration of an influenza pandemic, and the international response to a pandemic;
(5) to collaborate with Member States in implementation of the present resolution, and in voluntary compliance with the International Health Regulations (2005), as appropriate, including through:
(a) provision or facilitation of technical cooperation and logistical support;
(b) mobilization of international assistance, including financial support, in consultation with Member States, especially for [avian influenza or pandemic influenza- (Thailand)] affected countries lacking sufficient operational capacity;
(c) production of guidelines as support to Member States in development of capacities for a public-health response specific to the risk posed by avian influenza and pandemic influenza;
[~~(d) establishment of a framework to monitor voluntary compliance of Member States with the International Health Regulations (2005) (Thailand)~~];
[(e) reasonable stock piling of necessary drugs; (India)]

[(f) facilitating, in collaboration with international partners, development and commercial production of vaccines against avian influenza and pandemic influenza; (India)]

(6) to collaborate with Member States to the extent possible in providing support to developing countries in building and strengthening the capacities required under the International Health Regulations (2005);

(7) to mobilize and dedicate WHO's technical resources where possible, using capacities available in regional offices and collaborating centres, in order to expand and accelerate training efforts in the areas of epidemic surveillance, alert and response, laboratory capacity, [including regional networking of laboratories, (India)] biosafety, and quality control, in order to provide support to Member States in implementation of the International Health Regulations (2005);

(8) to report to the Sixtieth World Health Assembly through the Executive Board at its 119th session on implementation of this resolution, and to report annually thereafter on progress achieved in providing support to Member States on compliance with, and implementation of, the International Health Regulations (2005).

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that following informal consultations it was proposed that two new subparagraphs should be added. The first, to follow paragraph 4(4), would read: "to develop domestic influenza vaccine-production capacity or to work with neighbouring States to establish regional vaccine production capacity in order to promote adequate supplies of vaccine in the event of a public health emergency of international concern caused by a novel influenza virus". The second would follow paragraph 5(6) and would read: "to immediately search for solutions to reduce the current global shortage of and inequitable access to influenza vaccines and also to make them more affordable for both epidemic and global pandemic". In return for the acceptance of those amendments, Thailand would withdraw the amendment to paragraph 4(4) that it had proposed at the second meeting, namely the insertion of the words "for non-commercial purposes only" after "strains". For Thailand that was a difficult exchange, since it replaced a win-win solution with one that represented a win-lose situation. The winners would be the developed countries that produced vaccines, while poorer countries that could not gain access to the vaccines would be the losers. It was clear, however, that nobody wished to see a situation in which no new vaccines were available.

Dr TANGI (Tonga) recalled that Tonga had been instrumental in the insertion of paragraph 4(4) during consideration of the draft resolution at the 117th session of the Executive Board. The insertion proposed by Thailand at the second meeting was not perhaps in the best place and he preferred the alternative just proposed.

Professor HORVATH (Australia) supported the intention of the proposed amendment to paragraph 4(1) but suggested that clarity would be improved by amending the wording further so that, following "to communicate official information", it would read "and for the focal point to provide support for national participation in collaborative risk assessment with WHO".

Mr AITKEN (Adviser to the Director-General) read out the amendments proposed by the delegates of Australia and Thailand, and noted that Thailand had offered to withdraw the amendment proposed at the second meeting in respect of paragraph 4(4) in return for the addition of the two new paragraphs.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that he was unable to accept the proposed amendment to paragraph 4(1). It was not adequate to indicate provision of support alone as that did not preserve the scientific integrity of the focal point. In order to promote national capacity-building, the focal point should be able to participate in collaborative risk assessment as well as providing logistic support for such participation. He therefore proposed that the amendment suggested

by Australia should be further amended to read "and for the focal point to provide support for and participate in collaborative risk assessment with WHO".

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) explained that the intention of his original amendment had been to provide a degree of flexibility in the way in which national focal points operated. There was no intention to rule out their participation if that was what a Member State wished; rather it was intended to indicate that the focal point should provide support to whomsoever else was participating. He supported the amendment proposed by Australia.

Dr LI Jianguo (China) supported the proposed amendments. WHO should stimulate additional research and give advice on the conditions in which human to human transmission of H5N1 virus might take place. The Secretariat should also formulate guidelines to enable Member States to make adequate preparations before the International Health Regulations (2005) took effect and to implement them once they came into force.

In reply to a question from Dr TANGI (Tonga), Mr AITKEN (Adviser to the Director-General) confirmed that the amendment to paragraph 4(4) proposed by Thailand at the second meeting had been withdrawn. He suggested that, in order to meet the concern expressed by Thailand regarding the amendment to paragraph 4(1) proposed by Australia while maintaining the flexibility called for by the United Kingdom, the amendment was reworded to read "and for the focal point to provide support for, and if so decided by the Member State, to participate in national collaborative risk assessment with WHO".

Dr VIROJ TANGCHAROENSATHIEN (Thailand) confirmed that that wording was acceptable, subject to further minor editorial change.

On that understanding, the draft resolution, as amended, was approved.[1]

HIV/AIDS: Item 11.3 of the Agenda

- **WHO's contribution to universal access to HIV/AIDS prevention, treatment and care** (Document A59/39)

Dr HANSEN-KOENIG (representative of the Executive Board) said that the Executive Board at its 117th session had decided that the question of WHO's contribution to achieving universal access to HIV/AIDS prevention, treatment and care would be examined at the current Health Assembly. The report described WHO's work programme, the lessons learnt from the "3 by 5" initiative and the major obstacles to universal access. It also outlined the progress made, in particular the commitments made at the 2005 World Summit and by the G8 leaders in July 2005, and the five strategic directions on which WHO's contribution to progress towards universal access would be based. It was proposed that the Secretariat should report annually on the progress made by countries towards the achievement of universal access to treatment and care.

Mr URFJELL (Norway) said that Norway strongly favoured an evidence-based approach to the HIV epidemic and recognized the growing need for universal access to prevention, treatment, support and care. In the struggle to ensure universal access, vulnerable and marginal groups, such as injecting drug users, sex workers and men who had sex with men, should not be forgotten. The fight against HIV/AIDS should be linked to the draft global strategy for the prevention and control of sexually transmitted infections 2006-2015, and with the existing global health-sector strategy for HIV/AIDS.

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA59.2.

He supported the draft resolution on nutrition and HIV/AIDS contained in resolution EB117.R2 and stressed the need for more research in that area. He also supported the draft resolution on the implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors contained in resolution EB117.R8. That Team's work should be linked with United Nations reform and efforts to make aid more effective. He proposed that the Committee not only should take note of the report but also should endorse the goal of universal access to HIV/AIDS prevention treatment and care, which would send an important signal to the forthcoming 2006 High-Level Meeting on AIDS (New York, 31 May-2 June 2006).

The CHAIRMAN noted that proposal.

Professor HORVATH (Australia) expressed strong support for the strategy set out in the report. In order to make an impact on the HIV/AIDS epidemic, an evidence-based comprehensive package was needed that included prevention, treatment and care, with each element receiving appropriate and equal attention: it was particularly important not to lose the focus on prevention as access to treatment was increased. Australia was committed to the United Nations World Summit goal of developing and implementing a package for HIV prevention, treatment and care with the aim of coming as close as possible to the goal of universal access to treatment by 2010.

Dr KLEIN (Austria), speaking on behalf of the European Union and its Member States, and indicating that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, and the countries of the Stabilisation and Association Process and potential candidates, Bosnia and Herzegovina and Serbia and Montenegro aligned themselves with his statement, recalled that, at the 117th session of the Executive Board, the European Union had set out its position in regard to HIV/AIDS and the essential elements for meeting that challenge to global health.[1] The basic framework for any response must be a human rights-based approach, because stigmatization and discrimination impeded universal access to treatment. Priority must go to the promotion and protection of human rights for ethical as well as effective public health reasons. Gender equality must be promoted since gender inequality put the attainment of universal access at risk: harmful traditional practices and sexual violence impeded the empowerment of women, who needed new tools for prevention. It was equally important to persuade men and boys to adopt responsible and respectful behaviour. Most HIV infections were sexually transmitted and any comprehensive approach to prevention must aim at universal access to sexual and reproductive health information, services and supplies, including condoms. Links must be forged between HIV services and the general health system which also needed to be strengthened in other areas such as tuberculosis, malaria, and maternal and child health. An effective response had to involve those affected by HIV/AIDS more closely, by facilitating and supporting the participation of civil society and local community organizations. The response must be broad and multisectoral and not left to the health sector alone but integrated into broader development plans, including poverty reduction strategies.

Achieving universal access depended on expanding current prevention work, with support for those most at risk, especially children. Current strategies were insufficient; reinforced research should develop new technologies including vaccines and microbicides. Prevention methods must be evaluated in order to ensure that the target audience was reached. Prevention policies should target the particular situations in each country and the problems of all vulnerable groups. The principles of aid and sponsorship should be revised in order to enhance participation of, and assistance to, countries with low HIV prevalence so as to stimulate development of best prevention and treatment practices and new regional or subregional initiatives. The European Union was committed to comprehensive rights-based and evidence-informed HIV prevention programming.

[1] Document EB117/2006/REC/2, summary record of the fourth meeting.

Over the previous two years, access to antiretroviral treatment had improved remarkably in many countries but most people in need of treatment, especially children, still had no access. The situation was bad in the countries most in need and sustained access to treatment had yet to be ensured. The "3 by 5" initiative had mobilized action but missed its target and failed to contain or reverse the pandemic. Antiretroviral treatment must be made affordable and available in all affected countries. The European Union recommended making maximum use of the flexibilities of the Agreement on Trade-Related Aspects of Intellectual Property Rights combined with measures to avoid the taxation of antiretroviral treatments.

A significant barrier to progress was the crisis in human resources for health. The European Union was strongly committed to building local capacities, which were crucial to the fight against HIV/AIDS and delivery of essential health services. WHO should contribute significantly at the country, regional and global levels to creating an enabling environment for health-care workers and supporting health systems.

The European Union noted WHO's intention to base its work on five strategic directions and a five-year workplan and looked forward to receiving substantial annual progress reports. It welcomed the progress made in implementing the Global Task Team's recommendations and in particular the provision by UNAIDS of technical assistance at local level and improved coordination and harmonization. The division of labour between headquarters and the field, one of the Team's main recommendations, should clarify roles and collaboration within the United Nations family at country level. The European Union welcomed WHO's engagement, which would promote greater coherence at United Nations and country levels. It called for additional support to organizations of the United Nations system and other partners combating HIV/AIDS. He endorsed resolution EB117.R8 on the recommendations of the Global Task Team.

Significant resources would have to be mobilized nationally and internationally in order to secure a sustained and comprehensive global response to the pandemic. The European Union recognized the pivotal role of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and remained committed to strengthening its potential. It urged other donors to do likewise. It noted with interest the establishment of the International Drug Purchase Facility based on innovative financing mechanisms such as the "solidarity contribution" based on airline tickets in order to improve access to medicines at affordable prices.

Action was urgently needed. The goals required joint efforts and agreed strategic procedures. A multisectoral approach would provide a voice for new ideas and develop networks and partnerships. The forthcoming High-Level Meeting to follow up the United Nations General Assembly special session on HIV/AIDS would reaffirm the political commitment to fighting HIV/AIDS if it agreed on the necessary measures to be taken.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) drew attention to the estimated deficit in financial resources to developing countries for dealing with HIV/AIDS for 2005 to 2007. Universal access had become a necessity for comprehensive response to the HIV/AIDS epidemic, including universal access to prevention, care, treatment and support. Since the conception of the HIV/AIDS care programme in 1986, Cuba had taken account of all those aspects and given especial attention to maximizing synergies between prevention, care and treatment through political will and decisions, leadership, and the existence of a programme covering staff training, capacity building, and health infrastructure underpinning the country's universal health system.

Cuba guaranteed integrated care for all people infected with or affected by HIV. Six antiretroviral agents were being produced in the country, enabling five treatment programmes to cover 95% of cases; the rest were treated with imported medicines. There were 14 treatment centres specializing in integrated HIV/AIDS care, a national referral centre for medical care, and prevention centres in provinces and municipal areas offering outpatient care, counselling and training for people infected with HIV and their families, and mobile primary health care for all those infected or affected. Much remained to be done, and a principal problem was the need for human and financial resources for all those affected by HIV/AIDS.

Dr PARIRENYATWA (Zimbabwe) praised the report and expressed full support for universal access to prevention, treatment and care. Prevention remained his country's main strategy, but an antiretroviral therapy programme had also been started and was progressing well, with some 31 000 people (57% women and 9% children) receiving therapy. He welcomed the "roadmap" promoted by WHO.

Dr NOTTAGE (Bahamas) said that his country, along with many of its Caribbean neighbours, continued to strive towards the goal of universal access to prevention, treatment, care and support services for all people living with HIV/AIDS. That effort entailed a significant financial commitment. Governments in the region, with assistance from donors, had provided a comprehensive package of services to people living with HIV/AIDS, including free antiretroviral therapy for people requiring it, sometimes at the expense of other national programmes. The Bahamas had achieved universal access, Barbados 85% access and other countries in the region were making significant progress.

He commended the Global Task Team in streamlining, simplifying and harmonizing procedures and practices in order to make country-led responses to HIV/AIDS more effective. Shared responses by governments, civil society and other stakeholders had been a pillar of regional programmes. Caribbean countries also recognized the need for, and the benefits of, harmonizing the activities of multilateral institutions and international partners with national strategies, policies, systems, cycles and the operational plans of national AIDS coordinating authorities. In many Caribbean countries, the dearth of human and financial resources was compounded by external funding agencies' requirements not aligned with those countries' systems and priorities.

More effective multilateral responses, greater accountability and oversight, and strengthening evaluation mechanisms were all crucial. He supported the recommendations of the Global Task Team and expressed commitment to continued implementation of the "Three Ones" principle.

Nutrition counselling, care and support were important components of comprehensive family-centred HIV care. Research in the region had shown that HIV-positive children receiving antiretroviral treatment had normal growth patterns when nutritional support was integrated into national HIV/AIDS programmes. With the assistance of the Caribbean Food and Nutrition Institute, national food and nutrition policies had identified HIV/AIDS as one of the priority areas. He appealed to donor groups to support nutrition care; HIV programmes needed to be integrated into health systems. Furthermore, the disease must be de-stigmatized in order to allow those needing the resources available to obtain them.

The Caribbean Community supported the draft resolution recommended in resolution EB117.R2 and requested the Acting Director-General to provide effective technical support to national governments, with particular emphasis on strengthening health systems and human resources.

Dr TSHABALALA-MSIMANG (South Africa), commending the United Nations system's commitment to partner participation in advancing towards universal access to HIV/AIDS prevention, treatment and care, welcomed WHO's involvement and its plan for contributing to progress. Lessons learnt from the "3 by 5" initiative should encourage all countries to remove obstacles and would also unify the global community, in the spirit of the "Three Ones" principle. She expressed satisfaction that the United Nations system had responded to the limitations of a global target-setting approach and was placing prevention at the centre of its response to HIV/AIDS. A supportive health system was central to effective implementation. Nevertheless, it was disappointing that, even after the Global Meeting on Future Strategic Directions for Primary Health Care (Madrid, 27-29 October 2003), which had confirmed the validity of the primary health care approach, WHO continued to focus only on a health-sector, disease-specific response to HIV/AIDS. Such a response was inadequate to reverse the tide of communicable diseases, including HIV/AIDS. She endorsed the plea made the previous day by the President of the Health Assembly for the primary health care approach to be used as a platform for universal access to HIV/AIDS prevention, care and support in the form of equitable, available, accessible, affordable and acceptable services.

The UNAIDS policy paper on "Intensifying HIV prevention" emphasized that vulnerability and stigmatization had to be considered in any response to HIV/AIDS, in particular prevention. The President of the Fifty-eighth World Health Assembly had, in her report the previous day, identified

poverty as the "true disease" underlying other diseases, with access to clean water, sanitation, food and primary health care essential in dealing with communicable diseases. Underdevelopment, gender inequality, and illiteracy were also crucial factors as endorsed by the President of the current Health Assembly in his statement that "social determinants must be addressed in health leadership". WHO's health-sector response, with its five strategic directions, should be expanded to include development issues, which were an integral part of the primary health care package.

Dr SRIVASTAVA (India) said that his country's National AIDS Control Programme, begun in 1992, had evolved into a holistic and dynamic response to HIV/AIDS, and aimed to meet the goal of universal access to prevention, care and treatment. The Programme, which received technical support from WHO, included care and support services, providing free antiretroviral treatment since 2004 to all patients needing it. Antiretroviral treatment was given to people with a $CD4^+$ lymphocyte count of less than 200 cells/mm^3 in the following priority groups: seropositive mothers participating in the programme to prevent vertical transmission of HIV; seropositive children under the age of 15; and AIDS patients seeking treatment in government hospitals. To date, more than 38 000 had received free antiretroviral treatment in 52 centres in the public and nongovernmental sectors, with a further 25 000 receiving treatment in the private sector. Those services would provide free antiretroviral treatment to 100 000 AIDS patients by the end of 2007 and 188 000 patients by 2010.

WHO and international partners could provide assistance in: inventory management and supply of medicines and diagnostics; drug-resistance monitoring, as an operational research component for new strategies and programmes; devising appropriate paediatric treatments; and research into, inter alia, new medicines, cost-effective alternative regimens, simplified formulations and improved diagnosis.

India's strengthened public health systems under the National Rural Health Programme must work together in expanding HIV prevention, treatment and care services. His country was committed to equitable access to treatment, prevention, care and support for people who were marginalized, vulnerable or living below the poverty line. He acknowledged WHO's contribution to achieving universal access.

Dr SADRIZADEH (Islamic Republic of Iran) said that injecting drug use had been a major public health concern in his country. By late 2005, surveillance had indicated that Iran's HIV epidemic was concentrated among injecting drug users (61% of reported cases) and prisoners in certain provinces; 95% of infections were in men. Recognizing the magnitude of the problem, his Government had initiated comprehensive prevention and care responses, targeting drug users in both the community and prisons. A National AIDS Committee had been established in 2001 with the goals of harm reduction and reduced transmission of HIV among injecting drug users. A five-year plan had been prepared for 2002-2007 on substance-abuse harm-reduction measures. More recently, protocols and guidelines had been prepared for establishing government and private methadone-maintenance treatment clinics, establishing and operating outreach programmes, drop-in centres and shelters for drug users. A National Centre on Addiction Studies had been created in 2003, which included research into the effectiveness of harm-reduction measures. Some provinces had formed multisectoral, high-level AIDS committees in order to coordinate activities related to HIV/AIDS.

Achievements in HIV prevention and control included: a coordinated response involving different government agencies and other key stakeholders; changes in drug policies since 2002, according importance to reducing demand and harm; advocacy, resulting in support from the judiciary; strong and committed leadership; the establishment of many "triangular clinics", providing a sound infrastructure for care and support to all people living with HIV/AIDS; acceptance of methadone-maintenance treatment as an important element of treating addiction and of HIV prevention for opiate users; and plans for enhanced delivery in closed settings such as prisons; the establishment of triangular clinics in the prison system; and HIV information, sex and health education, and harm-reduction services for all prisoners in Iran. Iran's experience could be applicable to other developing countries.

Mr MARTIN (Switzerland) supported a broad approach to the fight against HIV/AIDS similar to that adopted in June 2001 by the United Nations General Assembly at its special session on HIV/AIDS. He welcomed the focus in the report on the need to exceed the "3 by 5" target. Resources had increased following that special session of the General Assembly and the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria; they had to be assigned to the different players involved, whose roles must be clearly defined. He welcomed the report's five strategic directions, and supported the incorporation of HIV testing into other screening services. Staff would need to be trained, and aspects of sexual and reproductive health care and counselling integrated as broadly as possible.

Services must promote non-discrimination, with respect for human rights. He welcomed WHO's second strategic direction and the prevention and care programmes adapted to different modes of transmission. Experience in Switzerland had shown prevention to be most effective when it was targeted and took into account specific realities and needs. WHO should stress to its partners the importance of such non-discrimination even in the field of nutrition, it having often been observed that food aid did not reach its intended recipients. In addition to working with UNICEF and WFP, both also cosponsors of UNAIDS, WHO should work in the area of nutrition and HIV/AIDS with other organizations such as UNESCO, UNDP, UNFPA, and the Global Fund in order to maximize synergy. In relation to the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, WHO should play its rightful role alongside those other organizations, focusing on the local level, for which the best possible "team players" should be employed. Recently, in Mozambique, Switzerland had co-signed a Code of Conduct for the HIV/AIDS Partners Forum. He supported the draft resolution contained in resolution EB117.R8.

Mr KAZENENE (Zambia), speaking on behalf of Member States in the African Region, and with special reference to the Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa (4 May 2006), expressed his appreciation of the late Director-General's support and WHO's pivotal role in the acceleration of universal access to HIV/AIDS prevention, treatment and care. Countries in sub-Saharan Africa accounted for only 10% of the world population but 60% of the estimated number of HIV-infected persons and 90% of AIDS orphans. Bearing in mind the recent Special Summit of the African Union on HIV/AIDS, Tuberculosis and Malaria (Abuja, 2-4 May 2006), the Brazzaville Commitment on Scaling up towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Support in Africa by 2010 (Brazzaville, 8 March 2006), the Maputo Declaration on HIV/AIDS, Tuberculosis and Malaria and Other Infectious Diseases (Maputo, 12 July 2003), Member States in the African Region remained committed to universal access to HIV/AIDS prevention, treatment and care. They therefore requested a stronger partnership in assuring long-term, predictable financing commensurate with the burden of HIV/AIDS; provision of financial and technical support; fostering of the "Three Ones" principle with country-led priorities, multilateral and bilateral donors' harmonization and alignment on national priorities, without conditions; and assistance in strengthening health systems, particularly inadequate human resources and access to essential medicines, major barriers to universal access to HIV/AIDS prevention, treatment and care. They also requested WHO to provide technical assistance to countries in planning, implementing, monitoring and evaluating the roadmaps, country milestones and targets towards universal access, and including HIV/AIDS in all national poverty reduction strategies, programmes and development plans. Human rights, particularly for women, youth and children and those infected and affected by HIV/AIDS, needed to be promoted.

Dr TIBAN (Kiribati) supported the recommendation in the report, and commended WHO's comprehensive attempt to raise the global response to the HIV epidemic to another level. The report could have included information relating to alcohol use as a contributing factor in sexually transmitted infections, including HIV. Alcohol misuse and its influence on behavioural patterns were well documented, and corresponding information in terms of both prevention and management of HIV infection should therefore be included in the otherwise comprehensive strategic framework elaborated in the report. It could also have referred to tuberculosis management and prevention as part of any

HIV prevention and treatment framework; despite the proven medical links, there was little coordination between the relevant health programmes.

Ms JABLONICKÁ (Slovakia) said that her country was implementing the national HIV/AIDS prevention programme based on WHO's strategy and guidelines. Since epidemiological and laboratory surveillance of HIV/AIDS had started in 1985, 158 people had been diagnosed as HIV-positive. An important focus of the national programme was mother-to-child transmission of HIV, of which there was no evidence in Slovakia. The situation was also stable regarding groups with risk behaviours. Those achievements were the result of long-term countrywide information and education campaigns, and easy access to HIV testing for all citizens. The low incidence in her country was no reason for less vigilance. She strongly supported WHO's work and its technical assistance in combating the AIDS worldwide epidemic. Its strategies and guidelines provided valuable help in the regular updating of national documents and programmes.

Dr ISHIDA (Japan) expressed his appreciation for the "3 by 5" initiative. He commended the WHO's five-year workplan for scaling up efforts towards universal access to HIV/AIDS prevention, treatment and care for the period 2006-2010. WHO should define concrete indicators and methods for implementation and mobilization of resources. There should also be a complete review of the achievements of the "3 by 5" initiative and lessons learnt. He particularly appreciated that strengthening of the health sector had been incorporated into all five of the "strategic directions" and thus building national capacity. A review of the expansion of antiretroviral therapy through the "3 by 5" initiative should be reflected in the five-year work plan.

In Asia, Thailand had achieved its "3 by 5" target at national level through commitment, a high-quality antiretroviral therapy system, and an effective community network for prevention, social care and assistance. Many lessons could be learnt from Thailand's experience. Every year Japan had conducted the ASEAN AIDS Workshop in conjunction with WHO in order to promote and support the "3 by 5" initiative in ASEAN countries. In 2006 the Workshop would be held in northern Thailand, where Japan had provided bilateral technical support between 1997 and 2003. The Workshop would provide a good opportunity for those in charge of national HIV/AIDS projects in each ASEAN country to study the achievements and problems of the "3 by 5" initiative and discuss the challenges of universal access.

Without social and economic support, HIV/AIDS patients whose health had been restored by antiretroviral therapy might not maintain regular treatment, with the attendant risk of drug-resistant strains appearing. He expressed strong support for the draft resolution contained in resolution EB117.R2, which promoted the integration of nutrition into a comprehensive response to HIV/AIDS.

Dr SOMSAK AKKSILP (Thailand), acknowledging that his country's response to the HIV epidemic had been hailed as a "success story", recalled that the epidemic had begun in the mid-1980s and peaked – with more than 100 000 HIV infections annually – between 1990 and 1993. The Thai response had been rapid, with the development in the early 1990s of a comprehensive multisectoral programme including HIV prevention, care and antiretroviral therapy. The "100% condom programme" in sex establishments had been launched in 1991, increasing condom use from under 20% in 1989 to over 90% in 1992. The programme had led to significant reductions in sexually transmitted infections and HIV prevalence in the following years. The estimated annual number of new HIV infections had dropped from over 100 000 in 1990 to 17 000 in 2005. Thailand had achieved its "3 by 5" target of 50 000 persons living with HIV/AIDS receiving antiretroviral therapy, although the financial implications of treatment with second-line medicines were a major policy concern. He endorsed the report, expressing support for the suggestion made by the delegate of Norway that Member States should be asked to endorse the report rather than simply taking note of it.

Dr BOTROS SHOKAI (Sudan) said that the mobilization and commitment of the international community were imperative in order to mitigate the disaster of the HIV/AIDS pandemic. Africa was the hardest hit continent, accounting for 25 million of the 35 million people infected so far. AIDS was

no longer simply a public health problem, but a real threat to development. It not only thrived on poverty but exacerbated it. The only hope left for people living with HIV/AIDS to improve their quality of life was antiretroviral therapy. Africa was most in need of those medicines, with 4.7 million of the 6.5 million people worldwide who required them. Evidence showed that Africans adhered to their antiretroviral treatment regimens. With the help of WHO's "3 by 5" initiative, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and pledges from donor countries, significant progress had been made in increasing access to antiretroviral therapy.

UNAIDS estimated that the total unmet financial needs for adequate HIV/AIDS prevention, treatment and care programmes across sub-Saharan Africa between 2005 and 2007 lay between US$ 5200 million and US$ 11 300 million. That cost did not cover the support of orphans and children. She commended the five strategic directions, but expressed concern that the response did not meet the growing challenges. Only 500 000 people in need of antiretroviral therapy in Africa had access to it, for reasons of price and availability. That shortfall was compounded by the lack of infrastructure and trained health care workers. Donors should provide the necessary budgetary support for the "3 by 5" initiative in order to reach the unreached. WHO, in conjunction with other agencies such as UNAIDS, should elaborate accreditation systems for HIV/AIDS competency among international agencies, companies and nations. Thus, WHO could encourage the integration of good practice, including streamlined and integrated interventions, into national health and development systems.

Mr DE CASTRO SALDANHA (Brazil), speaking also on behalf of Chile, France and Norway, said that six million people infected with HIV in the developing countries were in urgent need of antiretroviral therapy. In order to sustain a comprehensive and long-term global response to the AIDS epidemic significant resources would have to be mobilized both nationally and internationally. Developing countries needed more resources and above all improvements in quality. Innovative financing mechanisms should provide stable and predictable funding for long-term programmes. The amounts needed exceeded conventional development assistance. The international levy on air tickets would be the primary and long-term method of funding the new International Drug Purchase Facility. That would direct the market to meeting the specific needs of the developing countries in terms of production volume, price level and product suitability. It should also reassure national authorities as to the ability of the international community to fund long-term access to care, and encourage them to launch large-scale programmes and thus approach universal access by 2010, as called for at the World Summit in September 2005.

The International Drug Purchase Facility would concentrate on paediatric formulations and second-line antiretroviral treatments at affordable prices, as well as mother-to-child transmission of HIV, which remained a major challenge, and would work in close cooperation and partnership with the existing organizations promoting access to medicines in developing countries. An initial meeting of that Facility would be held the following week, in the course of the United Nations General Assembly special session on HIV/AIDS. He quoted from a speech that the late Director-General had intended to give at the current Health Assembly in which Dr Lee had warmly welcomed the initiative of several countries in proposing that Facility and indicated WHO's commitment to supporting the scheme.

Speaking as the delegate of Brazil, he supported the report, and warmly endorsed the useful proposal made by Norway.

Dr EL SAYED (Egypt), speaking on behalf of the Member States in the Eastern Mediterranean Region, agreed with the report that, although the target of "3 by 5" had not been met, the momentum created had been very marked in prevention and care, and he acknowledged WHO's contribution. Some countries previously unable to supply their citizens with antiretroviral treatment were ready to do so, in personnel and infrastructure. The provision of treatment on a small scale could be expanded gradually. Most countries eligible for Global Fund support had applied, and most had seen their projects approved. The Fund remained one of the main sources of funding for the scaling-up process.

WHO should continue to provide technical assistance in HIV/AIDS response, namely in relation to capacity-building activities, guidance in the best prices for pre-qualified antiretroviral medicines, and resource mobilization. He urged the Organization to support national programmes.

Dr ALOUWED (Syrian Arab Republic) supported the measures described in the report. His country had recorded few HIV/AIDS cases, and prevention was the pillar of its strategy. Medical care was provided to all those living with HIV/AIDS, who had a legally-guaranteed right to lead a dignified life. Women and children with AIDS were also provided with protection, both psychological and physical. Programmes were in place to implement all of those measures.

Refugees and immigrants were at increased risk of HIV infection, and therefore received greater protection. The international community had to live up to its responsibilities towards immigrants. Treatment of HIV/AIDS in his country was a matter related to the responsibilities of every citizen and to the precepts of Islam. The Government provided for full coordination with the United Nations in order to prevent the spread of HIV and was seeking assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr FEDOROV (Russian Federation) recalled that the Millennium Development Goals included reduction of the incidence of HIV/AIDS and other diseases. Providing access to inexpensive medicines was still an acute problem. The "3 by 5" initiative was reaching only one in 20 infected people, while the number of infected people worldwide continued to rise. There should be more emphasis on preventive activities, including health education for young people and those at high risk, with involvement of a broad range of bodies, including religious organizations and charities. Curbing the HIV/AIDS pandemic had been on the agenda of the pre-G8 summit meeting of health ministers in Moscow on 29 April. There was a need to increase mobilization of resources, and with international coordination, it would be possible to curb the spread of the disease. The Russian federal programme had increased 20-fold its budgetary allocations in the current year. Its objective was to find practical means of therapy and prevention.

WHO needed greater collective efforts against HIV/AIDS. His country supported the strategic directions defined for universal access to prevention, treatment and care by 2010. It also welcomed WHO's action to implement the recommendations of the Global Task Team to Improve AIDS Coordination among Multilateral Institutions and International Donors. He supported the draft resolution.

Dr AMMAR (Lebanon) welcomed the comprehensive report. In Lebanon, the national AIDS control programme had focused in the early 1990s on health education and awareness activities. That work had rapidly evolved into a large network involving all concerned ministries and nongovernmental organizations, as well as a reporting and surveillance system. In 1997 the Ministry of Health had started providing free antiretroviral therapy, and negotiations supported by WHO with pharmaceutical firms had led to a substantial decrease in the cost. The national strategy had been re-evaluated in 2003. The national AIDS control programme was implementing the "Three Ones" principle. The mobility of the target population remained a major challenge as Lebanon was a tourist destination with high migration rates in its young population. It was unfortunate that Lebanon did not meet the eligibility criteria for submission of proposals to the Global Fund to Fight AIDS, Tuberculosis and Malaria, and more flexibility in them might be desirable.

Ms MATA (Bolivarian Republic of Venezuela) said that in 2005 and 2006 her country had allocated US$ 70 million to programmes on HIV/AIDS and sexually transmitted infections, which had enabled the country to reach the goal of universal access to free treatment for all HIV/AIDS patients and to develop projects relating to health promotion and prevention of sexually transmitted infections.

A strategic alliance between the ministries of health and of communication and information, with support from UNAIDS and UNICEF, had made possible a campaign of prevention, making use of mass media and wide distribution of information material. Simultaneously, the country was increasing awareness in the population so as to reduce stigmatization and discrimination against

people living with HIV/AIDS. Since 2003 it had also financed local projects for prevention of HIV infection and promotion of the human rights of people living with HIV/AIDS.

Her country was providing free care, including medicines, consultations and examinations, to 16 000 seropositive patients. It had significantly reduced the cost of medicines by introducing generics. It was also providing, free of charge, care for childbirth and highly-effective antiretroviral therapy.

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

The meeting rose at 18:00.

FIFTH MEETING

Thursday, 25 May 2006, at 09:15

Chairman: Dr P. MAZZETTI SOLER (Peru)
later: Dr A. RAMADOSS (India)

1. FIRST REPORT OF COMMITTEE A (Document A59/47)

Dr CISSÉ (Guinea), Rapporteur, read out the first report of Committee A.

Dr CHANTANA PADUNGTOD (Thailand), referring to the draft resolution on eradication of poliomyelitis, asked what scientific basis existed for the proposal in paragraph 2(2) to use another composition of vaccine. In paragraph 2(3), the words "two to five million" should be replaced by "all", given the different sizes of affected populations. In paragraph 2(5), what scientific evidence existed to support the target of "greater than two cases per 100 000 children aged less than 15 years for surveillance of acute flaccid paralysis"?

Mr AITKEN (Adviser to the Director-General) said that, although the report was still in draft form, the debate on its substance could not be reopened. Moreover, the relevant Secretariat technical staff were not present to answer the questions raised. However, if it was felt that the report did not reflect the agreement reached on the draft resolution, the Committee could, if it so wished, request the presence of WHO's poliomyelitis experts to provide further clarification.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) asked whether, in adopting the draft report, the Committee would also be approving the draft resolution. The Committee could not neglect the scientific issues raised.

Mr AITKEN (Adviser to the Director-General) confirmed that, in adopting the draft report, the Committee would also be approving the draft resolution. However, the debate on that resolution could be reopened when the report was submitted to the plenary.

Mrs McKEOUGH (Office of the Legal Counsel) said that, under Rule 53 of the Rules of Procedure, the Committee's present task was to verify whether the report reflected the agreement reached in the Committee. The debate on its substantive content could not be reopened. Once the Committee had adopted the draft report, it would be referred to the plenary, where delegates would have a further opportunity to express their views on the substance.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) reiterated that the targets set in paragraph 2(3) and 2(5) were not attainable by countries with small birth cohorts and small target populations in affected areas, or with small populations. The figure of "two to five million" was a factual error and could not be retained in the resolution. Nor was there any scientific evidence, as far as he knew, for the target set in paragraph 2(5).

Mr AITKEN (Adviser to the Director-General) said that, before redrafting the resolution the previous day, he had consulted with the poliomyelitis team in order to determine whether the proposed amendments were technically acceptable. The team had said that they were. He suggested that the

delegate of Thailand should consult with the Secretariat's poliomyelitis experts in order to resolve the issue.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) asked whether that meant that the Committee would defer adoption of the report until those experts had been consulted. Otherwise, if they decided that the provisions of paragraphs 2(3) and 2(5) were not scientifically acceptable, would there be an opportunity to amend the draft resolution?

Mr AITKEN (Adviser to the Director-General) said that he would consult the experts again. If they felt that the relevant provisions were technically unacceptable, he would inform the Committee, but the issue would have to be resolved in the plenary.

THE CHAIRMAN said that, if she heard no objection, she would take it that the Committee agreed to adopt the draft first report of Committee A.

The report was adopted.[1]

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Intellectual property rights: Item 11.11 of the Agenda (continued from the fourth meeting)

- **Commission on Intellectual Property Rights, Innovation and Public Health: report** (Documents A59/16, A59/16 Add.1, A59/16 Add.1 Corr.1 and A59/16 Add.2)

- **[Global framework on]essential health research and development** (Documents EB117/2006/REC/1, resolution EB117.R13 and Annex 4, and A59/17)

The CHAIRMAN congratulated the Commission on Intellectual Property Rights, Innovation and Public Health on successfully completing its task. Its report would be a comprehensive resource for public health policy-makers.

Dr HANSEN-KOENIG (representative of the Executive Board), introducing the Commission's report, said that, as it had not been available in time for the 117th session of the Executive Board, the Board had set up a committee consisting of 12 of its members to review the report when it became available in April 2006. At its 117th session, the Board had also considered a draft resolution proposed by the members for Brazil and Kenya, which was recommended to the Health Assembly in resolution EB117.R13. Part of the text of the draft resolution, the subject of essential health research and development, was still in square brackets.

The Commission's report had been presented to the Director-General on 3 April 2006, and the Board's committee had met on 28 April 2006 to discuss it under the chairmanship of the member for Thailand, with the member for Australia as Vice-Chairman. The Commission's Chairperson had presented the report.[2] The committee's discussion was summarized in document A59/16 Add.1, which also contained the text of a draft resolution prepared by the Secretariat. The committee had then discussed the draft resolution, marking in square brackets areas on which there was no agreement.

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[1] See page 256.

[2] Document CIPIH/2006/1.

Dr TSHABALALA-MSIMANG (South Africa) speaking on behalf of the Member States of the African Region, commended the Commission's report. The Commission had engaged with a range of stakeholders in developing recommendations for the Health Assembly. She noted the divergence of views among Commission members on a range of issues. One of the Commission's terms of reference had been to produce concrete proposals for action by national and international stakeholders. The Commission's recommendations, although a good basis for further work, did not go far enough and were not action-oriented.

She recalled the reasons for investigating the impact of intellectual property rights and patents on public health. The purpose of intellectual property rights was to protect and encourage research and innovation, and patents were instruments to that end, giving researchers an opportunity to have a market monopoly for a defined period of time in order to recoup the cost of the research. In other words, the price of a patented product should be the sum of the costs of production and research plus a fair profit. Unfortunately, the price of a number of products far exceeded those costs, effectively abusing the intellectual property system. The Commission had reported that, in most developing countries which faced problems of access to medicines, there was no registration of patents. It had then argued that in such cases intellectual property could not be considered a barrier to access, but it did not clearly identify the barrier in such circumstances. The African countries argued that in such situations developing countries did not have access to life-saving medicines because the manufacturing industry had chosen to ignore their markets, mainly for the reason that the citizens of such countries could not pay the prices that manufacturers charged. Yet, if the companies in question lowered their prices, sales volumes would increase, resulting in profits similar to those in developed country markets. The report identified a lack of interest among companies to invest in finding remedies for diseases predominant in developing countries and recommended ways of stimulating research and development of medicines for those neglected diseases. It highlighted the need to strengthen awareness in developing countries and to promote the use of flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS). Specifically, it urged the incorporation of those flexibilities in the national systems and questioned the public health justification for "TRIPS-plus" rules, particularly data-exclusivity provisions. It proposed that WHO should establish an information database on patents in order to remove potential barriers to availability and access to products. What contribution could the Secretariat make on those matters?

Despite the commendable work of the Board's committee, most of the text of the draft resolution remained in square brackets and required further consideration. The draft resolution did not provide sufficient guidance and the Health Assembly should take the lead in driving the process. The Commission's mandate had been to contribute, in particular, to finding appropriate funding and incentive mechanisms for the development of new medicines for diseases that had a disproportionate impact on developing countries. The African countries still looked to WHO to do that. A dedicated action plan was needed. The African countries had already voiced concern at attempts by the pharmaceutical industry to influence the Commission's independence. Their current concern was how the resolution, as currently drafted, would provide for transparency, government involvement and sustainable funding. They urged Member States to promote research and development of interventions that would combat the diseases affecting the world's poorest countries.

Dr NYIKAL (Kenya), also speaking on behalf of the Member States of the African Region but with reference to the global framework on essential health research and development, said that the draft resolution contained in resolution EB117.R13 and that in document A59/16 Add.1 were distinct enough to be considered separately. Access to the products of research and innovation, including vaccines, diagnostics and treatment, was the key to improving the health of the people of Africa and other developing countries. UNDP's *Human development report 2005* highlighted the imbalance

between the interests of holders of innovation and the wider public interest.[1] Efforts to support developing countries would not yield positive results without a new framework of access to innovation. Many people continued to lack access to essential medicines and other technologies for health, in terms of both availability and affordability. A global framework was needed urgently. The African countries were keenly interested in the initiatives related to public health innovation and research. The WHO Task Force on Health Systems Research and the Alliance for Health Policy and Systems Research had drawn attention to the lack of health research relevant to developing countries. The United Nations Millennium Project Task Force dealing with access to medicines had also reported that current structures were inadequate to promote the necessary research and development of medicines and vaccines. Medicines for diseases of public significance in developing countries, such as trypanosomiasis and leishmaniasis, had been acknowledged as medicines for neglected diseases. Second-line treatments for malaria, tuberculosis and HIV/AIDS could fall into that category, as there was no profit incentive for innovation and production because the people affected could not pay for the medicines. The African countries agreed with the Millennium Project Task Force on access to essential medicines that WHO had a significant role to play in helping countries achieve the relevant Millennium Development Goals.

He strongly supported the draft resolution contained in resolution EB117.R13, in spite of the many square brackets in the text. A viable framework for medical innovation should provide for a wide range of mechanisms for innovation, within different institutional, cultural and social settings. It should also be global so that it could provide a multilateral process that recognized human rights and public health priorities. The draft resolution sought to achieve a balance between recognizing the importance of intellectual property rights and patent systems and ensuring access to health products for people who could not afford them. The proposed global framework would support essential medical research and development with an equitable sharing of costs. The Health Assembly should support it for the sake of those in the world who required health care but were too poor to pay. He underlined that the proposed framework would not be legally binding, but would take greater account of the principles of social responsibility and social solidarity. It should function rather as the "3 by 5" initiative, which although not legally binding had enabled many people in his country to gain access to antiretroviral medicines.

Dr VILLAVERDE (Philippines) agreed in general with the draft resolution on public health, innovation and intellectual property rights. However, the two alternative versions of paragraph 2(1) were complementary and could be merged to read "to consider the recommendations of the report and to contribute actively to the development of a global strategy and plan of action, taking into account their national context and priorities". One of the basic needs of all populations was public health care, and especially access to affordable medicines. A global strategy and plan of action on public health responded to domestic needs and priorities.

He accepted the wording proposed for subparagraphs 2(2) and 2(3) of the draft resolution and paragraph 3(1), subject to clarification of the term "open ended". It could conflict with paragraph 3(2), which implied a clear time-frame by which the intergovernmental working group would have to finish its work. According to that paragraph, the final strategy and plan of action would be ready for consideration by the Sixty-first World Health Assembly. He did not doubt the urgency of the tasks but analysis of the implications of the global strategy might require more time.

He recommended the inclusion of a new paragraph 3(4) to read as follows: "to facilitate the development of a system for information exchange that will track patents and the development of a surveillance and database system that will monitor the patent life of originator drugs". Such an information system would guide regulatory agencies and intellectual property offices in Member States, particularly in developing countries, in ensuring better access to essential drugs. The original

[1] *Human development report 2005. International cooperation at a crossroads: aid, trade and security in an unequal world*. New York, United Nations Development Programme, 2005.

paragraph 3(4) would then become paragraph 3(5) and should be amended to read: "to monitor, from a public health perspective, in close collaboration with intellectual property experts, the impact of intellectual property rights, as well as other issues addressed by the report, on the development of, access to and affordability of health care products". For clarity, a new paragraph 3(6) might be added as follows: "to report to the World Health Assembly the findings and results of the monitoring, including appropriate recommendations therein".

Dr GREGORICH-SCHEGA (Austria) said the agenda item under discussion fell predominantly within the competence of the European Community. She therefore requested that the representative of the European Commission be allowed to comment on it.

Mrs McKEOUGH (Office of the Legal Counsel) said that, under the Rules of Procedure, representatives of intergovernmental organizations such as the European Commission were permitted to speak at the invitation of the Chairman. In the Health Assembly they normally spoke after Member States, but the Committee could allow them to speak earlier, at the Chairman's invitation.

It was so agreed.

Dr RAJALA (European Commission), speaking on behalf of the European Union and its Member States and indicating that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, and the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina and Serbia and Montenegro aligned themselves with his statement, welcomed the Commission's report and the proposed resolutions on intellectual property rights. Those rights provided an important incentive for the development of new health-care products, and warranted ongoing dialogue. The European Community and its Member States had long pressed for relevant measures, particularly the Doha Declaration on the TRIPS Agreement and Public Health, and mechanisms existed to ensure that much-needed medicines were developed and made accessible. He strongly urged all countries to make use of those provisions. The developing countries should be assisted in order to benefit from the flexibilities provided for in the TRIPS agreement, and he welcomed the role played by WHO in that respect. The provisions should be monitored for effectiveness.

The draft resolution on intellectual property rights, innovation and public health should focus on appropriate pricing and availability of medicines and other health-care products, with due regard to intellectual property rights and patents. Member States and regional economic integration organizations should implement the recommendations of the report. The global plan of action recommended by the Commission would be welcome. An intergovernmental working group should be established and consider the recommendations of the Commission. He appreciated the systematic work done by WHO in order to identify pharmaceutical needs from a public health perspective.

The draft resolution on a global framework on essential health and development contained in resolution EB117.R13 largely duplicated the points covered in the Commission's report, and the two resolutions could be dealt with together. Mechanisms did exist for striking a balance between intellectual property considerations and health needs, and they should be used. The Commission's many useful recommendations for the global plan of action should be responded to, especially by developed countries.

Professor TOUMI (Tunisia) emphasized the significance of the TRIPS agreement for health policies, and especially medicines. It was essential to encourage and reward research and development, but without restricting access to medicines. Support for the TRIPS agreement must be accompanied by transparency in the financing and pricing of pharmaceuticals, and some of the income derived from patents should fund research into neglected diseases. The international community should avoid introducing additional protection through WTO for intellectual property in medicines, as that would make medicines even less accessible. Future Health Assemblies should examine WHO's policy and action on medicines.

Mr SHARMA (India), speaking on behalf of the Member States of the South-East Asia Region, expressed appreciation of the work done by the Commission. The two draft resolutions before the Committee were broadly similar in their objectives and could be considered together by a drafting group, with the aim of achieving consensus on a text that would also deal with the concerns raised by the Member States of the African Region.

Mr IWABUCHI (Japan) suggested further consideration of the divergent views in the Commission, as reflected in the Annex to the report. Appropriate protection of intellectual property rights was important, for the sake of ensuring innovation in pharmaceuticals and other health-care products. The patent system was an effective incentive for the creation of new medicines. He recognized the necessity of developing medicines in order to treat diseases that affected developing countries disproportionately and of improving access to medicines. However, from the viewpoint of investment in research and development, it was not cost-effective to treat the needs of developing countries in a uniform manner, because their priorities in public health were not all the same.

Mr ABDOO (United States of America) said that the Commission's report was generally evidence-based, informed with practical recommendations, and reflected the complex relationship between public health, innovation and intellectual property. It recognized that developing new medicines was a risky and expensive process that needed incentives. Intellectual property rights benefited patients in all countries. The report rightly acknowledged that the intellectual property system was not a barrier to developing new medicines for diseases predominant in developing countries. In some instances, however, the report exceeded its mandate, went beyond the evidence or made inappropriate references to other documents, particularly in its treatment of human rights. Moreover, in recommending compulsory licensing in order to promote research relevant to the health problems of developing countries, it offered no evidence that the idea would produce tangible results.

He agreed with recommendation 3.6 for more work on the idea of a treaty on research and development, so that governments and policy-makers could make an informed decision. He had submitted written comments on the report, based on analysis by experts in the National Institutes of Health in the United States. His country would participate fully in the drafting group on the resolutions.

Mr BENTO ALCÁZAR (Brazil) said that his country had, in April, commented on the report. The two draft resolutions were similar, and should be studied together by a working group. On 23 May the health ministers of 10 South American countries had signed a joint declaration on intellectual property, access to medicines and public health. A copy of the text was available within the Secretariat.

Mr McNEE (New Zealand) said that his country supported efforts to facilitate access to medicines and other technologies in order to improve health. It welcomed the Commission's report. All Member States should deal constructively with its findings and seek consensus on appropriate resolutions.

Dr LARSEN (Norway) welcomed the Commission's report. Access to affordable medicines was essential in achieving the right to health. The Commission had concentrated on the accessibility of medical products of particular importance for developing countries. He supported further intergovernmental examination of the report and the draft resolution contained in resolution EB117.R13. Nongovernmental organizations could make a valuable contribution and should be invited, with civil society representatives, to participate in a working group on the subject.

He agreed that more resources should be allocated to research into diseases disproportionately affecting poor countries, and with the proposal for a global plan of action. The current incentive system should be redesigned in order to take into account the limited purchasing power of poor countries. Intellectual property rights were an important incentive to providing medical products for economically advanced countries, but they were clearly incapable of dealing with the challenges faced

by poorer countries. He approved the Commission's recommendations concerning the TRIPS agreement and its waivers in regard to public health in developing countries. As a strong proponent of the Doha Declaration on the TRIPS Agreement and Public Health, Norway considered that countries should incorporate in their national legislation international agreements allowing recourse to TRIPS agreement waivers whenever needed. Norway ensured that bilateral treaties to which it was party fully respected the TRIPS agreement flexibilities in relation to public health, and urged all developed countries to do the same. He applauded the Commission's emphasis on human rights as an important dimension of access to medicines, including the guidance given by the United Nations Committee on Economic, Social and Cultural Rights in its General Comment on the right to health.

Mrs MATA (Bolivarian Republic of Venezuela), commending the work of the Commission and the Secretariat, objected not to the intellectual property rights of an inventor, as registered in a patent, but to the abuse of those rights, such as attempts to patent products or procedures that did not qualify as inventions, or seeking to prevent generic medicines from gaining a foothold. In spite of the Doha Declaration on the TRIPS Agreement and Public Health, large pharmaceutical companies frequently exploited intellectual property rights to the disadvantage of poor countries. There must be fair trade, based on complementarity, cooperation, solidarity and respect for the sovereignty of peoples. Those principles were upheld in her country's Constitution, which also defined health as a social right and placed human rights above commercial gain. The rights of patients and the rights of patent holders must be emphasized. Intellectual property rights should not hinder scientific and technological progress, nor should they be used to prevent access to medicines or the manufacture of generic medicines, an alternative route to effective treatment. Intellectual property should promote technological innovation and transfers of technology, rather than monopolies and unfair competition. She agreed that the two draft resolutions should be merged into a single text.

Mrs LE THI THU HA (Viet Nam) welcomed the Commission's report, with its emphasis on the moral imperative for all stakeholders to act decisively in order to protect and advance public health. Access to products of research and innovation, including vaccines, diagnostic tools and treatments, was the key to improving health in developing countries. The Commission had rightly emphasized the importance of pharmaceutical and biotechnology products in those countries, the need for reduced prices of essential medicines such as second-line AIDS medicines and the danger of trade pacts that hindered access to life-saving medicines. Cheaper generic versions of newer AIDS medicines were essential in order to stem the spread of HIV. She welcomed the recommendation that WHO should review the effects of the TRIPS agreement on a continuing basis. WHO should also assess the negative implications of the TRIPS-plus standards adopted in the context of free-trade agreements, such as data exclusivity, extension of the term of a patent and patent-drug registration linkage. WHO should initiate work on a global plan of action in order to fund the development and increased accessibility of products to treat diseases that disproportionately affected developing countries.

Ms WISEMAN (Canada) said that she recognized the urgency and complexity of the Commission's mandate and welcomed its considered report. Its recommendations needed a follow-up. The two draft resolutions before the Committee would encourage greater innovation in, and a wider access ability to, medicines for diseases that are predominantly affecting developing countries. She called for an intergovernmental drafting group, of limited duration, in order to reach agreement on the draft resolutions.

Professor AYDIN (Turkey) said that the comprehensive and useful report linked the discovery and development of products with fair delivery in a conceptual framework, describing the complex interfaces between them. It was appropriate to take advantage of the flexibility contained in the TRIPS agreement and recognized in the Doha Declaration in order to protect public health. New and affordable products must be produced urgently. Research and development priorities should be targeted to the needs of patients in disease-endemic countries with no attempt to hinder access by poor

people to life-saving medicines. He endorsed the Commission's recommendation for a plan of action providing specific guidance to developing countries.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the Commission's report. Intellectual property rights stimulated innovation, particularly in the production of medicines for diseases that principally affected developing countries. However, in some regions, especially developing ones, a strong intellectual property regime had not resulted in innovation. Other valuable incentive mechanisms discussed in the report should be examined in the follow-up to the process. In that context, a consistent policy towards developing countries should be followed. Interinstitutional and research cooperation between developed and developing countries should be encouraged, and the flexibilities contained in the TRIPS agreement and recognized by the Doha Declaration on the TRIPS Agreement and Public Health should be taken into consideration. Developed countries should have more flexibility on public health issues in their bilateral trade agreements with developing countries and should not attempt to impose the TRIPS-plus commitments on them. Cooperation between WHO with other relevant intergovernmental organizations, including WIPO, should be strengthened in order to implement the recommendations effectively. The Commission's proposals needed to be explored further. The preparation of a global plan of action and the setting up of a working group of limited time duration would respond to the concerns of Member States. He supported the draft resolution.

A new international mechanism for needs-driven research and development should be established promptly in order to facilitate access to medicines and ensure their affordability. Adequate, sustainable resources were also imperative. In that context, incentives were important, including intellectual property rights; due consideration should, however, be given to the needs of developing countries.

The Commission's report had identified Member States' concerns regarding financial support for research and development; equitable cost-sharing between beneficiaries was also crucial to success. In bilateral trade agreements with developing countries, TRIPS-plus conditions should be avoided: those countries did not have adequate intellectual property infrastructure and needed affordable medicines.

He called for the establishment of a working group to discuss proposals for setting up a global framework in support of efforts concerning research and development. The recommendations of the Commission should also be followed and Member States presented with annual progress reports at future Health Assemblies.

Dr GAD (Egypt) endorsed the Commission's conclusion that innovation should not be limited to research and development but should provide adequate cures for diseases that disproportionately affected developing countries. The closed-circuit nature of innovation in developed countries created a gap between them and developing countries. The establishment of mechanisms that encouraged innovation, such as pairing, twinning or other forms of cooperation, would stimulate innovation in those countries endowed with the necessary infrastructure. The free-trade agreements that contained provisions relating to the protection of intellectual property that exceeded those in the TRIPS agreement would have a negative effect on public health and access to medicines and were therefore contrary to WHO's goals. He supported both draft resolutions.

Mr LEÓN GONZÁLEZ (Cuba) thanked the Commission for its report, which contained many valuable recommendations. Most of the world's population had been left on the fringes of the unprecedented medical progress made in the twentieth century. In all the developing regions the mortality burden was still very high. The TRIPS agreement was responsible for the high costs of essential medicines because it required protection through patents of the medicines and their manufacturing processes. The Agreement should be applied in a way that supported health, promoting both access to existing medicines and further research and development. Standards of intellectual property protection should comply with the Convention on Biological Diversity. The trade-related and public health-related aspects of intellectual property could solve problems, in particular those deriving

from HIV/AIDS, tuberculosis, malaria and other epidemics. In that context, the TRIPS-plus provisions were entirely negative. The initiatives proposed should meet the needs of the countries that faced the greatest health problems. The proposed intergovernmental working group would enable all interested countries to discuss those matters.

Dr BOTROS SHOKAI (Sudan) commended the Commission's report. The invention of new medicinal products and increased accessibility of medicines in developing countries would depend on the willingness of Member States and other stakeholders to implement the recommendations. The report failed to examine ways of reducing the cost of clinical research and regulatory processes and of increasing the private sector's contribution to research and development, and to show in practical terms how the transfer of production technology to developing countries could be achieved. The report examined the need to make medicines for all categories of disease accessible and affordable but did not emphasize the importance of medicines for the treatment of neglected diseases that predominantly or exclusively affected poor people in developing countries. She supported the statement made by the delegate of the Islamic Republic of Iran.

Dr SUWIT WIBULPOLPRASERT (Thailand) proposed that Switzerland should chair the proposed drafting group to consider the two draft resolutions.

Dr NOEHRENBERG (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that he appreciated the Commission's recognition of the important contributions of the pharmaceutical industry to the development of medicines in order to meet the health needs of developing countries. He noted that 90% of the innovative drugs on the WHO Model List of Essential Medicines had been developed by the industry, which was also providing at cost, or even free, the best current treatments for the neglected diseases of African human trypanosomiasis, onchocerciasis and leishmaniasis. It was also developing and bringing to market many products in order to treat HIV/AIDS, respiratory infections, cardiovascular disease, cancer, depression and other major global causes of morbidity and mortality. The current system was therefore effective in tackling global health needs, including diseases that particularly affected developing countries. His organization welcomed the report's reaffirmation of the vital role that intellectual property rights played in promoting innovation, which saved lives and improved health worldwide.

Stronger incentives in order to promote further research into diseases that particularly affected developing countries, such as advance-purchase agreements and public-private sector partnerships, were important. Action at the national level in order to implement market-based incentives was also needed. The pharmaceutical industry looked forward to continuing to work with WHO, the public sector and civil society in further advancing research and development in order to improve health around the world, including in developing countries.

Ms DANIELS (Consumers International), speaking at the invitation of the CHAIRMAN, welcomed the Commission's report. She encouraged an intergovernmental process to agree an action plan to implement its recommendations, and endorsed the proposal to establish an intergovernmental working group in order to create a global framework for supporting essential health research and development. Innovations needed to meet real needs and to be accessible. The proposed working group would provide a forum for deciding how to set priorities for essential health research and development and how to share the costs. The draft resolution recognized both public- and private-sector research and development, and the balance between the protection of intellectual property, public interest and follow-on innovation. It also identified the need for research in priority areas while allowing governments to protect consumers from high prices and access barriers.

The response to the outbreak of severe acute respiratory syndrome had exemplified how political will could ensure swift and effective international cooperation. However, no system sustained response to diseases that predominantly affected poor people in developing countries. A new global

framework would provide ways to examine how the cost of research and development for all diseases, regardless of whether they affected rich or poor, could be shared.

She urged Member States to approve the draft resolution.

Dr KAMAL SMITH (OXFAM), speaking at the invitation of the CHAIRMAN, emphasized the role of generic competition in reducing the prices of medicines, as exemplified by antiretroviral agents. The TRIPS-plus measures introduced in bilateral and regional free-trade agreements had serious implications for countries that needed affordable medicines. OXFAM welcomed the report's insistence on the need for adverse health consequences to be explicitly recognized before such binding agreements were entered into. The flexibilities in the TRIPS agreement were not assisting countries to gain access to patented medicines. The report added to the mounting evidence of the ineffectiveness of the intellectual property rights system in ensuring research and development of medicines for poor people. Communicable and noncommunicable diseases required new mechanisms for promoting research and development. The framework proposed in the draft resolution would enable countries to tailor their research and development policies to their public health needs.

He urged the Health Assembly to adopt the report's recommendations. The two draft resolutions recognized the urgency of achieving access to medicines and supported the sustainable production of low-priced public health goods through competition and innovative ways of financing research and development.

Ms DE HOZ (Argentina) endorsed the statement by the delegate of Brazil, and welcomed the Commission's report. Strategic alliances for technology transfer should be strengthened. She was concerned by the growing burden of diseases that disproportionately affected some countries of the Region of the Americas, particularly those affecting women and children, and by the emerging health problems, posed by neglected and transmissible diseases. An international dialogue should be maintained on the impact of patent protection on access to medicines.

Dr NOTTAGE (Bahamas) said that the member countries of the Caribbean Community commended the work of the Commission. The Community had set up a Technical Advisory Committee on TRIPS in order to assess the preparedness of its members to use the flexibilities of the TRIPS agreement so as to gain access to affordable pharmaceuticals. However, the manufacture of pharmaceuticals was not economically feasible in the small developing nations of the Caribbean region, and the public health benefits offered by the TRIPS agreement were not attainable in a situation where access was affected by relatively high levels of poverty. Balancing patent and patients' rights was not easy. Pharmaceutical companies needed profits, but they also had a humanitarian responsibility. Current drug prices did not allow the countries in his region to provide all patients in need with continuous access to pharmaceuticals, especially as their major burden of disease was caused by HIV/AIDS and chronic diseases.

The countries of the Community supported the draft resolution in principle, and requested the assistance of WHO and PAHO in strengthening regional regulatory systems in order to ensure the quality of imported products.

Dr TÜRMEN (Representative of the Director-General) thanked delegates for their comments, and the Governments of Switzerland and the United Kingdom of Great Britain and Northern Ireland and the Ford Foundation for their support of the work of the Commission and its report.

Ms DREIFUSS (Chairperson, Commission on Intellectual Property Rights, Innovation and Public Health) commended governments' generous support and the contribution of nongovernmental organizations and pharmaceutical industry stakeholders. The Commission's report acknowledged the role of intellectual property rights in medical innovation but also highlighted their limitations. It viewed the matter within a broad context: upstream were the financing and creative momentum of basic research and, downstream, matters such as access to medicines and the organization of health systems or medical insurance. It therefore approached the question in terms both of a reasonable

exercise of intellectual property rights, taking account of all discussions since the Doha negotiations and fair application of the TRIPS agreement, and of other such incentive mechanisms as might be necessary where all the conditions were not met. Many of the Commission's recommendations were addressed to governments, the bodies chiefly responsible for creating an enabling environment for innovation and for public health, but many were addressed also, through Member States, to the Secretariat, which had a pivotal role to play in creating synergies and strengthening the ongoing momentum.

The Commission was grateful to Member States for their resolve to put a global framework in place in the form of a global plan of action in order to sustain that momentum, and to respond to the hopes that were being placed in science for the common benefit of all humanity.

Dr ANANT MASHELKAR (Vice-Chairperson, Commission on Intellectual Property Rights, Innovation and Public Health) said that the report reflected the Commission's mandate: how to make medicines available, accessible and affordable, with emphasis on both technical and policy innovation. A time of great opportunity had arrived, brought about by the confluence of four factors: heightened public awareness; breathtaking scientific advances, including the emergence of new producers of knowledge and hence opportunities to create new knowledge partnerships; the creation of new institutional forums, such as public-private partnerships; and new funding opportunities. The report's recommendations and the ensuing deliberations should lead to a new global understanding under which the haves and have-nots would be willing to work together and the interests of innovation and the interests of society would be protected.

The CHAIRMAN suggested that the draft resolutions and proposed amendments should be referred to an open-ended working group to be chaired by Switzerland, which would meet immediately.

It was so agreed.

(For approval of the draft resolution, see summary record of the eleventh meeting, section 2.)

Dr Ramadoss took the Chair.

HIV/AIDS: Item 11.3 of the Agenda (continued)

- **WHO's contribution to universal access to HIV/AIDS prevention, treatment and care** (Document A59/39) (continued from the fourth meeting)

Ms DE HOZ (Argentina) said that the content of the documentation before the Committee on HIV/AIDS was consistent with Argentina's National Strategic Plan for 2004-2007. With reference to the report on nutrition and HIV/AIDS (document A59/7), she noted the importance of the Secretariat's support to Member States in policy-making and implementing intersectoral nutrition plans and the value of the WHO/FAO manual on nutritional care for people living with HIV/AIDS.

She supported the recommendation of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors to create joint monitoring and evaluation support teams in countries. Noting the progress made in the Region of the Americas, she emphasized a comprehensive approach covering prevention, treatment, care and support. Argentina would be reviewing progress, at the United Nations General Assembly in May-June 2006, of implementation of the Declaration of Commitment on HIV/AIDS.

Dr KAGGWA (Uganda) endorsed WHO's five strategic directions. However, universal access to prevention, treatment, care and support to all those in need within the next five years was needed. That would involve: additional resources, nationally and internationally; building capacity in countries and technical support for the effective use of financial resources; improving coordination among

donors and governments based on the "Three Ones" principle; and strengthening health systems. Uganda reaffirmed its commitment to expanding access to HIV/AIDS services, including services for antiretroviral treatment. It had exceeded its "3 by 5" target of 60 000 people on antiretroviral treatment.

Mr HICKEY (United States of America) supported the draft resolutions contained in resolutions EB117.R2 and EB117.R8. He emphasized nutrition, particularly for people suffering from HIV/AIDS: morbidity and mortality could be decreased, and care and treatment programmes strengthened. As part of his country's effort to achieve the goal of universal access, the President's Emergency Plan for AIDS Relief had helped to increase the number of people receiving antiretroviral treatment in resource-poor nations. Treatment was being supported for 400 000 people living with HIV/AIDS in 15 focus countries, and for 470 000 people globally. He supported also the increased promotion of appropriate nutrition for persons with HIV/AIDS. As access to care and treatment increased throughout the world, better cooperation between nutritional care programmes and HIV/AIDS control programmes was needed. Cooperation was needed to ensure that antiretroviral therapy and nutrition programmes were synergistic and not competitive. Confidential, voluntary HIV counselling and testing should be expanded so that persons with HIV/AIDS could become aware of their status, make informed decisions and receive support regarding nutrition and treatment. The Global Task Team reinforced the "Three Ones" principle, which his Government strongly endorsed. He further supported the resolution on the implementation of the Global Task Team's recommendations.

Although universal access to prevention, treatment and care for HIV/AIDS was an admirable goal, which his Government was committed to help achieve, the Health Assembly should underscore its aspirational nature. With reference to the proposal by Norway that the Health Assembly should endorse the goal of universal access, he proposed that the goal should be "coming as close as possible to universal access".

Dr CONWAY (Tuvalu), expressing support for the draft resolutions, said that, although no case of HIV infection or AIDS had been detected in her country since 2002, the true level of infection was difficult to assess on account of very low turnout for voluntary testing and inadequate supplies of testing kits. A National AIDS Committee had been formed in order to coordinate activities after the first HIV case had come to light in 1995, and a policy for treatment, care and nutrition had been approved in 2005. No patient was currently under treatment, but a support group for people living with HIV/AIDS had been established. Tuvalu was grateful for the support provided by WHO and its partners. Support should be continued in the areas of capacity building, advocacy, prevention and control, medical supplies, assistance to the support group, and to a specific reference laboratory in the Pacific region for the benefit of countries that lacked laboratory facilities.

Professor MWAKYUSA (United Republic of Tanzania) commended WHO's continuing contribution to universal access to HIV/AIDS prevention, treatment and care. Although the "3 by 5" goal had not been met, the momentum it had generated had galvanized efforts towards attaining the Millennium Development Goals, especially in terms of the provision of packages of prevention, treatment and care for all those in need. In his country, the number of treatment sites had increased and coverage was countrywide, with plans to increase the number of trained counsellors. The target was to make antiretroviral treatment available to 100 000 AIDS patients by the end of 2006 and 400 000 by 2008. HIV/AIDS had been included in all development and poverty-reduction programmes, with prevention as the cornerstone of activities. He commended the first four strategic directions for universal access to HIV/AIDS prevention, treatment and care outlined in the report.

The major challenges were diagnostic and health services, supply of medicines, and sustained financing. He supported the draft resolutions.

Dr BUTLER-JONES (Canada) said that Canada had participated in the Global Steering Committee on Scaling up towards Universal Access, and would continue to support WHO's efforts to assist countries in need. The shift from the "3 by 5" target to moving towards universal access was

indicative of a sound, rights-based and equitable approach to public health. Canada supported the five strategic directions proposed, but would prioritize within those strategic directions in cooperation with other UNAIDS cosponsors. WHO should scale up towards universal access within the context of strengthening health systems and respect for gender equality. Such efforts should be effectively linked to sexual and reproductive health services, primary health care, prevention and control.

Dr CHAOUKI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the emphasis on nutrition in the prevention, treatment and care of HIV/AIDS. Complex emergencies and humanitarian crises were increasing in number and intensity in the countries of the Region, heightening the risk of HIV/AIDS. In that context, mother-to-child transmission of HIV raised the matter of balancing the risk from breastfeeding against that of introducing breast-milk substitutes. He welcomed the policies and practices that promoted the integration of nutrition into a comprehensive response to HIV/AIDS, particularly regarding the macronutrient and micronutrient needs of HIV-infected people. He strongly endorsed the draft resolution contained in resolution EB117.R2, and called for nutrition to be integrated into national HIV/AIDS programmes. The Secretariat should continue to support Member States with advocacy tools for decision-makers, in the implementation of the Global Strategy for Infant and Young Child Feeding. It should elaborate recommendations, guidelines and tools on nutrition care and support for people living with HIV/AIDS. More evidence and information were needed on the relationship between nutrition and HIV infection and its consequences. Several Member States needed technical and financial assistance urgently in order to build capacities for middle- and lower-level health workers who were supporting people living with HIV/AIDS, and for the overall and community-based management of malnourished, HIV-positive children.

His Government's policy to halt the epidemic included free treatment; 1300 of the identified 1990 people with AIDS in March 2006 were receiving highly active antiretroviral therapy. Morocco's strategic planning was based on political commitment, civil society involvement, intersectoral coordination, cooperation with partners, and governmental and external funding. Prevention was based on voluntary counselling and testing in 26 centres, a targeted surveillance system, mass communication and free antiretroviral therapy. Remaining challenges included: sustaining actions, particularly access to treatment; the expansion of voluntary counselling and testing centres; the provision of prevention services for youth, women, drug users and sub-Saharan migrants; and the promotion of prevention methods, in particular condoms. Morocco supported the draft resolution on nutrition and HIV/AIDS.

Dr KEDIR (Ethiopia) said that his country was implementing a policy on the supply and use of antiretroviral medicines within the framework of Ethiopia's existing HIV/AIDS prevention and control strategy. A five-year multisectoral strategic plan on HIV/AIDS, endorsed in 2005, had been incorporated into the Government's broader development plans. Advocacy had led to the involvement of other bodies in the United Nations system, bilateral organizations, community-based organizations, nongovernmental organizations, and the community at large in preventing and controlling HIV/AIDS. The main obstacles to effective prevention, treatment and care were the weak health system, disparate approaches by different partners and inadequate resources at the operational level. There was a need to increase capacity in the health system, empower the community, and implement more effective information, education and communication strategies, including behavioural change programmes. Development partners should also align their strategies with that of the Government and harmonize their approaches in order to practise the "Three Ones" principle.

Dr SANGALA (Malawi), recalling that HIV/AIDS continued to affect all aspects of society in sub-Saharan Africa, said that optimism had risen with the introduction of antiretroviral medicines. More than 40 000 people in Malawi were being treated and 180 000 were so far eligible for treatment. As treatment was extended to more patients, it would be necessary to strengthen health services, especially human resources. Malawi had qualified for funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to improve its health system. Increasing attention was also being

paid to the prevention of mother-to-child transmission of HIV, and to treatment for children. He endorsed the report and the statement by the delegate of Norway.

Mrs THIAM (Côte d'Ivoire) said that her country was among the sub-Saharan countries most affected by HIV/AIDS, with a prevalence rate of 7%; there were 570 000 people living with HIV/AIDS, including 40 000 children. Her Government's control strategy involved a multisectoral, decentralized approach, with free voluntary testing and subsidized antiretroviral treatment. Weaknesses had been identified, especially in the management and provision of antiretroviral treatment, laboratory infrastructure and human resources. The "3 by 5" initiative had improved access to antiretroviral therapy. Improved prevention of mother-to-child transmission of HIV, increased numbers of health workers and mobilization of resources were all needed in order to maintain prevention and control. A national fund had been set up for the control of HIV/AIDS, and the adoption of a national strategic plan would reduce prevalence. She commended the initiative taken by WHO and UNAIDS, and welcomed the report.

Mr RUÍZ MATUS (Mexico) said that his Government had reinforced its efforts to maintain universal access to prevention, treatment and care for everyone living with HIV/AIDS. The budget for those activities had increased by 25% between 2000 and 2006, guaranteeing integrated, high-quality treatment and care since 2003 and universal access to antiretroviral medicines, all being undertaken in a spirit of respect and equity and with the participation of people living with HIV/AIDS and of academic and educational institutions. WHO should endeavour to ensure that the production of innovative and generic medicines was maintained, with prices that would enable developing countries to attain their treatment targets. He supported the proposal by the delegate of Norway.

Mr GREEN (United Kingdom of Great Britain and Northern Ireland) emphasized the implementation of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors, as requested in the draft resolution contained in resolution EB117.R8. He welcomed the contribution made by WHO to strategic support for achieving universal access to HIV/AIDS prevention, treatment and care. He also agreed with the statements by the delegates of Canada and the United Republic of Tanzania, and the proposal by the delegate of Norway for achieving universal access.

Dr HERNAWATI (Indonesia), referring to the draft resolution on nutrition and HIV/AIDS contained in resolution EB117.R2, said that in 1993 her Government had elaborated guidelines for the care, including nutrition care, support and treatment of people living with HIV/AIDS. There were currently 75 hospitals with staff trained in such care, support and treatment, 60 of which were already providing services including nutritional care for people receiving antiretroviral therapy. One important limitation was the stigmatization associated with the condition. She supported the draft resolution.

Professor TLOU (Botswana), speaking on behalf of the Member States of the African Region, strongly endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. She also supported the draft resolution contained in resolution EB117.R8. The adoption of the "Three Ones" principle would ensure a country-led response, and effective coordination among partners would support delivery. The optimal use of donor support and country resources in fighting the HIV/AIDS epidemic was essential. Achieving universal access to prevention, care, treatment and support would be challenging. The "Three Ones" principle was accepted by almost all States in the Region, increasing support from multilateral and international organizations. Nevertheless, donors and partners required different strategies, committees, and reporting and monitoring systems, resulting in overburdened health systems and a duplication of effort, thus reducing the impact of scarce resources. She acknowledged the efforts of United Nations theme groups, joint committees and partnership forums at country level, but more needed to be done by all partners in the implementation of the "Three Ones" strategy. WHO must define its roles in the process and ensure that all HIV/AIDS partner support was aligned with

national strategic frameworks. Donors and developmental partners should commit themselves to that principle, so as to improve the efficiency of HIV/AIDS partnerships at national and international levels. She welcomed the report and expressed the Region's commitment to the draft resolution contained in resolution EB117.R8.

Mr KASE (Papua New Guinea) said that in his country the reduction in prevalence of HIV/AIDS was a strategic direction in the health sector's plan for 2006-2008, and the aim was to increase access to antiretroviral treatment, prevent mother-to-child transmission of HIV, and expand voluntary counselling and testing. The increase in prevalence of HIV/AIDS had led to a re-emergence of tuberculosis as a major public health problem. Tuberculosis programmes should be integrated with programmes for HIV/AIDS. He acknowledged the support provided by WHO and the Australian Government. He supported the draft resolutions contained in resolutions EB117.R2 and EB117.R8.

Mrs LE THI THU HA (Viet Nam) expressed full support for the proposed five strategic directions. In 2004 her Government had approved a national strategy for HIV/AIDS prevention and control that was in line with the targets of universal access. She noted that one obstacle to achieving that goal for poor countries was the high price of antiretroviral medicines. Generic formulations were being produced, but the prequalification process was time-consuming and expensive for small manufacturers, which made the scaling up of treatment difficult for countries with limited resources. She acknowledged the support given to her country by WHO, UNAIDS and other partners.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) supported the draft resolution on nutrition and HIV/AIDS contained in resolution EB117.R2. In Cuba, nutrition was provided in special centres for the care of people living with HIV/AIDS. Daily nutritional supplements had been provided since 1993.

Ms DLAMINI (Swaziland) acknowledged the support provided by WHO and other partners. In Swaziland, progress had been made towards universal access to HIV/AIDS prevention, treatment and care and support. The "Three Ones" principle had been adopted, with improved prevention strategies. Access to antiretroviral therapy had increased, with the medicines currently free of charge for those living with HIV/AIDS. Her country faced numerous obstacles, including human and financial constraints, nutritional inadequacies in people receiving antiretroviral treatment, tuberculosis and the need for behavioural change. She supported the draft resolution under discussion.

Dr SAÍDE (Mozambique) agreed that the Health Assembly should endorse the goal of universal access to HIV/AIDS prevention, treatment and cure. In his country a national initiative in order to increase public awareness of measures to prevent HIV infection had been launched, and he expressed appreciation of WHO's efforts to attain universal access. He supported the draft resolution.

Dr RUEDA (Colombia) said that his country had recently introduced new measures in order to combat HIV/AIDS, including social security benefits, second-line antiretroviral treatment, genotyping of HIV, and provision of powdered formula for HIV-positive mothers. Such interventions were cost-effective to the extent that preventing transmission of HIV and improving the quality of life of patients saved health-system resources. Efforts should concentrate on avoiding mother-to-child transmission of HIV and on research. Successful strategies would depend on reduced costs for medicines. Health insurance in Colombia, which covered more than 80% of the population, including the poorest segment, enabled free and integrated treatment for HIV/AIDS, and a treatment guide had recently been prepared. Satisfactory results would depend on an integrated strategy. He expressed his support for the draft resolution.

Mr JALLOW (Gambia) said that the major challenge in his country was how to deal with the stigmatization associated with HIV/AIDS, even though the laws prohibited discrimination in that regard. He requested information on how to prevent such discrimination. He acknowledged the support provided to Gambia by WHO, UNICEF and other partners. He supported the draft resolution.

Mr FAUGOO (Mauritius) expressed support for the draft resolutions contained in resolutions EB117.R2 and EB117.R8. In view of the high recent increase in the number of cases of HIV/AIDS among injecting drug users, his Government had recently introduced a programme for methadone-substitution therapy and needle exchange, and it looked forward to technical assistance from WHO and UNAIDS in that regard. He endorsed the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. Noting that his country did not qualify for assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria, he appealed to WHO and international donors to support financially its proposed programmes, and asked whether the rules could be modified in order to allow his country to become eligible for financial aid from the Fund.

The meeting rose at 12:30.

SIXTH MEETING

Thursday, 25 May 2006, at 15:05

Chairman: Dr P. MAZZETTI SOLER (Peru)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

HIV/AIDS: Item 11.3 of the Agenda (continued)

- **WHO's contribution to universal access to HIV/AIDS prevention, treatment and care** (Document A59/39) (continued)

Dr EMAFO (United Nations International Narcotics Control Board), referring to the second and third strategic directions in the report, said that the Secretariat and the Board had worked together in order to ensure that internationally controlled medicines were available for medical purposes and not diverted to illicit channels. Globally, licit consumption of narcotics had increased significantly over the years, but national consumption levels differed considerably. Consumption in the developed countries accounted for the increase, but opioid analgesics for pain management continued to be scarce in many developing countries. The Board, concerned that patients were being denied access to such medicines, welcomed WHO's initiative in developing a strategy for improved palliative care for HIV/AIDS, cancer and other chronic conditions. It looked forward to working with WHO in elaborating guidelines on substitution maintenance therapy in the management of opioid dependence, which might be a component of community-based approaches to prevent HIV infection among injecting drug users. In response to the United Nations Economic and Social Council resolution 2005/25 and resolution WHA58.22 on cancer prevention and control, his Board was working with WHO on a feasibility study on mechanisms for treatment of pain using opioid analgesics. This joint activity would identify factors preventing legitimate access to essential medicines and avoiding diversion to illicit use.

Ms MULLER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, voiced concern that, in cases of HIV/AIDS, not enough attention went to problems at household and community levels in overcoming stigmatization and seeking therapy, or to basic needs such as nutrition. Therefore, work beyond the clinic was essential, but needed trained volunteers for the management of successful programmes conducted with respect and dignity. Her Organization was the UNAIDS collaborating centre for reducing stigmatization and discrimination, and its affiliates were campaigning in 128 countries. It had also collaborated with WHO and the Southern African HIV and AIDS Information Dissemination Service on generic training modules in order to prepare volunteers in community education and mobilization, long-term treatment, and psychosocial and nutritional support. Such material, with the necessary country adaptation, could be a valuable resource in promoting universal access. All governments should recognize, support and foster volunteer work and give volunteers the respect and support they deserved.

Dr NOEHRENBERG (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry helped to meet the vital need for AIDS medicines in developing countries through funding, expanding access to medicines and infrastructure development. The seven companies working through the Accelerating Access Initiative were reaching more than 716 000 people in developing countries as of

December 2005, including 416 000 in Africa alone – an increase of 116% during the past year, and the trend was accelerating. The industry also dealt with the needs of children living with HIV/AIDS, a matter of great concern in the countries hardest hit by AIDS. Paediatric formulations existed for virtually all antiretroviral agents currently available on the market and indicated for children. Many of them were accessible at drastically reduced prices in many developing countries. Industry research and development into paediatric formulations continued, and innovative manufacturers of AIDS medicines were working with UNICEF, UNAIDS and authorities in the United States of America in order to improve access and treatment for children in developing countries. The industry was committed to improving access to second-line antiretroviral treatments in those countries. Because they were technically difficult to manufacture, they cost more – a reality faced by both generic producers and innovative companies. An analysis of price data gathered in June 2005 showed that, after taking transport costs into account, the prices of generic second-line treatments were similar to, or even higher than, the prices offered by the multinational originators.

The industry welcomed efforts to mobilize additional and better-quality resources, and reaffirmed its strong commitment to working with Member States, the Secretariat and nongovernmental organizations in the common fight against the HIV/AIDS pandemic.

Ms DANIELS (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of Health Action International, recalled that, at the United Nations General Assembly's imminent special session on HIV/AIDS, progress would be reviewed and innovative strategies were expected to be revealed. Prevention, treatment and care must be tackled equally. If progress were to be made towards universal access to treatment by 2010, 10 challenges must be faced: treatment interruption due to shortages of medicines and paediatric formulas; lack of access to diagnostic tests, leading to lack of awareness of HIV status (of particular concern were the needs of children and the lack of medicines; suitable medicines would require research involving children, and particular caution must be exercised in that regard); inequity in antiretroviral therapy coverage, both between and within countries; the lack of procurement coordination at national level; transport costs and user fees; overburdening of health workers through lack of investment in health services and the rapid scale-up of antiretroviral therapy; the continuing stigmatization of and discrimination against vulnerable people in need of treatment, especially injecting drug users; the lack of adherence to regimens and nutritional support for antiretroviral therapy users; uncoordinated planning and implementation at all levels; and planning for sustainability of antiretroviral therapy programmes, including future needs for second-line treatment.

She called on the Health Assembly to provide the leadership and technical expertise desperately needed in order to achieve universal access to treatment by 2010.

Ms BRYANT (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the strategic focus on universal access to prevention, care and treatment by 2010. Her organization emphasized prevention and care integrated with access to treatment, and was collaborating with WHO to that end. Goals would not be achieved if health-care providers were themselves dying of AIDS. Treating health-care workers was the key to strengthening infrastructure and retaining health professionals. She acknowledged the recent WHO initiative to treat, train and retain health professionals. That alone, however, would not suffice: health workers with sick families would be tempted to share antiretroviral and other therapy, thus leading to treatment failure. It was best to treat the family, which is what her organization had been doing in its projects in Swaziland and Zambia. In the former, the Wellness Centre had provided antiretroviral therapy to HIV-positive health workers and their families and organized preventive measures. These experiences were for sharing. She called on WHO, governments and others to provide health workers with a comprehensive package, including access to prevention, care and antiretroviral therapy. She asked when the Secretariat would create new nursing positions in order to help face the HIV pandemic.

The Committee noted the report.

- **Nutrition and HIV/AIDS** (Documents EB117/2006/REC/1, resolution EB117.R2 and Annex 4, and A59/7)

Dr HANSEN-KOENIG (representative of the Executive Board) said that national, regional and global activities concerning nutrition and HIV/AIDS had been strengthened following the recommendations of WHO's technical consultation on nutrition and HIV/AIDS in Africa (Durban, South Africa, 10-13 April 2005) and the Executive Board's deliberations at its 116th session, which formed the basis for setting priorities and drawing up a plan of work for WHO in that area. The Board had discussed the matter at its 117th session, noting the scope of the work and progress made, and invited the Health Assembly to consider the draft resolution contained in resolution EB117.R2.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that people on antiretroviral treatment, and children in particular, needed a balanced diet including micro- and macro-nutrients. The countries most affected by HIV/AIDS were also those facing major nutrition problems. He welcomed the proposal in the draft resolution to include nutrition as a priority for countries in their response to the HIV/AIDS problem.

Since 1993, people living with HIV/AIDS in Cuba had received extra food supplies, and since 2003 had further received extra vegetable oil, cereals, fruit juices and yoghurt. Information material had been prepared and workshops held. At city and health district levels, integrated nutrition support teams consisting of health workers and people living with HIV/AIDS and their families had been set up to promote healthy eating habits. He supported the draft resolution.

Dr EDIRISINGHE (Sri Lanka) said that the prevalence of HIV infection was low in his country because of the strong public health system, political commitment to prevention and favourable cultural and religious practices. The first case of HIV infection had been detected in 1987, and the total currently stood at 743 cases, in a population of 19 million. Some 74 people currently received antiretroviral treatment. Risk factors threatening to increase HIV prevalence included the fact that one million people worked abroad in high-prevalence countries, the trend towards marriage at a later age, and stigmatization of and discrimination against HIV-positive people. The Government conducted awareness-raising programmes on HIV transmission and its prevention for the general public and special interventions for vulnerable groups, promoted safer sexual practices, worked to reduce stigmatization and discrimination and supplied antiretroviral medicines free of charge. Sexual contact was the main mode of transmission, and the Government therefore particularly emphasized the "safer sex" message, hoping to maintain the current low prevalence rate.

Dr GARBOUJ (Tunisia) said that the action outlined in the draft resolution would increase the responsibilities of the health and other relevant sectors. She supported the integration of nutrition into HIV/AIDS programmes. Member States would need technical assistance to review nutrition programmes, including capacity-building, improved procedures, promotion of scientific research and sharing of experiences.

Mr KEZAALA (Uganda) said that nutrition was essential for successful HIV/AIDS treatment and patient compliance. His country had incorporated nutrition in a comprehensive package of care for people with HIV/AIDS. A nutritionist was employed within the Ministry of Health in the programme for control of sexually transmitted infections and AIDS. A follow-up meeting after the WHO technical consultation on nutrition and HIV/AIDS in Africa (Durban, South Africa, 10–13 April 2005) had brought together participants from eastern and central Africa. His Government had disseminated guidelines and simplified educational materials and counselling cards on nutrition and feeding children in the context of HIV/AIDS. He strongly supported the integration of nutrition into HIV/AIDS prevention, care and treatment, particularly in sub-Saharan Africa. Uganda had applied unsuccessfully to the Global Fund to Fight AIDS, Tuberculosis and Malaria for nutrition-related HIV/AIDS programmes. He called for greater consideration in the future.

Dr SOMSAK AKKSILP (Thailand) said that nutrition could improve the quality of life of people living with HIV/AIDS, especially pregnant women and breastfeeding mothers. He proposed the following amendments to the draft resolution. In subparagraph 1(1)(e), the word "financial" should be inserted, to read: "social-service, education, financial and nutrition sectors". In subparagraph 1(3)(b), the phrase "mothers and caregivers" should be inserted, to read: "community-based health workers, mothers and caregivers in order to improve …".

Mr BALL (Canada) supported the draft resolution. Providing nutritional care and support for people living with HIV/AIDS was an important part of a comprehensive response. He called on WHO and its main partners to improve nutrition in the context of HIV/AIDS, taking into account gender vulnerabilities. The Secretariat should deal with stigmatization and discrimination, which were impediments to effective prevention and care, in all programmes and policies, and should support multisectoral food and nutrition plans integrated with national HIV/AIDS plans. The absence of a nutrition component might significantly reduce the impact of other efforts to prevent and treat HIV/AIDS.

Ms NGHATANGA (Namibia) said that nutrition was an essential part of her country's programme to combat HIV/AIDS. Her Government had drafted nutrition and HIV/AIDS guidelines for health workers involved in the management of people living with AIDS. She supported the draft resolution, with its focus on multisectoral coordination between health, agriculture and other sectors. In Namibia, nutrition was closely connected with food safety and security, especially in some rural areas subjected to sporadic drought. With the support of development partners, the Government was distributing food to vulnerable children, particularly AIDS orphans.

Dr ZOMBRE (Burkina Faso), speaking also on behalf of the Central African Republic and the African group on nutrition and HIV/AIDS, said that Africa suffered chronic undernutrition, acute and chronic malnutrition and high rates of deficiency in iron, iodine and vitamin A. In most African countries, over 15% of children under five years of age were affected by acute malnutrition and over 35% by chronic malnutrition, and about one woman in five of childbearing age suffered from a chronic energy deficit. HIV/AIDS had an impact on not only morbidity and mortality rates but also the food and nutritional security of people living with, or affected by, HIV/AIDS. It affected individuals, households, communities and entire countries. Lower productivity and shortages of human resources led to food insecurity and malnutrition. HIV infection increased the person's energy needs and micronutrient requirements. Micronutrient supplementation helped the person to maintain a healthier weight and reduced the risks of death, opportunistic infections and mother-to-child transmission of HIV. Nutrition policies were being implemented in HIV control programmes. The African group took note of the report and called on WHO to continue technical assistance and capacity-building in countries in order to integrate nutrition policies into the management of persons living with, and affected by, HIV/AIDS, especially pregnant women and infants. He supported the draft resolution.

Dr TSHABALALA-MSIMANG (South Africa) said that her country and the other Members in the African Region saw nutrition as an integral part of the management and treatment of HIV/AIDS. She supported the draft resolution, but suggested the following amendments. Subparagraph 1(1)(c) should refer to "HIV/AIDS prevention, treatment and care programmes", since good nutrition improved the quality of care of people with AIDS as well as those who were HIV-positive, and helped to delay the development of full-blown AIDS. In South Africa the usual phrase was "HIV and AIDS" rather than "HIV/AIDS", since HIV and AIDS were considered to form a spectrum of conditions whose clinical expression and natural progression were affected by different predisposing factors. Paragraph 1(2) should be amended to read: "… people living with HIV and AIDS at different stages of disease and for sex- and age-specific approaches including provision of antiretroviral therapy". Paragraph 2(1) should be amended to read: "… incorporating nutrition considerations into HIV and AIDS policies and programmes". Paragraph 2(8) should refer specifically to funding proposals

submitted to the Global Fund to Fight AIDS, Tuberculosis and Malaria. She was encouraged to note that the Global Fund would include nutrition as an element of its funding proposals in future.

Dr LALA (Central African Republic) added that the prevalence of HIV infection in his country stood at 15%, the highest in central Africa. The country's gross domestic product continued to grow at less than 2.5% per year, and malnutrition and micronutrient deficiency were widespread among those living with or affected by HIV, particularly infants and pregnant women. A food and nutrition policy for people living with HIV still needed to be fully integrated into the country's HIV/AIDS programme. He expressed his support for the draft resolution.

Dr MAJARA (Lesotho) said that HIV prevalence in Lesotho was 23%, a very high rate in an already nutritionally weakened population. Concerted efforts were needed to improve the situation. Initiatives had been launched, including issuing adult and infant feeding guidelines for nutrition and HIV/AIDS, which emphasized the use of indigenous foods easily available to marginalized communities. Exclusive breastfeeding for the first six months of life was promoted (the current rate was 36%) and the national code of marketing of breast-milk substitutes had recently been updated. However, food insecurity had been exacerbated by drought and inadequate human resources adversely affected the delivery of health services. Lesotho supported the draft resolution.

Dr MADZIMA (Zimbabwe) supported the draft resolution and was grateful for support from WHO, UNICEF, WFP and nongovernmental organizations for nutrition and HIV/AIDS care, including food assistance for people receiving antiretroviral therapy. HIV prevalence had declined from a peak of 33% in 2000 to 20% in 2005. Various traditional medicines, especially herbs, were being used in communities for boosting the immune system and relieving some HIV/AIDS symptoms. The Ministry of Health had therefore established a research department in traditional medicine, which WHO should support. Zimbabwe had also undertaken capacity-building on nutrition (including breastfeeding and infant feeding) and HIV/AIDS, produced nutrition guidelines for the health sectors and individuals, which emphasized use of traditional, local foods, and revitalized the WHO/UNICEF Baby-friendly Hospital Initiative. Obstacles included inadequate coordination between partners and lack of awareness of nutrition among the general public, exacerbated by food shortages due to drought and the marketing of foods for which unsubstantiated benefits were claimed.

Dr CABOTAJE (Philippines) supported the draft resolution. Poor nutritional status rendered individuals more vulnerable to infection, and malnutrition was common among people living with HIV/AIDS. The Philippines had elaborated a road map to universal access to prevention, treatment and care services for people living with HIV/AIDS or at high risk, and nutrition was crucial. It had a policy of exclusive breastfeeding for infants up to the age of six months and other infant feeding options for HIV-positive mothers, such as wet nursing and use of milk banks. It was considering other approaches for the nutrition of infants born to infected mothers and those receiving antiretroviral therapy. External support was needed in drawing up specific guidelines on nutrition and HIV/AIDS.

Mrs THIAM (Côte d'Ivoire) supported the draft resolution. A technical committee for the integration of nutrition in HIV/AIDS programmes, established in Côte d'Ivoire in 2004, promoted capacity-building and the introduction of various tools. Thanks were due to WHO, FAO, UNICEF and WFP for their support in implementing the national nutrition plan.

Dr VIOLAKI-PARASKEVA (Greece) asked when the results of the studies on the feeding of infants of HIV-positive mothers and HIV transmission mentioned in paragraph 18 of the report would become available. She supported the draft resolution.

Mr SHARMA (India) supported the draft resolution but proposed that it should include a reference in paragraph 1(2) to nutrition counselling and the special nutritional needs of vulnerable and marginalized populations.

Mr CHO Do-yeon (Republic of Korea) said that provision of proper treatment and care for people living with HIV/AIDS were vital to human rights and control of the HIV/AIDS pandemic. Good nutrition could enhance the results of treatment and improve quality of life; nutritional support was therefore indispensable. Support for developing countries should also be increased since poverty encouraged the spread of HIV. He emphasized measures to prevent mother-to-child transmission of HIV, including counselling, education and replacement feeding. His country would continue to provide treatment and care for people living with HIV/AIDS and would cooperate in international efforts in that area.

Mr GAUDÊNCIO (Brazil) emphasized routine monitoring of the nutritional status of people living with HIV/AIDS. Brazil had elaborated education and communication materials on food and nutrition, aimed at various age groups. Guidance on nutrition and treatment of infants under six months born to HIV-infected mothers was included in general health care in order to improve nutritional status and reduce mother-to-child transmission of HIV.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) said that her country supported the draft resolution as recommended by the Executive Board. She requested that the amendments proposed by South Africa should be read out again and circulated in writing. The guidelines for the sixth round of financing prepared by the Global Fund to Fight AIDS, Tuberculosis and Malaria did not currently include support for nutrition interventions; the matter should be discussed in the Global Fund's Board rather than in Committee A.

Dr ISHIDA (Japan) pointed out that the integration of nutrition into a comprehensive response to HIV/AIDS required close multisectoral collaboration and high-level political commitment. The Secretariat should support Member States in obtaining such commitment. Many countries still required support to meet basic nutrition needs, and care should therefore be taken to avoid any potential for inequality when establishing nutrition programmes targeted specifically at people living with HIV/AIDS. Further discussion of the ethical issues involved was needed.

Mr A.B. SINGH (Nepal) supported the draft resolution. Nepal was developing a multisectoral plan that covered all key sectors and relevant programmes even though HIV prevalence was low.

Mr MSELEKU (South Africa) withdrew the amendment to paragraph 2(8) proposed earlier by his country, as it had been made in error on the basis of an earlier version of the draft resolution. He agreed with the United Kingdom that it was more appropriate for matters relevant to the Global Fund to be discussed by its Board.

Ms WANGMO (Bhutan) expressed support for the draft resolution.

Mr NIKIEMA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, recalled the situation when it was recognized that HIV could be transmitted through breastfeeding, threatening to wipe out the gains made in protecting, promoting and supporting breastfeeding in the 1980s and early 1990s: the Baby-friendly Hospital Initiative had lost momentum with dwindling funds and declining political will for its implementation; policies recommending artificial feeding had been hastily adopted in many parts of the world and the relevance of the International Code of Marketing of Breast-Milk Substitutes had been questioned because it had been misrepresented and misunderstood as aiming to protect breastfed babies and their mothers only from commercial pressures.

The breastfeeding movement had been in the forefront of resolving the conflict between breastfeeding and artificial feeding for infants of HIV-positive mothers. The 1999 research findings on exclusive breastfeeding in South Africa had raised hopes, and the decline in breastfeeding had since slowed. The implementation of the Baby-friendly Hospital Initiative and the International Code were currently listed among the five priorities for safe infant feeding by HIV-positive mothers and for the

achievement of Millennium Development Goal 4, as set out WHO's framework for priority action.[1] The current year marked the twenty-fifth anniversary of the International Code. It had been implemented by many Member States but greater efforts were needed in monitoring and enforcement. Countries that had not yet implemented the Code were urged to do so as soon as possible.

Ms ARENDT LEHNERS (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcomed the report, especially paragraphs 10 to 16 and paragraph 1 highlighting the macronutrient and micronutrient needs of HIV-infected people, including pregnant and lactating women. Her organization endorsed the relevant United Nations recommendations. Its position paper on HIV and infant feeding (2002) emphasized that properly treated breast milk would not transmit HIV and remained nutritionally and immunologically superior to infant formula. The Global Strategy for Infant and Young Child Feeding and the Baby-friendly Hospital Initiative with its added emphasis on HIV in the training of the health-care workers were particularly important. The latest findings from the Zvitambo project in Zimbabwe had reaffirmed the protective effect of exclusive breastfeeding in regard to postnatal HIV transmission which was also clearly represented by the International Code of Marketing of Breast-milk Substitutes. The framework for priority action[1] had highlighted implementation of the International Code as one of five key priority governmental actions to tackle HIV and infant feeding issues. Her organization urged that the 25th anniversary of the Code should be used to turn that commitment into action. It supported the draft resolution.

Mr KONANDREAS (FAO) said that few crises in history had presented such a threat to human health and socioeconomic progress as the HIV/AIDS epidemic, and it was imperative that HIV/AIDS should no longer be seen solely as a health-sector problem. In the most affected countries, up to 80% of the population depended on agriculture, fishery and forestry activities for their livelihoods. Those activities were also mainstays of the economy, and vital safety nets for rural communities. By undermining such activities the epidemic had had widespread and long-term damaging effects on development and food security. FAO had been raising awareness of the disease, including protection and promotion of good nutrition. Unfortunately, many people living with HIV/AIDS were unable to meet their food and nutrition needs. Affected families and communities lost income, time and energy, and increased expenditure for treatment could lead to destitution. The food security and nutrition of all affected individuals and family members were essential to national HIV/AIDS programmes. The nutritional needs of AIDS orphans must be given priority by all parties It would not be easy to break the cycle of malnutrition-infection-poverty. The fight against HIV/AIDS could not be won by any sector alone. FAO would collaborate with WHO in improving nutritional care and support for people living with HIV/AIDS. A manual[2] and the companion training course for health workers were invaluable tools that should be more widely available. Adequate resources should be found to support the demand for such training. FAO would continue its collaboration with WHO and other partners in the fight against the epidemic.

Mr HICKEY (United States of America) proposed adding the words "family members and other" to Thailand's proposed amendment to paragraph 1(3)(b) of the draft resolution, so that the first line of the text would read "building the capability of hospital- and community-based health workers, mothers, family members and other caregivers. ...".

The CHAIRMAN asked the Secretary to read out all the proposed amendments.

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[1] HIV and infant feeding: framework for priority action. Geneva, World Health Organization, 2003.

[2] *Living well with HIV/AIDS. A manual on nutritional care and support for people living with HIV/AIDS*. Geneva, World Health Organization and Rome, Food and Agriculture Organization of the United Nations, 2002.

Dr ISLAM (Secretary) said that Thailand had proposed an amendment to paragraph 1(1)(e) reading: "ensuring close multisectoral collaboration and coordination between agricultural, health, socioeconomic services, education and financial and nutrition sectors". South Africa had proposed an amendment to paragraph 1(2) which read: "to strengthen, revise or establish new guidelines and assessment tools for nutrition care and support of people living with HIV and AIDS at different stages of the diseases, and for sex- and age-specific approaches to providing antiretroviral therapy"; India had then proposed that the sentence should continue: "including nutritional counselling and the special nutritional needs of vulnerable and marginal populations". Thailand had proposed an amendment to paragraph 1(3)(b), further amended by the United States of America, which read: "building the capability of hospital- and community-based health workers, mothers, family members and other care givers in order to improve the care of severely malnourished children exposed to, or infected by, HIV/AIDS". South Africa had proposed an amendment to paragraph 2(1) which read: "to strengthen technical guidance to Member States for incorporating HIV and AIDS issues in national nutrition policies and programmes".

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

- **Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors** (Documents EB117/2006/REC/1, resolution EB117.R8 and Annex 4, and A59/8)

Dr HANSEN-KOENIG (representative of the Executive Board) said that, after discussing the report on universal access to prevention, care and treatment of HIV/AIDS at its 117th session, the Board had approved resolution EB117.R8 which contained a draft resolution recommending that the Health Assembly should endorse the recommendations of the Global Task Team; urge Member States to accelerate implementation of the "Three Ones" principle with regard to their national HIV/AIDS responses; and request the Director-General to implement the Global Task Team's recommendations, report to the Board at its 119th session and to the Sixtieth World Health Assembly on progress made in implementing those recommendations, and provide effective technical support in conformity with the division of labour agreed with UNAIDS. The report in document A59/8 described the Global Task Team's process and reported on WHO's experience in implementing the Team's recommendations.

Dr XUNDU (South Africa) commended the recommendations of the Global Task Team and the leadership of the late Director-General in that area. The report and the draft resolution should be considered together. All four areas of the recommendations by the Global Task Team were relevant, especially the third concerning division of labour within the United Nations system in order to achieve a more effective multilateral response. She commended the identification by WHO and UNAIDS of lead organizations for specific responsibilities, and the corresponding paragraph 3(3) of the draft resolution. However, activities under annual or biennial operational AIDS plans, referred to in the first set of recommendations, should remain internal mechanisms of programme management at country level, rather than global monitoring processes, and the 2008 and 2010 reporting milestones should be regarded as goal posts for the global monitoring processes. She noted that, on request, the United Nations could assist countries with their annual and biennial plans.

She expressed concern about WHO's response to the Global Task Team's recommendation that financing for technical support should be increased (paragraph 13 of the report). That only appeared to be support for making effective use of large grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria. As only some 30% of additional funding in South Africa derived from that Fund, most aid would not benefit from those excellent recommendations. South Africa endorsed paragraph 1 of the draft resolution but would like the relevant recommendation to cover all aid, particularly large

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA59.11.

donor programmes like the Emergency Plan for AIDS Relief, launched by the President of the United States of America. In regard to paragraph 2, South Africa considered that the "Three Ones" principles should be upheld but tailored to each situation and applied to all countries.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) emphasized harmonization of practices by all stakeholders in order to create synergy and simplify funding to Member States. In 2001 a national strategic plan had been elaborated with a multisectoral approach involving organizations of the United Nations system and nongovernmental organizations, all of which had contributed to Cuba's national plan through specific projects. Cuba endorsed the draft resolution.

The meeting rose at 16:50.

SEVENTH MEETING

Thursday, 25 May 2006, at 18.00

Chairman: Dr P. MAZZETTI SOLER (Peru)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

HIV/AIDS: Item 11.3 of the Agenda (continued)

- **Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors** (Documents EB117/2006/REC/1, resolution EB117.R8 and Annex 4, and A59/8) (continued)

Dr CABOTAJE (Philippines) expressed support for the recommendations of the Global Task Team, which had been included in her country's Fourth AIDS Medium Term Plan. Her Government was implementing the "Three Ones" principle, with one agreed HIV/AIDS action framework created through appropriate legislation; one national AIDS coordinating authority, in the form of the Philippine National AIDS Council, through the Department of Health; and one country-level monitoring and evaluation system, with the involvement of the Health Action Information Network. She commended the improved coordination and harmonization of all partners and donors.

Ms ANDERSON (Australia) strongly endorsed the recommendations of the Global Task Team. Her country had participated in preparing the Team's report, and had endorsed its recommendations in the governing bodies of various UNAIDS cosponsors. WHO should endorse those recommendations, and implement them on the ground. Expressing support for the draft resolution contained in resolution EB117.R8, she said that all international parties, including donors, must strengthen the global response to HIV/AIDS by more effective coordination, alignment and harmonization.

Dr SOMSAK AKKSILP (Thailand), welcoming the draft resolution, said that an effective response to the HIV pandemic required streamlining and harmonization among all partners at country level, including national programme managers, national AIDS councils, civil society, bilateral donors and multilateral agencies, with a view to implementing the "Three Ones" principle. However, UNAIDS studies in 2004 had indicated that most countries were not able to comply with that policy, chiefly because of lack of institutional and human resources capacity to negotiate with other partners. As a result, programmes tended to be fragmented and uncoordinated, and did not respond to national priorities. In addition, countries were obliged to produce different sets of reports in order to meet the requirements of different donors. Unless countries strengthened their capacities and donor communities respected the "Three Ones" principle, an integrated, multisectoral response to HIV/AIDS would not be a realistic target.

He suggested that the phrase "to identify barriers and strengthen its institutional capacity, including human resources, in order..." should be inserted after the words "Member States" in paragraph 2 of the draft resolution.

Dr SRIVASTAVA (India) noted that the report and the draft resolution focused on improving the institutional response to HIV/AIDS. There was a need to streamline and coordinate the organizations of the United Nations system so as to improve country-led responses to HIV/AIDS. He

supported the draft resolution and its call for implementation of the "Three Ones" principle. The draft resolution should, however, also reflect the need to devise a mechanism for the clear allocation of roles and responsibilities to partners at country level, whereby UNAIDS would draw up a unified country-support programme in order to overcome barriers to national implementation and increase financing for technical support. A mechanism for accountability and oversight was also needed, including formal review by national AIDS authorities of the performance of international donors and the establishment of standards and criteria for review and coordination of donor assistance.

Mr KEZAALA (Uganda) expressed support for the recommendations of the Global Task Team, which should be implemented as soon as possible. In Uganda, WHO and UNAIDS country-support programmes were coordinated with those of other bodies in the United Nations system. WHO and UNAIDS had established a functional division of labour: for example, UNFPA procured condoms, UNICEF supported prevention of mother-to-child transmission of HIV and WHO provided technical assistance. However, implemention of the "Three Ones" principle at country level would need care, so that AIDS coordination did not lead to competition between partners. Monitoring and evaluation of HIV/AIDS activities, based on the multisectoral system, also needed to be strengthened.

Dr XIAO Donglou (China) supported the draft resolution and emphasized prevention and control. Through multisectoral cooperation and the participation of society, a strategy for prevention and control had been established, with policies for the support of people living with HIV/AIDS. Those policies provided free antiviral treatment for people with AIDS among populations in difficult circumstances in both rural and urban areas; free voluntary and anonymous blood testing in areas of high HIV/AIDS prevalence; free schooling for AIDS orphans; and free HIV/AIDS counselling, screening and antiretroviral treatment for pregnant women in integrated AIDS prevention and control demonstration zones.

Funding for AIDS was continually being increased. A fast-track reporting and approval system had been established for AIDS medicines, and their duty-free import had been authorized. Since 2002, China had been producing some antiviral agents. Civil society was being mobilized, and health education and advocacy activities were being carried out regularly.

WHO and UNAIDS had important roles. Implementing the "Three Ones" principle required support from the bilateral and multilateral agencies and organizations concerned. Coordination between those bodies should be strengthened, ensuring harmonization between national programmes, providing high-prevalence areas with technical support and enhancing capacity for AIDS prevention.

Mr HICKEY (United States of America), referring to the amendment suggested by the delegate of Thailand, proposed that paragraph 2 should read: "URGES Member States to strengthen institutional capacity, including human resources, to overcome barriers and to accelerate implementation of the 'Three Ones' principle according to country realities".

Dr SOMSAK AKKSILP (Thailand) said that it would be more logical for Member States first to identify barriers and then to strengthen their capacity, including in human resources. He preferred his original wording.

The CHAIRMAN invited the two delegates to confer and report back to the Committee.

Ms MANE (UNAIDS) welcomed the overwhelming support shown for the three draft resolutions on HIV/AIDS. WHO played a special role as the leading agency for AIDS treatment and care within the UNAIDS family, and was proactive in the scaling up towards universal access at global, regional and country levels. She expressed appreciation for its support for the Global Steering Committee on scaling up towards universal access and for country and regional consultations. WHO's contributions were highlighted in the assessment report prepared by UNAIDS for the 2006 High-Level Meeting on AIDS (New York, 31 May–2 June 2006). Its leadership on AIDS treatment, care and

support in the health sector was appreciated as was its work with UNAIDS in order to strengthen HIV prevention within national responses.

Better-aligned and better-harmonized support was needed in moving towards the goal of universal access. Those concerns would be reflected in a renewed commitment to the goals and tenets of the Declaration of Commitment on HIV/AIDS (June 2001), and lead to a resolution of the United Nations General Assembly on the subject.

Dr SOMSAK AKKSILP (Thailand) said that it had been agreed to propose that paragraph 2 of the draft resolution should read "URGES Member States to identify barriers and strengthen institutional capacity, including human resources, in order to accelerate implementation of the 'Three Ones' principle according to country realities".

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

Sickle-cell anaemia: Item 11.4 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.3 and Annex 4, and A59/9)

Dr HANSEN-KOENIG (representative of the Executive Board) said that during the Board's discussion on sickle-cell anaemia at its 117th session members had stressed the need for more comprehensive prevention and management, encompassing early diagnosis, registration and follow-up of affected individuals, and training at both primary and secondary health care levels in order to improve recognition and care. Sickle-cell disorders should be covered by health service planning in all countries where they were common. Some Member States had expressed willingness to cooperate in preparing a global prevention and control strategy, and to provide training for laboratory, clinical and primary health-care professionals from developing countries. Board members had stressed the fact that sickle-cell anaemia prevention and care could form part of general health services and programmes to combat all types of genetic blood disorders. The Board had adopted resolution EB117.R3, recommending that the Health Assembly should adopt the draft resolution contained therein.

Dr DANKOKO (Senegal), speaking on behalf of Member States of the African Region, said that sickle-cell anaemia remained a disease associated with ignorance and poverty, and therefore with unequal opportunities. Although much was known about the disease, which was the most widespread genetic disorder in the world, it still presented health, medical, economic, social and cultural challenges. The report described a serious situation. In some areas of sub-Saharan Africa, half the children with sickle-cell anaemia died before they were five years old. The disease affected couples, since it could cause priapism, and could lead to renal failure and serious respiratory conditions which reduced life expectancy.

Progress made in tackling sickle-cell anaemia, improving quality of life and extending life expectancy had so far benefited only sufferers in rich countries and rich sufferers in poor countries. Not only did large numbers of people carry the gene but there was a lack of awareness among populations and decision-makers in certain countries; a paucity of centres for providing specialized treatment; a lack of early screening programmes in developing countries; and insufficient training of medical and paramedical staff in dealing with the disease. The main steps to be taken were: to design an information and awareness-raising programme for the population, including genetic counselling; to set up reference centres for health care, training and research; to train medical and paramedical staff at all levels, for patient follow-up; to promote premarital screening, in order to improve prevention; to set up programmes for neonatal screening and patient follow-up; and to create a multidisciplinary network of practitioners involved in treatment.

[1] Transmitted to the Heath Assembly in the Committee's third report and adopted as resolution WHA59.12.

Resolution WHA57.13 called upon Member States to mobilize more resources in the field of genomics and world health. In order to raise the awareness of development partners calls had been made at the Conference of African Ministers of Health (Gaborone, 10–14 October 2005) for greater mobilization against the disease; an international conference had been held (Brazzaville, 14-17 June 2005); UNESCO's General Conference had adopted resolution 22 on "sickle-cell anaemia, a public health priority" in 2005; and the third international congress of the International Organization to Combat Sickle-Cell Anaemia was due to be held in November 2006 in Dakar.

He welcomed the draft resolution, which marked the start of a new era in combating sickle-cell anaemia in the African Region.

Mr KEZAALA (Uganda) said that prevalence of the sickle-cell trait was high in his country, where some 25 000 children a year were born with a double abnormal gene. Sickle-cell services were currently based at the national teaching hospital, with regional facilities yet to be established. A major challenge was training health personnel and procuring the necessary equipment. Under the Sickle-cell Initiative, an association had been set up, which provided community health education and counselling to those not within easy reach of the teaching hospital. Sickle-cell anaemia and other noncommunicable diseases were priorities in the new Health Sector Strategic Plan. A national survey of noncommunicable diseases was planned for 2006, which would provide more accurate information on the scale of the problem and the preparedness of the health sector to manage it, and enable a comprehensive programme for the prevention and management of sickle-cell anaemia to be drawn up.

He fully supported the draft resolution, but noted that its implementation in his country would depend on resources, which were currently insufficient.

Dr PUANGPEN CHANPRASERT (Thailand) supported the initiation of national programmes for sickle-cell anaemia in countries with a high prevalence of the disease and its carriers. She welcomed the draft resolution, and proposed certain amendments. In the ninth preambular paragraph the word "management" should be replaced by the words "prenatal screening". Paragraph 1 should be amended to read: "URGES Member States having sickle-cell anaemia as a public health problem". The word "counselling" should be inserted before the words "and screening" in paragraph 1(1), and the term "Health system" after "socioeconomic,". In paragraph 1(3) the words "and community volunteers" should be inserted after "health professionals". For greater clarity, paragraph 1(4) should be amended to read: "to develop and strengthen systematic medical genetics services and holistic care, within existing primary health care systems, in partnership with national and local government agencies and NGOs, including parent/patient organizations". The reference to World Health Day in paragraph 2(1) should be deleted; to make sickle-cell anaemia part of the Day would be inappropriate for those countries with no case of the disease. The Secretariat should document good practice and success stories from countries with different socioeconomic situations. She therefore suggested that in paragraph 2(4) the words "including good practices and practical models," be inserted after the words "WHO's normative functions in drafting guidelines,".

Dr WINT (Jamaica) spoke on behalf of the member countries of the Caribbean Community, in which the prevalence of sickle-cell disease was 10%. The University of the West Indies boasted a long-standing research centre of excellence, which had been supported by the Medical Research Council of the United Kingdom of Great Britain and Northern Ireland, and required ongoing support in order to conduct research into new treatments. The Centre had supported early detection programmes through cord-blood screening; long-term follow-up for persons suffering from sickle-cell disease; the training of health providers; and screening programmes for adults, especially in relation to reducing maternal mortality. Results included relatively long-term survival and improved quality of life. One complication not mentioned in the report, but frequently seen in the Caribbean region, was chronic leg ulcers. He welcomed the increased global awareness of the disease.

He supported the draft resolution and suggested insertion of a new subparagraph in paragraph 1 to read: "to ensure that adequate, appropriate, accessible emergency care is available to persons living

with sickle-cell anaemia". Provision should be made in the resolution for the need to reduce associated morbidity and mortality.

Dr LUKITA (Indonesia) said that the most common anaemia in Indonesia was nutritional. According to the most recent national health survey, the prevalence of anaemia was about 48% for children under the age of five; 40% for pregnant women; 28% for women of reproductive age; 50% for adolescents; and 60% for the elderly population. Preliminary investigations among the different ethnic groups in Indonesia had shown that the frequency of thalassaemia traits ranged from 1% to 15%, and it was estimated that about 2000 neonates were born with thalassaemia each year.

He welcomed the draft resolution, but suggested that it should target those Member States where sickle-cell anaemia was a public health problem. There was insufficient evidence to indicate that was the case in Indonesia.

Dr AL-JOWDER (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended WHO's efforts in the prevention and management of sickle-cell anaemia, which together with thalassaemia represented a major health problem and burden for health services. The estimated frequency of blood disorders was unevenly distributed, with a figure of 5% in Member States of the Gulf Cooperation Council. Many countries of the Region lacked good epidemiological data. Sickle-cell anaemia was a preventable disease and premarital detection was important, particularly in communities with a high degree of consanguinity. Premarital screening was therefore mandatory in Bahrain and Saudi Arabia. Bahrain had reduced the incidence of sickle-cell anaemia in infants and neonates from 2% in 1985 to 0.09% in 2005, through national education, awareness-raising and counselling. Premarital counselling had been voluntary from 1992 and mandatory since 2005.

She welcomed the draft resolution, but noted that its implementation would be difficult for some Member States, as it had been drawn up with developed countries in mind. Countries of the Region needed solutions to sickle-cell anaemia at the primary care level and were seeking the WHO's assistance in: elaborating guidelines on the prevention and care of blood disorders; guidance on cost-effective measures for sickle-cell prevention and care; collaboration between WHO partner centres and institutions in the area of blood diseases; identifying centres of excellence; and strengthening prevention and control programmes for blood disorders.

Dr AMMAR (Lebanon) commended the report. Sickle-cell anaemia and thalassaemia were the most common inherited haemoglobin disorders in Lebanon. Half the neonates diagnosed with sickle-cell anaemia were the result of consanguinity. The number of patients was increasing with wider diagnosis and treatment. Because patients were living longer, they represented a growing social and financial burden. Health education, premarital screening and genetic counselling reduced disease with financial, social and health benefits. Treatment and follow-up substantially reduced clinical events that required transfusion and admission to hospital. Mediterranean countries with comparable epidemiological profiles could share their experiences in tackling both thalassaemia and sickle-cell anaemia, using the same multidisciplinary team for both disorders. Targeting both disorders through one programme was particularly cost-effective. In view of its significant health and socioeconomic implications in developing countries, particularly in Africa, sickle-cell anaemia should be officially recognized as a public health priority, and he therefore supported the draft resolution.

Dr BIN AL-ZAHRANI (Saudi Arabia) also supported the draft resolution. Sickle-cell anaemia was a problem especially in eastern, western and southern areas of Saudi Arabia. Premarital screening had been mandatory since February 2004. Centres of excellence had been set up in order to follow up cases of sickle-cell anaemia and related diseases.

Dr ASSOGBA (Benin) welcomed the inclusion of sickle-cell anaemia on the agenda of the Health Assembly, as it had long been a major public health problem in his country. The focus should be on early detection of neonates with sickle-cell anaemia and the setting-up of an integrated

health-care service. Since 1993 Benin had had an unique integrated health-care programme for sickle-cell anaemia, adapted to sociocultural and economic constraints. The medical and scientific results had been internationally acknowledged. He expressed support for the draft resolution. Benin could play a leading role in combating sickle-cell anaemia in Africa.

Mr SESS ESSIAGNE (Côte d'Ivoire) said that sickle-cell anaemia was a major public health concern in his country and the African Region because of its high prevalence and the accompanying mortality and morbidity. Surveys in his and neighbouring countries had led to improved treatment. Prescribing antioxidants and other free-radical scavengers, such as vitamins A and E and polyphenols, had reduced the number of vaso-occlusive sickling crises and improved the quality of life of the patients. There was still much to be done in prevention and research. Supporting the draft resolution, he said that his country would be implementing the relevant recommendations.

Ms NOGUIERA GUEBEL (Brazil) strongly supported the draft resolution. Brazil had 3500 children born each year with sickle-cell anaemia. The disease was a health priority; in 2004, the Ministry of Health had set up a technical committee in order to determine the profile of the disease and tackle the health-care needs of the affected population. The national programme included prevention, based on neonatal screening, genetic counselling, with special attention to the sexual and reproductive rights of affected people, and universal treatment. Brazil was committed to strengthening cooperation for capacity-building and improved diagnosis and treatment.

Ms BIKOUTA (Congo) said that carriers of sickle-cell anaemia were best treated in referral centres. She suggested amending paragraph 2(3) of the draft resolution to read: "to promote and support: (a) intercountry collaboration to develop training and expertise of personnel and to support the further transfer of advanced technologies and expertise to developing countries; (b) the construction and equipment of referral centres for care, training and research;".

Ms WANGMO (Bhutan) supported the draft resolution, with the amendments proposed by the delegate of Thailand, particularly to paragraph 2(1). She did not favour inclusion of sickle-cell anaemia as part of World Health Day, because it did not affect all countries.

Dr GARBOUJ (Tunisia) supported the draft resolution and agreed that special programmes should be developed for sickle-cell anaemia, in view of the huge cost of the disease to the individual and the community. Progress in early diagnosis and treatment could improve patients' quality of life. In Tunisia, the disease was found in 1% to 12% of the population, depending on the region. Great effort was made to provide patients with the necessary care and treatment. Prevalence of the disease has been reduced through early diagnosis and prenatal screening.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that an effective approach to the prevention of sickle-cell anaemia must take account of the specific epidemiological situation of each country concerned, and of the broad geographical variations in the prevalence of the disease. That approach must, as far as possible, be incorporated into primary health-care for treatment and prevention. At every stage, however, the ethical, legal and social aspects involved must also be taken into consideration.

Mr AITKEN (Adviser to the Director-General) said that, pending the distribution of a revised version of the draft resolution incorporating the proposed amendments, delegates might consult informally with a view to reaching agreement on the amendments proposed concerning "World Health Day" and "prenatal".

Ms VALDEZ (United States of America) suggested that the proposal by the delegate of Jamaica to insert a new paragraph 1(2) might be further refined by introducing the phrase "work to" before "ensure".

The CHAIRMAN said that the Committee would consider the revised draft resolution at a subsequent meeting.

(For approval of the draft resolution, see summary record of the ninth meeting.)

Smallpox eradication: destruction of variola virus stocks: Item 11.5 of the Agenda (Documents A59/10 and A59/10 Add.1)

Dr HANSEN-KOENIG (representative of the Executive Board) said that, at its 117th session, the Board had restated its view that the complete destruction of all remaining variola virus stocks remained the ultimate goal of Member States. General consensus was needed on the timing for the destruction. The temporary retention of virus stocks at the two high-security laboratories had been authorized on the condition that all research requiring access to the live virus should be outcome-oriented, time-limited and subject to periodic review. The WHO Advisory Committee on Variola Virus Research was responsible for monitoring the research agenda, approving individual research proposals and assessing the progress of research deemed essential for public health. WHO regularly conducted inspections of the two laboratories so as to be able to assure the international community that all measures necessary for the safe retention of the virus stocks were in place. Board members had agreed that research progress had been considerable. In the view of some, many public health objectives had already been met. Others felt, however, that it would be premature to set a deadline for destruction of the stocks, and according to one speaker there was no guarantee that stocks of live virus might not be held in places other than the two officially designated laboratories. Since no clear consensus could be reached on all the points, the Board had established an open-ended intergovernmental working group to work on a draft resolution in order to deal with these matters. That text was submitted to the Health Assembly in document A59/10.

Dr KAMWI (Namibia), speaking on behalf of the Member States of the African Region, welcomed the efforts of the working group to reconcile differing views on the draft resolution. The African Member States had made proposals on the basis of concerns about the security of variola virus stocks raised at the fifty-fifth session of the Regional Committee for Africa. Its proposal that stocks should be securely retained in WHO was not feasible because WHO had no laboratory with the appropriate level of security. Members of the Committee had also opposed genetic engineering of variola virus, because of the risk of laboratory accidents, deliberate release of the virus or bioterrorism, and the possibility that more dangerous forms of the virus might emerge. The Regional Committee had also expressed concern about the composition of the WHO Advisory Committee on Variola Virus Research. Contrary to the Health Assembly decision that the Committee should comprise experts from each of the WHO regions, it appeared to have no experts from developing countries. Its composition should have balanced representation, including public health specialists and a range of advisers and observers. Moreover, Committee members should be independent of the scientists working at the two repositories, in order to ensure freedom from bias and full credibility.

The discussion point was the eventual destruction of the remaining variola virus stocks rather than the expansion of research. The report indicated that most of the essential research requiring the use of live variola virus had been concluded. It had to be considered whether the benefits of destroying the remaining stocks did not far outweigh those of continued research. The African Member States considered that it was time reach a consensus on the timing for the destruction of existing variola virus stocks. Although the Committee had recognized that further work to gain regulatory approval of candidate antiviral agents might require the use of the live variola virus, it was possible to conclude the regulatory approval process within a relatively short period. A destruction date of 30 June 2010 had therefore been proposed, which would allow completion of the outstanding work. Destruction should be preceded by a thorough review, to ascertain that further retention was no longer justified. In the interests of public health, the Health Assembly should support a definite date for destroying the remaining stocks.

Ms HALTON (Australia) said that she was aware of the concerns about retaining a virus if it was not needed. Australia nevertheless favoured retaining a limited, carefully monitored stock of the variola virus for essential research only. Currently, it was difficult to determine a precise timetable for completing the research. Security arrangements were in place in order to meet all such concerns. In a world where the threat of bioterrorism seemed more real than at any time in the past 20 years, it would be premature to set a date for destruction of the live variola virus.

Dr KLEIN (Austria), speaking on behalf of the Member States of the European Union, with the acceding countries Bulgaria and Romania, the candidate country Turkey and the potential candidate Bosnia and Herzegovina aligning themselves with his statement, reaffirmed the provisions in resolutions WHA49.19, WHA52.10 and WHA55.15 to the effect that remaining stocks of variola virus should be destroyed but at a date to be determined. He recommended retention of the stocks at the locations specified in resolution WHA55.10, for further approved, oriented and time-limited research to be carried out in a transparent manner and periodically reviewed. A date for destruction should be set only when research outcomes permitted a consensus on the timing and process of destruction.

Ms MAFUBELU (South Africa) recalled that, since the global eradication of smallpox, the Health Assembly had adopted several resolutions providing for temporary retention of the variola virus but with commitment to its eventual destruction. She was encouraged by the reports of the efficacy and safety of second- and third-generation vaccines. She noted that the WHO Advisory Committee on Variola Virus Research saw no need for the use of live virus in order to assess smallpox vaccines, for DNA sequencing, or for further research on hybrid viruses. Also, most members of that Committee considered that further research with live virus for diagnostic assays was not needed. It was regrettable that the requirements for regulatory approval of antiviral agents in the United States of America might necessitate further work involving live variola virus. That work should be speeded up. South Africa supported an urgent review of all current research proposals. She welcomed the draft resolution and the efforts of the intergovernmental working group. South Africa urged all Member States to support amendments for the destruction of all variola virus stocks by 30 June 2010. She also sought agreement on the principle that members of the Advisory Committee should be independent of the researchers in the two laboratories.

Dr CONWAY (Tuvalu) said that, although smallpox had been eradicated, there was no guarantee that it would not re-emerge, and it might therefore be appropriate to retain a stockpile of live variola virus for making vaccines. Evidence was lacking for the claim that monkeypox virus was as effective as variola virus as a source of smallpox vaccines. Stocks of virus should be used exclusively in order to produce better-quality vaccines.

Smallpox had been eradicated through public health monitoring and vaccination, at a time when there were no antiviral agents. Subsequently, research had gone beyond the production of better-quality vaccines, and the question had been raised whether variola virus should be used in research in order to produce antiviral agents. The genetic engineering of variola virus had also been mooted. The Organization should assure that the research initiatives of the designated laboratories were harmonized with Health Assembly decisions. He called for the monitoring of any research not intended to produce a better quality of vaccine, in compliance with Health Assembly resolutions.

Dr SLASTNYKH (Russian Federation) said that eradication of smallpox in the 1980s placed a huge responsibility on everybody in order to prevent its return, especially as half the world's population was not immune to it. The possibility that stocks of variola virus existed outside the two official repositories could not be excluded; the Director-General had stated at the 117th session of the Executive Board that it was uncertain whether the stocks in the Russian Federation and the United States of America were the only ones in existence. It could be deliberately released for bioterrorism. There were no wholly reliable smallpox vaccines. Existing vaccines were too reactogenic to be suitable for wide-scale use, and could result in serious and even lethal side-effects. Despite recent progress, research with live virus was incomplete and must be continued. He stressed that scientific

work in the Russian Federation and the United States of America using the variola virus had been approved and was conducted under the strict supervision of WHO. The 1995 and 2005 inspections of the relevant Russian laboratory had confirmed that it was operating in full compliance with international biosafety requirements. A decision on the destruction of the variola virus stocks had to be made with great caution and only after exhaustive analysis of the possible negative consequences. Moreover, the decision would have to be taken on the basis of consensus whereas the proposal within one working group to set a date for destruction had not obtained a consensus. The Russian Federation was among the many Member States opposing the setting of an artificial deadline for destroying variola virus stocks. Until reliable and effective methods of treatment had been developed, such a decision would be counterproductive.

Mr OLANGUENA AWONO (Cameroon) expressed the particular concern of his and other countries in the Congo basin, where monkeypox was prevalent and was a risk to humans; in 2004 there had been an outbreak of monkeypox in the rainforest. The WHO Advisory Committee on Variola Virus Research should include experts in virology and public health from the Congo basin countries. Greater transparency, openness and accountability were needed among the researchers in both the Russian and United States laboratories because smallpox eradication and bioterrorism were of global concern. The Secretariat should inform the Health Assembly every year of progress in research. He supported both the ongoing research and the proposed date for destruction of the variola virus stocks, subject to a thorough review.

Dr AL KHARABSEH (Jordan), speaking on behalf of the Member States of the Eastern Mediterranean Region, expressed appreciation of the hard work of the Advisory Committee. Progress in sequence analysis of the virus and improving diagnostic assays meant that no additional research involving the use of live variola virus or hybrid viruses was required for those purposes. Second- and third-generation vaccines had been developed that showed fewer adverse effects among vulnerable groups. Accordingly, there was no need, for scientific reasons or regulatory purposes, for the use of live variola virus in animal models in order to assess smallpox vaccines. However, although the available antiviral agents were promising, further work might be needed on live variola virus in animal models in order to gain regulatory approval of other candidate compounds. He reaffirmed previous Health Assembly decisions that a timeframe should be set for the destruction of the remaining stocks of the virus. He requested that the new technology for variola virus identification (real-time polymerase chain reaction), together with the validated detection kits, should be made available in order to ensure adequate surveillance and timely detection of smallpox if an outbreak occurred, and that the IgM-based enzyme-linked immunosorbent assay for differentiating smallpox from monkeypox should be made available to Member States in sub-Saharan Africa, and especially Sudan.

Dr CHANTANA PADUNGTOD (Thailand) expressed appreciation of the thorough work done by the Advisory Committee. A major research achievement was the development of a highly specific diagnostic test and efficacious and safe vaccine against variola virus infection, although there was a lag in the development of antiviral medicines. The report of the Committee made clear that that there was no need for the use of live variola virus for sequencing, diagnostics or vaccine development. She agreed with paragraphs 3 and 4(5) of the draft resolution.

Dr BRUNET (France) said that it was premature to set a date for the destruction of the existing stocks, although they should be destroyed at some point in the future. He drew attention to the legal status of the remaining stocks, in particular their ownership and use. The same points could arise in future in relation to stocks of poliovirus or pandemic influenza viruses. Without questioning the trust placed in any laboratory holding stocks of virus, the Health Assembly should tackle the question of the legal status of stocks held under WHO auspices, so that the legal conditions applicable were clear to Member States.

Mr BAYAT MOKHTARI (Islamic Republic of Iran), recalling resolution WHA52.10 in which the Health Assembly had emphasized that approved research should be outcome-oriented and time-limited, said that progress in the past four years in the work on antiviral agents, diagnostic assays and vaccines had eliminated the need for more research with live variola virus. In order to draw closer to the goal of destroying the stocks of virus, the research agenda should be narrowed and international oversight of the existing stocks tightened. The Advisory Committee should be reformed with a better geographical and scientific balance, greater transparency and a firmer will to control any approved further research. Since the item had last been discussed by the Health Assembly[1] steps had been taken to reassert control over research, but governments should put WHO firmly in charge. The Health Assembly should end its temporary authorization to retain live virus stocks for the purposes of sequencing and the research and development of diagnostic assays and vaccines. Experiments with primates infected with large quantities of live virus were risky and of questionable value. Under no circumstances should WHO permit the genetic engineering of variola virus or the distribution of segments of its DNA, especially to unknown destinations. The risks of catastrophic laboratory accidents, release of virus or creation of a more pathogenic virus far outweighed the potential benefits.

Mr MOLCHAN (Belarus) urged great caution and a thorough analysis of the consequences before a decision to destroy the viral stocks was taken. Since the eradication of smallpox and the subsequent cessation of immunization, half the world's population was no longer immune. The current vaccine had serious side effects and was not useful for immunocompromised people. Nor were there enough effective antiviral agents to cope with the possible consequences of a bioterrorist attack, which was a real threat. The Health Assembly should refrain from establishing a deadline for destruction of the two remaining official stocks of natural virus. The two Member States with the authorized repositories should continue to collaborate closely with the Secretariat, and especially the Advisory Committee, in ensuring safe storage of the viral stocks and the development of acceptable new vaccines.

Dr BODZONGO (Congo) noted that the Advisory Committee had identified the need for strengthening the animal model, but had called for a specific research strategy for that purpose. It appeared that more remained to be done, and the Committee had not proposed any date for destroying the viral stocks. As his country had experienced an outbreak of monkeypox in 2004, he was in favour of continuing research but with the participation of experts from developing countries, in complete transparency and under the supervision of WHO.

Dr SRIVASTAVA (India) approved retention of the two variola virus stocks on a temporary basis at the two current locations, under strict control and regular WHO supervision, in full compliance with international biosafety and biosecurity requirements.

Mr HEINE (Marshall Islands) expressed appreciation of the work of the Advisory Committee. The Health Assembly was responsible for deciding whether to retain viral stocks for the purpose of research into antiviral agents for use in the event of a natural re-emergence of smallpox or the deliberate release of variola virus as a biological weapon. He was uncertain of the implications of destroying the stocks, and therefore favoured retaining them for research purposes, under the aegis of WHO and the Advisory Committee.

Dr LEVENTHAL (Israel), supported by Mr EINARSSON (Iceland), said that destruction of the viral stocks was inevitable, but only in due course. There was no urgency to set a date as long as the research and the work on vaccines were incomplete.

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[1] Document WHA58/2005/REC/3, summary record of the sixth meeting.

Dr NAKASHIMA (Japan) said that, although the ultimate goal was to destroy the stocks, the potential threat of biological agents being deliberately used lent urgency to management by WHO of variola virus research, as decided in previous Health Assembly resolutions. That included inspection of the two official repositories by a third body, the sharing of research findings and transparent review of progress. Research had to yield further results before the stocks could be destroyed, and thus no timetable could be set. There was still no consensus on further research using live virus. WHO should continue its supervision of the stocks and its evaluation of the research, periodically assessing the need to continue it.

Ms DE HOZ (Argentina) supported the proposal for further temporary retention of the viral stocks for the purpose of the research necessary to produce new improved vaccines, subject to strict control and observance of the highest requirements for biosafety and biosecurity.

Mr CHO Do-yeon (Republic of Korea) considered the threat of bioterrorism to be an international crisis, needing research in order to improve technical capacities. He affirmed the goal of destroying stocks of the virus. A committee should be formed in order to share scientific information on vaccines and antiviral agents under WHO supervision.

Dr STEIGER (United States of America) agreed with the call for further research with live variola virus at the two officially sanctioned repositories. The potential of such research, particularly for the development of better diagnostic tools, new antiviral agents and improved vaccines, had not yet been exhausted and must be allowed to reach fruition. The smallpox vaccines currently available were inappropriate for large numbers of people with poor immune systems, including those with HIV infection or malnutrition. Research could also lead to improved public health responses to outbreaks of monkeypox in humans. It was almost certain that unauthorized stocks of variola virus existed, with the potential for use by bioterrorists. That reality, as well as the potential of research, meant that it was premature to set an arbitrary date for destruction of the viral stocks.

He also agreed that the results of research with live virus should be more widely disseminated, the scope and membership of the Advisory Committee should be broadened and the progress of the research be subjected to periodic independent review. No matter how desirable it might be to set a timetable for the development of new antiviral agents from the laboratory to the market place, meeting the required standards of safety and efficacy demanded the use of an animal model. No timetable could be set for that process.

He accepted much of the text of the draft resolution and the long-term goal of destroying the viral stocks, but had difficulty with the setting of limitations on future research (such as a ban on research into safer vaccines), the exclusion of scientists working at the two official repositories from the Advisory Committee, and the choice of an arbitrary date for destruction of the stocks.

Ms NOGUIERA GUEBEL (Brazil) supported further retention of the existing stocks of variola virus at the two current locations under strict security and the supervision of WHO. Further outcome-oriented research into antiviral agents was necessary before the remaining stocks could be destroyed. She supported a review of the Advisory Committee in order to balance geographical representation with the presence of experts from developing countries.

Professor PRUIDZE (Georgia) opposed the destruction of the limited stocks of variola virus.

Mr OLDHAM (Canada), affirming the goal of destroying the stocks of variola virus, emphasized that all research must remain outcome-oriented and time-limited. The timing of destruction should only be established when the outcomes of research allowed for a consensus. He did not favour setting an arbitrary date. He appreciated the reassurances by the WHO inspection teams that the viral stocks in the two repositories were safely protected, and sought continued assurance that all smallpox research remained under the strictest possible control in order to prevent the creation of more

virulent strains or the accidental release of virus. He called for substantial representation of public health experts on the Advisory Committee.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) welcomed the report and the draft resolution. Further research was needed, for example, on animal models for vaccine development as was a thorough review before a date could be set for destroying the viral stocks. He agreed with calls for openness, transparency and inclusiveness in the work of the Advisory Committee. The legal point raised by the delegate of France warranted further consideration, in which his Government would be pleased to participate.

There had been little discussion of the merits of the alternative texts of the draft resolution. He would welcome the advice of the Secretariat on how to proceed.

Dr CHAN (Assistant Director-General) said that she had noted the recommendations and suggestions on improving the membership of the WHO Advisory Committee on Variola Virus Research, in terms of geographical balance and expertise in both public health and virology. The Secretariat was working to that end. The periodic inspections of the two repositories would continue in order to ensure adherence to the highest standards of biosafety and biosecurity.

Mr AITKEN (Adviser to the Director-General) said a working group would meet the next day to consider the draft resolution.

It was so agreed.

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

The meeting rose at 21:00.

EIGHTH MEETING

Friday, 26 May 2006, at 09:45

Chairman: Dr K. LEPPO (Finland)

1. SECOND AND THIRD REPORTS OF COMMITTEE A (Documents A59/49 and A59/50)

Dr CISSÉ (Guinea), Rapporteur, read out the draft second and third reports of Committee A.

The reports were adopted.[1]

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the agenda (continued)

Prevention and control of sexually transmitted infections: draft global strategy: Item 11.6 of the Agenda (Documents A59/11 and A59/11 Add.1)

Dr HANSEN-KOENIG (representative of the Executive Board) said that the draft strategy had been developed through an inclusive consultative process in all regions with representatives from health ministries, nongovernmental organizations, partners in the United Nations system, the private health sector and other key stakeholders. The process had started in 2002 with an outline of core elements of a new strategy and had culminated in a working draft incorporating recommendations from all the consultations and from members of the WHO Gender Advisory Panel and the Expert Advisory Panel on Sexually Transmitted Infections including those due to Human Immunodeficiency Virus. The final draft took into account further comments received from Member States and complemented the global health-sector strategy for HIV/AIDS. It recognized that prevention and control of sexually transmitted infections were core aspects of sexual and reproductive health, in order to accelerate progress towards the attainment of international development goals and targets related to reproductive health. The Health Assembly was invited to consider the draft global strategy and the draft resolution contained in document A59/11.

Dr BLOOMFIELD (New Zealand) said that the draft strategy provided an excellent framework for dealing with a significant public health problem at the international, regional and national levels. New Zealand had a comprehensive approach to the prevention and treatment of sexually transmitted infections, aimed especially at young people in early adolescence. He emphasized provision of information and skills, tailored to their needs and evolving capacities, in order to prevent infection, sexual abuse and unwanted pregnancy. The draft resolution should clarify the term "age-appropriate": he proposed adding to the end of paragraph 1 the words "recognizing that age-appropriate interventions are those that respond to people's health and development needs and rights, and provide access to sexual and reproductive health information, life skills, education and services and, in the case of young people, in a manner consistent with their evolving capacities".

[1] See pages 256 and 257, respectively.

Dr CHANTANA PADUNGTOD (Thailand) commended the draft global strategy and endorsed the draft resolution, agreeing that it was vital that strategies for sexually transmitted infections should be appropriate to the local epidemiology of such infections.

Dr CHAOUKI (Morocco), speaking on behalf of Member States in the Eastern Mediterranean Region, expressed support for the global strategy and urged its implementation. Interventions in the control of sexually transmitted infections must be culture-sensitive for successful implementation. Member States in his Region would participate in all technical consultations and requested that interventions should be developed that were applicable or adaptable to the specific cultural context of each country. The Secretariat's support for the advocacy, adaptation, planning, capacity building, implementation, and monitoring and evaluation of the global strategy was crucial.

Morocco's programme for the control of sexually transmitted infections and HIV/AIDS, established in 1988, had been successful in transfusion safety, epidemiological surveillance, care and treatment for persons living with sexually transmitted infections and HIV/AIDS, implementing preventive measures, and involving civil society in prevention. The strategy for the treatment and care of women suffering from sexually transmissible infections was being revised.

Dr KLEIN (Austria), speaking on behalf of the European Union and its Member States, said that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates, Bosnia and Herzegovina and Serbia and Montenegro, aligned themselves with his statement. He welcomed the draft strategy, but regretted the late release of the document. He expressed strong commitment to the promotion of sexual and reproductive health and rights, to universal access to HIV and AIDS prevention, treatment and care, and access to the information, skills, services and supplies necessary for protection against all sexually transmitted infections. The term "age-appropriate" reflected a particular view as to who should benefit from access to some interventions, information and services, and should be explained unambiguously. The strategy should emphasize that education, information and services should be available in order to respond to the evolving capacities and needs of young people and this should be included in the resolution.

It was essential to incorporate sexually transmitted infections and HIV/AIDS into maternal, reproductive and child health. Social, cultural, political and economic barriers to accessing prevention and treatment should be tackled. He urged the Director-General to call on governments to ensure accessible and affordable procurement of prevention commodities, in particular microbicides and male and female condoms. Prevention should be comprehensive and evidence-based rather than selective. Sexually transmitted infections and HIV/AIDS shared the same root causes, including poverty, gender inequality and exclusion of vulnerable groups. Efforts to prevent sexually transmitted infections were needed urgently. Sexual and reproductive health services must be linked with those for HIV/AIDS, and relevant organizations must be strongly involved in prevention and treatment if the Millennium Development Goals were to be met in full and on time.

Governments should integrate prevention of sexually transmitted infections, including voluntary counselling and testing for HIV infection, into other health services, including those for sexual and reproductive health, family planning, maternity and tuberculosis. Policy and coordination between HIV and sexual and reproductive health should be strengthened and included in national development plans in order to fight the spread of sexually transmitted infections, including HIV/AIDS, and mitigate their impact.

The Health Assembly should adopt the draft resolution, requesting the Director-General to develop, with United Nations partners, clear benchmarks and time lines for action in the implementation and monitoring of the strategy.

Ms ANDERSON (Australia) supported the draft strategy, particularly the provision of services for sexually transmitted infections within the context of reproductive health, which would accelerate attainment of the Millennium Development Goals. She supported integration of those services across all primary health-care services and the inclusion of HIV prevention in those programmes, especially

where HIV epidemics were being driven by heterosexual transmission. Programmes for the prevention and control of HIV and sexually transmitted infections should include male participation. Australia supported the draft resolution as amended by New Zealand.

Dr ISHIDA (Japan), welcoming the draft global strategy, stressed the importance of a comprehensive approach, encompassing HIV/AIDS and reproductive health. Its potential impact on primary prevention of HIV was crucial and should be strengthened. Many technical points needed to be resolved and time and resources were required before starting a full-scale operation, making it difficult to set a clear timetable for implementation.

Public information and community involvement called for sensitivity and updated technologies which had been fostered in other fields such as HIV/AIDS and reproductive health. Implementation should involve the communities in which those affected by such chronic diseases lived. Prevention and care should be the core activities rather than attempts to eradicate diseases rapidly through criminalization and subsequent witch hunts. Effective services were needed for the most vulnerable and those most seriously affected by HIV/AIDS and sexually transmitted infections. The general population needed social development methods in order to promote expertise in HIV/AIDS and sexually transmitted infections in local communities, and a strong community response.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the prevention and control of sexually transmitted infections was an effective way of preventing HIV infection. Regional difficulties included inadequate health-care coverage, poverty, scarcity of diagnostic materials and too few trained health workers. Cuba, with its experience in the prevention and control of sexually transmitted infections, had contributed to a regional plan for the eradication of congenital syphilis. Its long-standing syphilis control programme had been expanded with comprehensive preventive and control measures implemented by full-time health workers. Gonorrhoea and HIV/AIDS prevention and control programmes had followed, all of which were integrated into the family-care programmes run by the primary health-care services.

To succeed, the global strategy needed full commitment and adequate funding. Programmes should take account of cultural specificities, gender equality and the effects of stigmatization, and the response must be coordinated. The general framework for the prevention and control of sexually transmitted infections, like national programmes, must be adapted to the specific circumstances of countries and regions. The draft resolution could help to strengthen health systems towards effective prevention and control. He endorsed the recommendation to foster collaboration among countries and with all interested stakeholders and taking account of the strong presence of Cuban medical assistance in the region and elsewhere. Cuba would implement strategies for the prevention and control of sexually transmitted infections wherever its health workers operated.

Mr RUÍZ MATUS (Mexico) supported the draft global strategy, with which Mexico's approach was consistent, and undertook to expand and strengthen high-quality care services. Mexico had had a strategic plan for the prevention and control of HIV/AIDS and other sexually transmitted infections since 1997; it included sex education, promotion of proper use of condoms and specific preventive action targeted at the most vulnerable groups. The diagnosis and treatment of sexually transmitted infections were part of ongoing health reform measures, which would result, inter alia, in a better supply of medicines, especially in less well-covered areas. Mexico had made significant progress in the fight against stigmatization and discrimination.

Mr LUCES (Bolivarian Republic of Venezuela) endorsed the draft strategy. In his country, services for the prevention, diagnosis, treatment and effective control of sexually transmitted infections were provided through the public health system. A manual on symptoms, treatment and prevention had been distributed, together with preventive materials, to all health workers. Care under that system was free of charge. Information on the prevention of sexually transmitted infections was also included in educational curricula and provided at community level. Currently some 2000 primary

health-care workers were receiving appropriate training with a view to integrating care for sexually transmitted infections into reproductive health care.

Dr DLAMINI (South Africa), welcoming the draft strategy, identified a strength in its harmonization with the Secretariat's strategy in the area of reproductive and sexual health. Its implementation should be promoted as part of primary health care in order to reach as many people as possible. Institutions that trained health workers should re-focus on instilling knowledge of the most effective methods of prevention, treatment and care of sexually transmitted infections. Syndromic management was effective in most cases, but laboratory confirmation would still be required for some cases. Partner notification was desirable but could result in more gender-based violence against women. The strategy should emphasize more strongly a gender-based approach and the empowerment of women.

She supported the promotion of healthy behaviour in section 3 of the draft strategy, but more emphasis should be placed on community dialogue and the reduction of stigmatization and discrimination. Section 3.4.3 could be strengthened in that regard. Information for patients, including in local languages, would encourage healthy behaviour and correct use of medication, thereby avoiding drug resistance. Health ministries should guide implementation of strategies and monitor their effectiveness, but financial incentives to reward those who sent in data to ministries could lead to unethical practices. The text could be strengthened by inclusion of specific proposals for prevention in special groups such as pre-teens, adolescents, and incarcerated persons. The inclusion of "uniformed services" in section 3.2, however, could be misinterpreted and alienate certain categories.

Further policy guidelines on integrating the strategy into HIV/AIDS and sexual and reproductive health programmes and clarification of the roles of research and evidence-based tools and of the roles of other United Nations agencies, such as UNFPA and UNICEF, were also needed. Advocacy support would be required to mobilize both financial and technical resources.

Dr XIAO Donglou (China) supported the draft global strategy. At the 2005 World Summit, world leaders had committed themselves to policies and strategies for achieving universal access to reproductive health services by 2015. In that context, WHO should enhance its cooperation with other relevant international organizations, mobilize financial resources, establish concrete plans of action and increase technical guidance.

Ms MUIRURI (United States of America) commended the strong, evidence-based strategy, and noted in particular the inclusion of delay of sexual initiation and abstinence, promotion of fidelity and partner reduction, and condom use as essential interventions against sexually transmitted infections. Recognizing the crucial role played by religious and faith-based organizations in those areas, his country's President had announced in December 2005 the New Partners Initiative, which would provide US$ 200 million through the President's Emergency Plan for AIDS Relief for grants to faith-based and other community organizations. Sex workers were an important target population for the strategy. Effective prevention campaigns must acknowledge that prostitution was often involuntary and the result of international human trafficking. The implications of involuntary prostitution by children, women and men should also be considered in the strategy; unique interventions were needed for those groups. Rescue from sexual slavery, and exit strategies for persons wishing to leave prostitution had also to be considered.

She observed that the Programme of Action of the United Nations International Conference on Population and Development was not a legally binding document, and did not create any new rights. It was not appropriate, moreover, for the Health Assembly to endorse a strategy that had not been reviewed at the country level. Endorsement implied formal implementation that might not reflect public health reality. The strategy should be a guide for countries to implement flexibly. Her Government understood that the term "reproductive health" did not create any rights and could not be interpreted to constitute support, endorsement or promotion of abortion. Likewise, it did not interpret the term "reproductive health services" to include abortion.

In the third preambular paragraph of the draft resolution, she proposed that the words "and reaffirming" should be deleted and that the wording used in the 2005 World Summit document should be reproduced. The phrase "as set out at the International Conference on Population and Development" should therefore be inserted after "by 2015", and, following "Millennium Declaration," the text should read: "aimed at, among other health-related goals, combating HIV/AIDS, and recognizing further that attainment of the Millennium Development Goals will require investment in….".

In paragraph 1, the word "endorses" should be replaced by "takes note of", just as the Fifty-sixth World Health Assembly had in resolution WHA56.30 on the Global health-sector strategy for HIV/AIDS. Language from the first principle of the International Conference on Population and Development should be added at the end, reading: "bearing in mind that the implementation of the recommendations is the sovereign right of each country, consistent with national laws and development priorities, with full respect for the various religious and ethical values and cultural backgrounds of its people, and in conformity with universally recognized international human rights;". In paragraph 2, language from that same first principle should also be added after "to adopt and draw on the," that would read: "elements of the Strategy that are age-appropriate, are consistent with their national laws and development priorities, that fully respect the various religious and ethical values and cultural backgrounds of their people, and are in conformity with universally recognized international human rights…".

Referring to New Zealand's proposed amendment to paragraph 1, she proposed that the word "services" should be replaced by "care".

Dr MASSÉ (Canada) supported the draft strategy's emphasis on comprehensive and integrated programming for sexually transmitted infections for people of all ages and situations, and its equal attention to prevention and treatment. The discussion on the role of health systems, the high turnover of human resources at the dispensary and district levels, and the need for community health workers was welcome. More information would be useful on how WHO would forge effective partnerships with other stakeholders, including governments, multilateral organizations such as UNICEF, UNFPA and UNAIDS, and civil society in order to implement the strategy. He supported the amendment proposed by New Zealand concerning age-appropriate interventions.

Dr LARSEN (Norway) endorsed the strategy. He commented on the stigmatization associated with sexually transmitted infections and observed that those most affected, particularly adolescents, could not afford the cost of screening and treatment. Services should be provided on the basis of both needs and the rights of adolescents in terms of their health and well-being as set out in the Convention on the Rights of the Child, which had been ratified by most United Nations Member States. There were also other conventions applicable to reproductive rights that promoted health and protected life. He supported New Zealand's proposed amendments, and stressed an evidence-based approach to the prevention of sexually transmitted infections.

Mr MARTIN (Switzerland) supported the statement made on behalf of the Member States of the European Union. Sexually transmitted infections should be integrated into reproductive and sexual health care, and every effort made to reach those most at risk of infection, particularly adolescents who should have access to information, services and products, particularly condoms. He approved the draft strategy, but reserved the right to comment further when the various proposed amendments were considered; those proposed by the United States of America were too substantive to be noted and incorporated without further debate.

Dr OTTO (Palau) endorsed the strategy, which should be incorporated into the national strategic plan. He expressed support for the amendment proposed by New Zealand and the comment by Norway on the rights to health of children, as set out in the Convention on the Rights of the Child.

Mrs TOELUPE (Samoa) said that the prevention of sexually transmitted infections and HIV/AIDS remained a challenge in Samoa. However, the continuing support of international, regional and bilateral partners would strengthen local efforts. She endorsed the strategy, as amended by Australia and New Zealand. WHO and other relevant United Nations organizations such as UNICEF, UNFPA and the United Nations Development Fund for Women should apply it to country-specific situations and enhance international coordination. WHO should work with the Secretariat of the Pacific Community in linking global regional initiatives, as agreed by the Pacific island countries in their regional strategy for the prevention and control of HIV/AIDS. She acknowledged the integration of strategic activities into primary health-care programmes and encouraged community participation. She also acknowledged the guiding principle of the strategy and re-emphasized the value of gender sensitivity, in line with the spirit of the Convention on the Elimination of All Forms of Discrimination against Women.

Mr AUAHDI (Algeria) said that, as sex workers were unable to work legally in many countries, it would be difficult to ensure their access to diagnosis and treatment. The problem was not so much the setting up of infrastructures as ensuring that the facilities were used and infections detected and treated.

Mr JALLOW (Gambia) said that his country had invested heavily in the training of all health workers in the syndromic management of sexually transmitted infections and had integrated its services in order to reduce the associated stigmatization. It would require substantial technical support in order to implement the strategy, especially for laboratory and other screening services.

Ms DLAMINI (Swaziland) said that her country had prioritized sexually transmitted infections, having already intensified activities for HIV/AIDS. The national diagnosis referral laboratory had been expanded. All public and private health professionals had been trained in the management of sexually transmitted infections. National guidelines had been updated and the national care protocol had been integrated into the nurses' training curriculum. Priority had been given to ensuring an adequate supply of medicines for treating sexually transmitted infections, with support from international partners. Prevention by means of health promotion would also be emphasized.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) supported the amendments by Canada, Norway, South Africa and, especially, New Zealand. The global strategy should concentrate on the available evidence base and the action to be taken, rather than on statements of values. It was unfortunate that the many amendments proposed by the United States of America had not been made available in advance in order to permit some negotiation. An informal meeting of interested delegates might be the best way of reaching agreement on the text.

Dr NETO DE MIRANDA (Angola), speaking on behalf of the Member States of the African Region, noted that the draft global strategy incorporated the recommendations of key stakeholders, including the WHO regional committees, other organizations in the United Nations system and the private sector. Sexually transmitted infections accounted for 17% of economic losses due to ill-health in developing countries. Their high prevalence had contributed to the HIV/AIDS burden in sub-Saharan Africa. The draft global strategy recognized that their prevention and control were core aspects of reproductive health, emphasized the importance of integrating their prevention and control into all primary care services, including HIV/AIDS programmes, and paid due attention to investment in prevention and control, the imperatives for success and the reasons for failures. However, it failed to appreciate the need to emphasize compliance with, and completion of, prescribed courses of treatment and to encourage people to seek treatment early. It should also include more specific interventions for vulnerable groups such as adolescents, prisoners, displaced people and refugees, clarify the roles of the Secretariat, Member States and relevant United Nations agencies at country level, and provide specific recommendations on resource mobilization and pooling, payment and purchasing.

The African Region would benefit from the global strategy despite established services and guidelines for the prevention and control of sexually transmitted infections, and case management based on a syndromic approach at the primary health-care level. Although guidelines had been produced for the management of such infections, the training provided in their use varied considerably. Supply of medicines, condoms and laboratory reagents for routine screening was hampered by resource constraints. The private sector and the community would need to be involved in service delivery and management. The challenges were providing access to high-quality services and designing a regional strategy in the context of universal access to prevention, care and treatment. She agreed that interventions should be age-specific rather than targeted at "adolescents", and endorsed the draft global strategy and the draft resolution as amended by New Zealand.

Mrs TELLIER (UNFPA) welcomed the draft global strategy. Sexually transmitted infections were a major contributor to the global burden of disease and hindered attainment of Millennium Development Goals 4, 5 and 6, concerning child and maternal health and AIDS. The strategy would be a major part of efforts to implement the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly at its twenty-sixth special session and the global commitment to achieving universal access to good reproductive health by 2015 assumed at the International Conference on Population and Development in 1994, since sexually transmitted infections were relevant to both. All too often, policies, programmes and initiatives on sexual and reproductive health or HIV/AIDS failed to make a link between those two global commitments.

UNFPA would share its experience at country level in the implementation of the strategy, especially within the WHO/UNFPA Strategic Partnership Programme. Field experience indicated that gender equality could be studied and quantified and gender-sensitive services provided. Monitoring and programme implementation of the strategy should be gender-specific, as in the second-generation surveillance system.

Young people, who contracted most new sexually transmitted infections, must have access to gender-sensitive information, the means to protect themselves against infection and youth-friendly services for the detection and treatment. UNFPA was willing to share its experience in that area, and could help to provide access to life-saving commodities for the prevention, diagnosis and treatment of sexually transmitted infections.

Ms CALDWELL (International Council of Nurses and International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that the two organizations, which represented millions of nurses and midwives, commended the draft global strategy. Nursing and midwifery personnel were crucial to increasing the availability of high-quality, comprehensive sexual and reproductive health care. They were essential in expanding prevention and diagnostic support and treatment services, incorporating gender-sensitive approaches, reaching neglected populations and providing sexual health education and services, especially for adolescents. The attainment of internationally agreed development goals and the targets of WHO's priority programmes was being jeopardized by the global shortage of nurses and midwives; accelerated action and sustained resources were needed. The Council and the Confederation were committed to working with WHO and other organizations in the United Nations system to attain the health-related Millennium Development Goals. They called on Member States and the Director-General to strengthen the contribution of nurses and midwives to sexual and reproductive health.

Mrs PHUMAPHI (Assistant Director-General) acknowledged the expressions of strong support for the draft strategy, which had been proposed originally by the Member States themselves. The Secretariat looked forward to implementing the strategy in Member States, thereby supporting the tremendous work already done by them. An equally comprehensive plan for the implementation of the strategy would be needed. The Secretariat would work with Member States in order to ensure that the strategy responded to their needs and examined essential points such as gender in more detail. It would give special attention to vulnerable populations such as sex workers and young people and would

establish strong linkages with HIV/AIDS programmes, especially in countries where transmission of HIV was predominantly sexual. The Secretariat would work with and involve regional experts and was aware of the current shortcomings in syndromic management, especially for women. It was also working with other partners on simple, rapid diagnostic tests. She drew attention to WHO's documentation on gender and violence. The Secretariat was elaborating a draft strategy on gender, women and health.

Mr AITKEN (Adviser to the Director-General) suggested that, since the amendments proposed to the draft resolution were extensive, all interested parties should convene shortly to hold informal consultations on how to proceed.

It was so agreed.

(For approval of the draft resolution, see summary record of the ninth meeting.)

Prevention of avoidable blindness and visual impairment: Item 11.7 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R4 and Annex 4, and A59/12)

Dr HANSEN-KOENIG (representative of the Executive Board) said that resolution EB117.R4, which originated with a resolution adopted by the Regional Committee for the Eastern Mediterranean,[1] had been adopted following discussion at the 117th session of the Executive Board. Board members had stressed the impact of visual impairment and blindness on the socioeconomic status of societies and the unfulfilled potential of Member States in achieving the elimination of avoidable blindness. They had affirmed that prevention of blindness should be given priority and had highlighted the cost-effectiveness of known interventions to control its major causes.

The Secretariat's agenda for prevention of avoidable blindness and further implementation of the VISION 2020: The right to sight had also been strongly endorsed by WHO's Elimination of Avoidable Blindness Monitoring Committee at its meeting in January 2006.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that only 32% of countries had established national action plans by 2005, despite the requirement of resolution WHA56.26. Since cataracts were the avoidable cause of more than 50% of cases of blindness worldwide, between 2000 and 4000 cataract operations per million persons would have to be performed annually for any gradual eradication of the disorder. Implementation of the Cuban-designed project, *Misión Milagro* (Miracle Mission), for people suffering from eye problems, mainly cataracts, had begun in the Bolivarian Republic of Venezuela, where some 190 000 patients had already undergone operations. It had since been extended to 14 Caribbean and 9 Latin American countries, with operations on 34 000 patients. Between its launch in 2004 and early May 2006 a total of 284 750 patients had been operated on. The project comprised: surgery in Cuba, installation and equipment of eye surgery centres, and training of ophthalmologists through scholarships. All medical services, together with air transport, accommodation, food, local transport in Cuba and post-operative check-ups, were free for both patients and their governments. Patients travelled either with individual carers or in groups, accompanied by social workers. The average recovery stay in Cuba was one week. Cuba's President had pledged to continue the programme, in order to preserve and restore the sight of six million Latin Americans and Caribbeans and train 200 000 health professionals in 10 years.

He urged the Monitoring Committee to review the work done by *Misión Milagro*. Action to avoid visual impairment might be frowned upon by some medical groups on the grounds that it was losing them customers, but such action benefited the very poor who could not afford private operations. WHO would need to mobilize resources for the least developed countries and promote

[1] Resolution EM/RC52/R.3.

alliances if the problem was to be solved by 2020. The draft resolution was similar to resolution WHA56.26 on elimination of avoidable blindness and it only remained to apply it, for which purpose his country offered its own experience.

Prince BIN AHMAD BIN ABDELAZIZ (Saudi Arabia), speaking as the delegate of Saudi Arabia and also for the International Agency for the Prevention of Blindness, recalled that the Global Initiative for the Elimination of Avoidable Blindness had been launched as a partnership between WHO and that Agency. Some 90% of cases of blindness and visual impairment were to be found in developing countries experiencing difficult socioeconomic circumstances. The Millennium Development Goals concentrated on the economic and social development of such countries so that they could put their resources to the best possible use. Yet the costs of blindness and visual impairment were currently estimated at US$ 35 000 million. Without action, by 2020 there would be 200 million visually impaired persons in the world, of whom 75% would be blind, at a huge cost to the international economic community.

Cataracts could be cured however, by safe and highly successful surgery costing about US$ 50 per operation. The situation could, therefore, be improved and human suffering alleviated. His country and the International Agency were eager to cooperate with the Secretariat to that end and supported the draft resolution contained in resolution EB117.R4 with its call for prioritization of prevention of visual impairment. Work to devise a long-term programme in order to improve means of avoiding blindness and visual impairment needed support. Given all the new cases of blindness and visual impairment among the elderly and children, he urged approval of the draft resolution.

Dr BIN AL-RAJHI (Saudi Arabia) reiterated support for the draft resolution and proposed that it should be amended in order to request incorporation of blindness-prevention activities in the medium-term strategic plan 2008–2013, the Proposed programme budget 2008–2009, and the Eleventh General Programme of Work, 2006–2015 with technical support for Member States and the strengthening of global, regional and national blindness-prevention activities.

Dr VILLAVERDE (Philippines) supported the draft resolution and the Global Initiative. Even before the adoption of resolution WHA56.26, his Government had begun implementing a blindness-prevention programme with four components: cataract extraction, prevention of vitamin A deficiency, primary eye care and upgrading of ophthalmic personnel and facilities. In 1996, the National Committee on Sight Preservation had been set up in order to maximize resources for blindness prevention and deal with the major areas of concern identified in resolution WHA56.26. However, capital investment for eye-care equipment and facilities together with human resources, particularly among case-finders at the community level, were all lacking. He strongly recommended support for capacity-building among health workers, especially in the benchmarking of programmes in other countries, and the development of a comprehensive, system for the acquisition of appropriate eye-care equipment and supplies, particularly for public hospitals.

Dr DUERKSEN (Paraguay) supported the draft resolution, as amended by Saudi Arabia, and welcomed the increased recognition within WHO of the diseases that caused blindness or severe visual impairment. As recommended in resolution WHA56.26, his Government had set up a National Vision 2020 Committee comprising representatives from across the eye-health spectrum. It was also implementing a national plan for eye health.

Nine out of 10 blind people lived in low-income countries and 17 million of the 37 million blind people in the world could be cured by cataract surgery, which had a nearly 98% success rate. Blindness-prevention programmes were among the most cost-effective measures and could save more than US$ 42 000 million annually worldwide. The right to sight was an essential component of national development and poverty alleviation. Blindness must be reduced in order to improve access to education and employment opportunities.

Dr TRAN TRONG HAI (Viet Nam) commended WHO's leading role in the prevention of avoidable blindness. His country had committed itself to VISION 2020: The right to sight, and had resolved to reduce the burden of blindness, increase human resources, and strengthen infrastructure, advocacy, programme development and management. He supported the draft resolution.

Dr MARQUES DE LIMA (Sao Tome and Principe) regretted that most Member States had not yet drawn up their national VISION 2020 plans. His own country was finalizing its national plan with WHO's technical assistance. The Secretariat's report listed the countries which, according to Elimination of Avoidable Blindness Monitoring Committee, should be the focus of most VISION 2020 activities over the next three years. What criteria had been used for that decision, since other countries undoubtedly needed assistance just as much? He supported the draft resolution.

Dr MUÑOZ (Uruguay) said that blindness was an important issue in her country, where 17% of the population was over 60 years of age and 13% over 75. Diabetic and infant retinopathy were problems and, in the former case, a diabetes control programme encouraging use of subsidized medicines had been established. The prevalence of cataract among the population was not known, because no cataract operations had been carried out among the poor before 2005, since when, more than 1000 had been performed free of charge, with the assistance of Cuba.

She supported the draft resolution, with its call for research in order to determine the global prevalence of avoidable blindness. The work of countries such as Cuba and the Bolivarian Republic of Venezuela had contributed to multilateralism and provided valuable assistance to countries like Uruguay and Bolivia, which were unable to offer free treatment. A new surgical hospital for people with cataract and diabetic retinopathy in Uruguay would be built with such technical assistance.

The Ministry of Public Health had supported a blindness prevention programme throughout the country but it had been opposed by professional associations and few health workers had undertaken the necessary training in neighbouring countries. She welcomed WHO's support for the prevention of avoidable blindness, and requested the assistance of Member States in the training of health professionals. Her country would willingly share its experience of setting up an eye hospital.

Ms HEFFORD (Australia) supported the draft resolution. In response to resolution WHA56.26, Australia had approved a national framework for eye health and prevention of avoidable blindness and vision loss. It would contribute to international initiatives, participate in the Elimination of Avoidable Blindness Monitoring Committee, provide technical support for countries in the Asia-Pacific region and fund research into eye health.

Ms MATA (Bolivarian Republic of Venezuela) said that, in the past, eye health had not been a priority in her country. Most services had been available only to those able to afford private clinics. Older people, in particular, were affected by degenerative eye diseases, which were avoidable or treatable by highly effective, low-cost surgery. Her Government had made eye-health services a priority and provided them free of charge. Coverage had improved through the *Barrio adentro* (Into the Barrio) project.

The *Misión Milagro* (Miracle Mission) project aimed to retrain and reintegrate people suffering from eye diseases into ordinary life. It had opened 457 eye clinics throughout the country, 27 hospital-based clinics and 30 operating rooms and outpatient clinics. Since 2004, an average of 1.4 million patients had been treated every year. An estimated 300 000 operations on Venezuelan patients would be performed in Cuba during 2006, and more than 17 000 patients had undergone operations in her country. The Government aimed to train many thousands more physicians in order to provide better care for the most underprivileged groups. The project was open to patients from many Latin American countries, and aimed to care for six million patients in the 10 years ahead. The 27th Meeting of Ministers of Health of the Andean Region had prioritized eye health.

She suggested the following amendments to the draft resolution: it should call upon Member States to promote and offer better access to health services for eye diseases, both prevention and treatment, and to promote integration, action and solidarity between countries in the prevention and

care of blindness and visual impairment. WHO should acknowledge the achievements of *Misión Milagro* in the service of eye health in Latin America.

Mr JALLOW (Gambia) said that his country's national eye-care programme demonstrated the effectiveness of the primary-health care strategy, as eye care had been taken into the community. Community health workers had been trained in the early diagnosis and appropriate management of trachoma. Using the concept of "*nyateros*" ("friends of the eye"), community members had been encouraged to recognize eye disease and help to treat it. Community cataract camps for children were organized free of cost. Primary health care should be central to the prevention of avoidable blindness and visual impairment. The construction of a regional eye-care centre would provide a centre of excellence for training in and management of eye diseases in the west African subregion.

Dr RESIDA (Suriname), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolution. Since the adoption of resolution WHA56.26, many of them had adopted the prevention of avoidable blindness and visual impairment as a national priority and promoted healthy lifestyles in order to reduce the incidence of chronic noncommunicable diseases.

The Government of the Bahamas provided free optometry services for children. Some members of the Community had benefited from the *Misión Milagro* initiative offered by Cuba and the Bolivarian Republic of Venezuela: between July 2005 and March 2006, over 4000 people in Grenada had undergone screening and 1130 had undergone surgery. That initiative should continue, and he called upon other Member States to assist Caribbean countries in building local capacity in the prevention and treatment of blindness and visual impairment.

Dr SRIVASTAVA (India) supported the draft resolution. India's VISION 2020 plan, prepared in 2002, formed part of the national priority programme for the control of blindness. That programme, which was being incorporated in the existing health-care delivery system, had attracted impressive support from nongovernmental organizations and the private sector over the past 12 years, especially for cataract surgery and eye banks. India's tenth five-year plan had set a target by 2007 of 450 cataract operations per 100 000 population, with intraocular lens implantation in more than 80%; 2000 vision centres in rural areas and 25 eye-bank networks were also planned.

Dr ISHIDA (Japan) welcomed the increased global interest in prevention of avoidable blindness and visual impairment that had resulted from the Global Initiative because of the enormous socioeconomic burden on communities and reduced quality of life of individuals. Much of the vision loss in developing countries was caused by conditions that were avoidable and rarely seen in developed countries.

The delay in implementing VISION 2020 activities was a matter of concern and Japan therefore supported the recommendations of the Elimination of Avoidable Blindness Monitoring Committee. Japan was considering providing technical and financial support for national VISION 2020 planning in the selected countries requiring intensified assistance. Cataract surgery was highly effective and should be expanded in many countries. Greater control of noncommunicable diseases was needed, especially those related to lifestyle such as diabetes mellitus, in order to avoid further vision loss.

Professor AKOSA (Ghana), speaking on behalf of the Member States of the African Region, recalled the provisions of resolution WHA56.26. Although some Member States had begun implementing the resolution, greater effort was needed in order to reduce the global burden of avoidable blindness. In Africa there were 6.8 million blind people and 20.4 million with low vision – 18.4% of the global total even though the Region accounted for 11% of the world's population. Cataract affected 3.4 million people in Africa, with an annual incidence of 1 per 1000 population. Trachoma was endemic in 55 countries, the majority in Africa. Glaucoma represented 12% of the global burden of blindness and onchocerciasis was endemic in 30 sub-Saharan African countries, with

19 million people affected of whom about 300 000 were blind. Some 1.5 million children in the world were blind, about 320 000 of them in Africa.

VISION 2020 offered a unique opportunity to develop comprehensive, viable and sustainable eye-care systems, focused on manageable, defined populations, with government ownership so as to increase coverage. For it to succeed in Africa, policies were needed for national and regional implementation, coordination within countries, evaluation and optimal use of resources. Countries must give more support for prevention of blindness and visual impairment. National action should include the integration of blindness prevention into national investment plans and the intensification of public-private partnerships. Since blindness precipitated and intensified poverty, prevention of avoidable blindness would accelerate progress towards attainment of the Millennium Development Goals.

He supported the draft resolution as amended by Saudi Arabia.

Mr ARIYA BUNNGAMCHAIRAT (Thailand), commenting on the significant but uneven progress on VISION 2020, drew attention to remaining challenges, including the ageing of populations (which increased the prevalence of cataract), problems with access to care, human resource limitations, inadequate prevalence data, and the need to integrate eye care into existing health-care systems. Action required strong commitment by countries and technical and financial support from WHO and other development partners.

Thailand had adopted the VISION 2020 initiative. As a result of infection prevention and cataract surgery campaigns, blindness prevalence had been reduced from 1.14% in 1983 to 0.31% in 1994. Trachoma and vitamin A deficiency blindness were no longer public health problems but diabetic retinopathy and refractive errors were new challenges. Eye care was integrated with primary, secondary and tertiary health care and an effective referral system, and cataract surgery capacity exceeded incidence, so that the cataract backlog was diminishing fast. However, human resources for eye care remained a concern.

As paragraph 1 of the draft resolution focused on policy and planning without a concrete recommendation on health-care delivery systems and human resources, he proposed the insertion of a new paragraph 1(6) to read "to develop, strengthen and integrate eye-care services into the existing health-care system at all levels, including the training and retraining of health workers in visual health".

Ms BELLO DE KEMPER (Dominican Republic) recalled that members of the Board at its 117th session had emphasized the need to prioritize retinopathy of prematurity in WHO's blindness prevention programmes. The Dominican Republic included blindness-prevention strategies in its national plan for primary health-care. She supported the draft resolution, as amended by Saudi Arabia, which should increase WHO support for the completion of national VISION 2020 plans. The amendments proposed by Thailand and the Bolivarian Republic of Venezuela were also of great interest. She supported the establishment of alliances between developed and developing countries as well as among the latter for blindness-prevention activities, in particular cataract surgery.

Mrs EBELLE (Cameroon) said that Cameroon had integrated its strategic VISION 2020 plan into the onchocerciasis-control programme in operation since 1997 under the African Programme for Onchocerciasis Control. Blindness prevalence in Cameroon was around 1%: some 80 000 people with bilateral cataract, five million infected with *Onchocerca volvulus* and 18 000 with glaucoma. Diabetic retinopathy was on the rise. Constraints included shortages of qualified personnel and consumables, inadequate funding, outdated equipment and the fact that the poor were unable to afford eye care. However, thanks to strong partnerships and mobilization of funds resulting from debt reduction, a cataract surgery programme for the poorest population groups had been launched in 2005. Further effort was needed.

She proposed amendments to the draft resolution. The words "or treatable using known and affordable technologies" should be added at the end of the second preambular paragraph. In paragraph 1(2), "by sustaining necessary funding at national level" should be replaced by "by mobilizing internal

funding". Paragraph 1(4) should be amended to read "to include prevention of avoidable blindness and visual impairment in primary health care and in existing plans and programmes at regional and national levels". In paragraph 1(5), a comma should be inserted after "private sector", followed by "civil society and communities". A new paragraph 1(6) should be added in order to read "to make available within national systems the essential medicines and medical consumables needed for eye care". Paragraph 2(2) should be subdivided in order to read "(a) to provide technical support to Member States; (b) to support collaboration between countries for the prevention of avoidable blindness and visual impairment, in particular for the training of all categories of personnel".

Dr AYDINLI (Turkey) supported the amendments proposed by Saudi Arabia.

Dr MASSÉ (Canada) said that the Canadian International Development Agency actively supported prevention and treatment of blindness programmes in various developing countries. Canada supported the draft resolution, with the amendments proposed by Thailand and Cameroon concerning human resources development, and encouraged the Secretariat to provide Member States with additional technical support.

Dr AL-MADAF (Kuwait) commended the importance attached by WHO to the prevention of avoidable blindness and visual impairment, which had socioeconomic impact on communities and individuals alike, besides burdening health-care systems. Kuwait supported the draft resolution and requested the Director-General to give priority to provision of the necessary technical support.

Dr CHAOUKI (Morocco) supported the draft resolution as amended by Saudi Arabia. The VISION 2020 initiative was worthy of global support; investment in combating blindness would bring tangible results. Under the national VISION 2020 plan, centres had been established and the blindness-prevention programme had been incorporated in the national health policy. Partnerships with intergovernmental and nongovernmental organizations had also been expanded. Successes, particularly in respect of trachoma, should encourage other countries. In collaboration with partners, public education programmes had been introduced especially for children, in order to increase awareness of trachoma-prevention measures.

Dr BIN SHAKAR SHUKR (United Arab Emirates) supported the draft resolution as amended by Saudi Arabia. His country was implementing national VISION 2020 plans. Countries could not respond in isolation and WHO also had an important role to play. His country's own plan was in line with recommendations made for the prevention of blindness, which caused real suffering.

The meeting rose at 12:30.

NINTH MEETING

Friday, 26 May 2006, at 15:10

Chairman: Dr A. RAMADOSS (India)
later: Dr P. MAZZETTI SOLER (Peru)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

Prevention of avoidable blindness and visual impairment: Item 11.7 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R4 and Annex 4 and A59/12) (continued)

Mr HERBERT (Saint Kitts and Nevis) commended WHO's work on the prevention of avoidable blindness and visual impairment and for the inclusion of three member countries of the Caribbean Community among the group needing intensified assistance. He supported the draft resolution and acknowledged the invaluable assistance his country had received from regional partners for its VISION 2020 programmes. The Miracle Mission project had screened almost a quarter of the total population from 3 to 89 years old, finding that almost a quarter of them needed specialized treatment. The national eye-care programme continued to involve public and private-sector partnerships. His country would continue to implement its comprehensive programme to prevent avoidable blindness and visual impairment, with the continued assistance of its regional and international partners.

Dr ALLAGE (Libyan Arab Jamahiriya) affirmed the priority given to prevention in VISION 2020: The right to sight. The causes of blindness had to be tackled by trained doctors and health personnel providing appropriate services. He fully supported the draft resolution, with the amendments proposed by the delegate of Saudi Arabia. Work on the prevention of avoidable blindness and visual impairment should be included in the Medium-term strategic plan and Proposed programme budget 2008–2009, which should also include a list of all countries needing support and assistance in that area.

Mr MAMPILLY (United States of America) commended WHO's achievements in combating avoidable blindness. Its cooperation with the International Agency for the Prevention of Blindness was a good example of how resources and leadership could benefit from public/private partnerships. Trachoma, onchocerciasis and xerophthalmia were challenges facing many countries. Examples of his country's contribution to global efforts to avoid blindness included programmes to prevent micronutrient malnutrition, regional surveillance of onchocerciasis and research for new treatments for trachoma. Since 1979, its technical agencies had worked with the Secretariat to eliminate avoidable blindness. Cataracts affected older people in all countries including half the American population over 65 years of age. The United States welcomed the partnerships organized by the Secretariat to combat avoidable blindness, and the generosity of private-sector partners.

He supported the draft resolution and endorsed the amendments submitted by Saudi Arabia, Paraguay, and Thailand. He proposed a minor change to the amendment proposed by Cameroon to paragraph 1(6). The word "national" in the phrase "within national health systems" should be deleted, because other stakeholders, including the private sector and foundations, were crucial to the provision of better eye-care services.

Mr RUÍZ MATUS (Mexico) emphasized programmes to combat avoidable blindness and visual impairment through the VISION 2020 initiative. Since 1999 Mexico had had national standards for the treatment of disabled persons, and especially those with visual impairments. Its 2005 law on disability sought to include such people in various activities. The Government had also introduced a national programme for the prevention of blindness, and had established a national council for the prevention of visual impairment, with the participation of the public and private sectors, civil society organizations and affected people. There was a national centre to support training in and promotion of cataract surgery. He welcomed the draft resolution and agreed that the activities specified in it should be included in the Medium-term strategic plan, the Proposed programme budget 2008–2009 and the Eleventh General Programme of Work, 2006–2015.

Dr AL-JOWDER (Bahrain) fully supported the draft resolution as amended by Saudi Arabia. Programmes aimed at the prevention of avoidable blindness and visual impairment should be included in the Medium-term strategic plan 2008–2013, the Proposed programme budget 2008–2009 and the Eleventh General Programme of Work.

Dr MAKUBALO (South Africa) strongly supported the Global Initiative for the Elimination of Avoidable Blindness. Her country had signed the VISION 2020 Declaration of Support, and recognized the relationship between blindness and social marginalization and poverty. It was committed to improving the quality of life of affected people. She fully supported the draft resolution. The Secretariat should provide Member States with the necessary technical support in order to implement it.

Professor TLOU (Botswana) commended the attention being given to avoidable blindness and visual impairment. In Botswana about 1% of the population was blind – in at least 50% half the cases because of cataracts, which were treatable, and the rest due to other causes, such as glaucoma, diabetes or traumatic injuries to the eye. Visual impairment in adults accounted for 80% of curable or avoidable blindness. Botswana's Prevention of Blindness Programme had been incorporated into primary health-care services, so as to improve access to eye care and increase community awareness. Non-specialist health workers were being trained in eye care, and nongovernmental organizations and private-sector partners were providing access to cataract surgery and other eye-care services, but shortages of personnel persisted. In 2005 more than 4000 patients had been awaiting cataract surgery. She urged the Director-General to continue to provide technical support for eye-care services in Member States. Botswana fully supported the draft resolution.

Dr HERNAWATI (Indonesia) expressed strong support for the draft resolution. Under its National Strategic Plan for Prevention of Blindness 2003, his country was conducting a comprehensive programme for the prevention of blindness, which included the integrated management of childhood illnesses and routine vitamin A supplements for mothers after childbirth, infants and children under five. Indonesia had about 210 000 cataract cases each year, representing 0.1% of the population. Only 80 000 of them had access to surgery, so there was a sizeable backlog. The main pillars of VISION 2020 were disease-control activities, the strengthening of human resources and the use of low-cost appropriate technology in order to improve the accessibility and affordability of eye care. She emphasized the importance of WHO's technical support and cooperation among countries.

Dr AHMED (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported for the draft resolution, as amended by Saudi Arabia. The burden of visual impairment had not received the attention it deserved. The right to sight could not be denied. More than 90% of the blind lived in developing countries, and the linkages with poverty and deprivation were obvious. Political commitment to tackling the problem had so far been lacking, owing to competing government demands on limited resources. He was grateful to WHO for its guidance in preventing blindness. His Government's new National Programme for Prevention and Control of Blindness was based on the principles and guidelines of VISION 2020: The right to sight. It sought to

reduce avoidable blindness and to promote the social inclusion of the blind through strategies aimed at poverty reduction, gender equality and the education of visually-impaired children.

Dr KAGGWA (Uganda) said that in his country blindness and visual loss had a devastating impact on individuals, families, communities and the whole of society. A child had a 60% chance of dying within a year of going blind; women were at greater risk of visual impairment than men. However, reducing blindness and visual impairment improved access to education and employment and alleviated poverty. Uganda had put the prevention of avoidable blindness high on its development agenda. He supported the draft resolution and the inclusion of programmes and activities for the prevention of blindness in the Medium-term strategic plan 2008–2013, the Proposed programme budget 2008–2009, and the Eleventh General Programme of Work. Uganda was implementing plans based on the VISION 2020 initiative.

Dr SALGADO (Chile) said that visual impairment needed emphasis because in many countries priority in funding was given to potentially fatal conditions. In Chile there were thousands of visually impaired people, the main causes being cataracts, diabetes and premature births. However, among the 40 health conditions that resulted in guaranteed access to treatment and financial protection were five problems of visual health: cataracts, diabetic retinopathy, refraction, detached retina and retinopathy in neonates. In schools, all pupils were given eye examinations and follow-up treatment if necessary. A recent change in the law made it possible to acquire spectacles for presbyopia without a prescription from an ophthalmologist. However, like many other countries, Chile had difficulty finding personnel willing to work in the public health system. The resolution should therefore include some provision for training personnel and supplying the necessary advanced technology to countries in need of it.

Dr AL-HOUSAMI (Syrian Arab Republic) supported the draft resolution as amended by Saudi Arabia. The activities aimed at preventing blindness and visual impairment should be included in the WHO's Medium-term strategic plan, Proposed programme budget 2008–2009 and Eleventh General Programme of Work. Visual impairment could often be corrected, and both glaucoma and cataract could be prevented or treated cheaply if the necessary human and financial resources were available.

Mrs NADAKUITAVUKI (Fiji) fully supported the draft resolution. Fiji had a strategic plan for the prevention and management of conditions leading to blindness and visual impairment. The plan, linked to the VISION 2020 initiative, also dealt with capacity building among health professionals. Fiji recognized the value of partnerships between the public sector, nongovernmental organizations and the private sector, at both national and international levels, in implementing its strategies. The Secretariat's monitoring role, together with regular reports on progress to the Health Assembly, would encourage each Member State to implement the initiative.

Ms AKINFOLAJIMI (United Kingdom of Great Britain and Northern Ireland) said that the United Kingdom was committed to the principles of VISION 2020, and had initiated a range of activities covering cataracts, glaucoma, diabetic retinopathy and age-related macular degeneration. It was also working to raise public awareness of behaviours and lifestyles that affected eye health. Its programme of work should meet the aims of VISION 2020. Implementation of the resolution would require flexibility and monitoring. She supported the draft resolution.

Dr GREGORICH-SCHEGA (Austria), acknowledging the significant impact severe visual impairment had on the socioeconomic development of individuals and societies, emphasized prevention, because ophthalmic interventions could be both effective and efficiently delivered. However, lack of access to such services increased the number of people with severe visual impairment and caused considerable human suffering as well as loss of productivity. Stronger global action was needed if the aims of VISION 2020: The right to sight were to be achieved. Austria, and the European Union as a whole, welcomed the draft resolution but, speaking on behalf of the Member States of the European Union, she expressed reservations about the proposed inclusion of activities

relating to the prevention of avoidable blindness in the Medium-term strategic plan 2008–2013 and the Proposed programme budget 2008–2009. That would be premature. She pointed out that the Eleventh General Programme of Work had already been approved by Committee B the previous day.

Dr AL-NAIMI (Qatar) supported the draft resolution as amended by Saudi Arabia. Qatar paid close attention to improving all programmes for the prevention of blindness, and supported VISION 2020: The right to sight. All those working in the health sector had received training so that the level of visual acuity among schoolchildren could be improved. National programmes were in place in order to prevent blindness, and a national committee was responsible for their implementation. She favoured inclusion of a paragraph on the prevention of avoidable blindness in both the Proposed programme budget 2008–2009 and the Eleventh General Programme of Work, since that would ensure the necessary technical support for all countries for eliminating avoidable blindness.

Ms ZHANG Lingli (China) said that her country, with more than five million blind people, constituting 18% of the total worldwide, and every year more than 400 000 people losing their sight, had a major programme to deal with blindness and visual impairment. China had always emphasized preventing and treating visual diseases; as early as 1950, there had been a national campaign against trachoma, then the chief cause of blindness. The principal cause was currently cataracts. The rise in incidence of cataracts was slowing, and more than 600 000 cataract operations were being performed every year.

China was aware of the importance of visual health for socioeconomic progress, and its authorities and civil society participated actively in the prevention of blindness. International organizations had given significant support, and China had its own project within the framework of VISION 2020, aimed at eradicating avoidable blindness by 2020. A special group had responsibility for preventing blindness: its chief aim was to assist health workers in dealing with blindness by organizing training and technical exchanges, and finding new technologies to deal with visual impairment. A new national plan for 2006–2010 was in preparation. China would strengthen its cooperation with WHO, the International Agency for the Prevention of Blindness and other international organizations in order to contribute to the implementation of VISION 2020.

Mr GAUDÊNCIO (Brazil) expressed support for the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) and Dr AMMAR (Lebanon) also supported the draft resolution as amended by Saudi Arabia.

Mr GHEBREYESUS (Ethiopia) said that blindness was one of his country's major problems; trachoma and cataract alone accounted for more than 70% of all cases. The main cause of childhood blindness appeared to be corneal scarring, which was related to measles, vitamin A deficiency, acute infections and trauma. More than 80% of blindness in Ethiopia was avoidable. The country's main achievements were the launch of the VISION 2020 initiative, the establishment of national and regional committees for the prevention of blindness, and a national five-year strategic plan for eye care. The numbers of ophthalmologists and eye-care units had increased, as had the number of patients receiving cataract surgery.

Several major difficulties had been encountered in implementing measures to prevent and control blindness in Ethiopia, notably shortages of human resources, infrastructure for eye care, and medical and surgical eye-care supplies, and inadequate funding. It was intended to increase the number of cataract surgeons and the number of districts implementing the comprehensive safe strategy recommended by WHO and the national five-year strategic plan, in order to achieve the goals of VISION 2020. He supported the draft resolution.

Mr AUAHDI (Algeria) said that his country had established a national programme for the prevention and treatment of avoidable blindness, including cataract and trachoma. Short- and

medium-term technical and financial assistance was urgently required from WHO in order to implement the programme, and he supported the draft resolution, as amended by Saudi Arabia.

Prince BIN AHMED BIN ABDELAZIZ (Saudi Arabia) observed that the nongovernmental organizations that provided most support for humanitarian efforts in general, and for the prevention of blindness in particular, came from the European Union and the United States of America. The prevention of blindness was among the Millennium Development Goals and should be included in the Eleventh General Programme of Work. He added that, since the beginning of the Health Assembly, an estimated 74 000 adults and 6000 children would have gone blind.

Ms PÉREZ ALVAREZ (Cuba) supported the amendments proposed by Saudi Arabia. In recognition of the contribution made by Member States, including Saudi Arabia, to preventing avoidable blindness, she suggested the addition of a new preambular paragraph, to read: "Welcoming the important actions developed at regional, subregional and international levels by Member States with a view to achieving substantial progress in the elimination of avoidable blindness by an increase in international cooperation and solidarity," and a new paragraph 2(3bis), to read: "to strengthen cooperation through regional, subregional and international efforts with a view to achieving the goals set up by this resolution".

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked delegates for their support and the partners involved in the VISION 2020 initiative, including the International Agency for the Prevention of Blindness, the Christoffel Blindenmission, Sight Savers International, Lions Club International, Helen Keller International, and ORBIS. Without them and the many business leaders engaged in promoting public health services progress could not have been made.

She welcomed the emphasis placed on cooperation between developed and developing countries and among the latter, which should be further developed. The prevention of blindness and visual impairment would be given due consideration for inclusion in the Medium-term strategic plan 2008–2013 and the Proposed programme budget 2008–2009.

Dr ISLAM (Secretary) said that, in view of the various amendments proposed to the draft resolution, a revised text would be prepared for consideration at a later meeting.

It was so agreed.

(For approval of the draft resolution, see summary record of the eleventh meeting, section 2.)

Prevention and control of sexually transmitted infections: draft global strategy: Item 11.6 of the Agenda (Documents A59/11 and A59/11 Add.1) (continued from the eighth meeting, section 2)

Dr ISLAM (Secretary) read out some amendments proposed by a working group to the draft resolution contained in document A59/11. The third preambular paragraph would read: "Recognizing and reaffirming that, at the 2005 World Summit (New York, 14–16 September 2005), world leaders committed themselves to achieving universal access to reproductive health by 2015, as set out at the International Conference on Population Development,[2] and integrating this goal in strategies to attain the internationally agreed development goals, including those contained in the Millennium Declaration, and that attainment of the Millennium Development Goals, requires investment in, and commitment to, sexual and reproductive health, which includes prevention and control of sexually transmitted infections,". The new footnote 2 would read "International Conference on Population and Development, Cairo, September 1994.".

Paragraph 1 would read: "ENDORSES the Global Strategy for the Prevention and Control of Sexually Transmitted Infections, recognizing that, as appropriate, interventions are those that respond to the people's right and health and development needs, and provide access to sexual and reproductive

health information, life skills, education and care, and in the case of young people, in a manner consistent with their evolving capacities".

Paragraph 2 would read: "URGES Member States: (1) to adopt and draw on the strategies, as appropriate to national circumstances, in order to ensure that national efforts to achieve the Millennium Development Goals include plans and actions, appropriate to the local epidemiological situation, for prevention and control of sexually transmitted infections, including mobilization of political will and financial resources for these purposes;".

The CHAIRMAN invited the Committee to consider the draft resolution, as amended.

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

Dr GREGORICH-SCHEGA (Austria), speaking on behalf of the Member States of the European Union and Norway and supported by Mr MARTIN (Switzerland), said that the term "care" in paragraph 1 of the resolution, should be understood to include access to services, as set out at the International Conference on Population and Development (Cairo, 1994).

Mr BONNICI (Malta) expressed his country's full support for actions aimed at preventing and controlling sexually transmitted infections, and welcomed WHO's work and involvement in that area. In joining the consensus to approve the draft resolution, he reiterated his country's position that the references to sexual and reproductive health services contained in the Global Strategy should not be interpreted as creating an obligation on any party to consider abortion as a legitimate form of sexual and reproductive health service.

Ms MUIRURI (United States of America) maintained that there was an international consensus that the terms "reproductive health services" and "reproductive rights" did not include abortion, nor did they constitute support, endorsement or promotion of abortion or the use of abortive agents. She emphasized the value of comprehensive prevention strategies, and drew attention to abstinence for young people and other unmarried persons. It was essential to recognize the rights, duties and responsibilities of parents and other persons legally responsible for adolescents to provide, in a manner consistent with the evolving capabilities of the adolescent, appropriate direction and guidance on sexual and reproductive matters, education and other aspects of children's lives for which parents had the primary responsibility. Nothing in the Global Strategy created any right to abortion or could be interpreted to constitute support, endorsement or promotion of abortion.

Mr SOLANO (Costa Rica) said that he had interpreted the resolution to mean that sexual health and rights did not include abortion. In his country the right to life was a cardinal principle, not only from a legal perspective but also in terms of values and principles.

Sickle-cell anaemia: Item 11.4 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R3 and Annex 4, and A59/9) (continued from the seventh meeting)

The CHAIRMAN drew the Committee's attention to a revised draft resolution, as amended:

> The Fifty-ninth World Health Assembly,
> Having examined the report on sickle-cell anaemia;[2]

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA59.19.

[2] Document A59/9.

Recalling resolution WHA57.13 on genomics and world health, and the discussion of the Executive Board at its 116th session on control of genetic diseases, which recognized the role of genetic services in improving health globally and in reducing the global health divide;[1]

Recalling decision Assembly/AU/Dec.81 (V) of the Assembly of the African Union at its Fifth Ordinary Session;

Noting the conclusions of the 4th International African American Symposium on sickle-cell anaemia (Accra, 26–28 July 2000), and the results of the first and second international congresses of the International Organization to Combat Sickle-Cell Anaemia (respectively, Paris, 25–26 January 2002 and Cotonou, 20–23 January 2003);

Concerned at the impact of genetic diseases, and of sickle-cell anaemia in particular, on global mortality and morbidity, especially in developing countries, and by the suffering of patients and families affected by the disease;

Recognizing that the prevalence of sickle-cell anaemia varies between communities, and that insufficiency of relevant epidemiological data may present a challenge to effective and equitable management;

Deeply concerned at the absence of official recognition of sickle-cell anaemia as a priority in public health;

Recognizing the current inequality of access to safe and appropriate genetic services throughout the world;

Recognizing that effective programmes for sickle-cell anaemia must be sensitive to cultural practices, and appropriate for the given social context;

Recognizing that the pre-natal screening of sickle-cell anaemia raises specific ethical, legal and social issues that require appropriate consideration,

1. URGES Member States having sickle-cell anaemia as a public health problem:

   (1) to develop, implement and reinforce in a systematic, equitable and effective manner, comprehensive national, integrated programmes for the prevention and management of sickle-cell anaemia, including surveillance, dissemination of information, awareness-raising, counselling and screening, such programmes being tailored to specific socioeconomic, health systems and cultural contexts and aimed at reducing the incidence, morbidity and mortality associated with this genetic disease;

   (2) to work to ensure that adequate, appropriate and accessible emergency care is available to persons living with sickle-cell anaemia;

   (3) to develop their capacity to evaluate the situation regarding sickle-cell anaemia and the impact of national programmes;

   (4) to intensify the training of all health professionals and community volunteers in high-prevalence areas;

   (5) to develop and strengthen systematic medical genetics services and holistic care, within existing primary health care systems, in partnership with national and local government agencies, and nongovernmental organizations**,** including parent/patient organizations;

   (6) to promote community education, including health counselling, and associated ethical, legal and social issues;

   (7) to promote effective international cooperation in combating sickle-cell anaemia;

   (8) in collaboration with international organizations, to support basic and applied research on sickle-cell anaemia;

[1] See document EB116/2005/REC/1, summary record of the first meeting, section 4.

2. REQUESTS the Director-General:

(1) to increase awareness of the international community of the global burden of sickle-cell anaemia, and to promote equitable access to health services for prevention and management of the disease;
(2) to provide technical support and advice to national programmes of Member States through the framing of policies and strategies for prevention and management of sickle-cell anaemia;
(3) to promote and support**:**
(a) intercountry collaboration to develop training and expertise of personnel and to support the further transfer of advanced technologies and expertise to developing countries;
(b) the construction and equipment of referral centres for care, training and research;
(4) to continue WHO's normative functions in drafting guidelines, including good practices and practical models**,** on prevention and management of sickle-cell anaemia with a view to elaborating regional plans and fostering the establishment of regional groups of experts;
(5) to promote, support and coordinate the research needed on sickle-cell disorders in order to improve the duration and quality of life of those affected by such disorders.

The draft resolution was approved.[1]

Infant and young child nutrition: quadrennial report: Item 11.8 of the Agenda (Document A59/13)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Bahrain, Belize, Benin, Botswana, Costa Rica, Fiji, Gambia, Ghana, Libyan Arab Jamahiriya, Marshall Islands, Micronesia, Nauru, Nicaragua, Oman, Palau, Papua New Guinea, Samoa, Solomon Islands, Swaziland, Tuvalu, Yemen and Zimbabwe, which read as follows:

The Fifty-ninth World Health Assembly,

Having considered the report on infant and young child nutrition which highlights the contribution of optimal infant feeding practices to achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration;[2]

Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA47.5, WHA49.15 and WHA54.2 on infant and young child nutrition, appropriate feeding practices and related questions;

Reaffirming in particular resolutions WHA44.33 and WHA55.25 which respectively welcomed the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding and endorsed the Global Strategy for Infant and Young Child Feeding as the foundations for action in the protection, promotion and support of breastfeeding;

Welcoming the Call for Action contained in the Innocenti Declaration 2005 on Infant and Young Child Feeding;

Mindful that 2006 marks the twenty-fifth anniversary of the adoption of the International Code of Marketing of Breast-milk Substitutes and recognizing its increased relevance in the

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA59.20.

[2] Document A59/13.

wake of the HIV/AIDS pandemic, rising frequency of complex human and natural emergencies, and concerns about intrinsic contamination of powdered infant formula;

1. REITERATES its support for the Global Strategy for Infant and Young Child Feeding;

2. ENDORSES in its entirety the Call for Action made in the Innocenti Declaration 2005 on Infant and Young Child Feeding as a significant step towards achievement of the fourth Millennium Development Goal to reduce child mortality;

3. URGES Member States to implement this Call for Action and, in particular, to renew their commitment to policies and programmes related to implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions and to the revitalization of the Baby-Friendly Hospital Initiative to protect breastfeeding;

4. CALLS on multilateral, bilateral and international financial institutions to increase financial resources for Member States to carry out these efforts;

5. REQUESTS the Director-General to mobilize technical support for Member States in the implementation and independent monitoring of the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions.

Dr AL KHARABSEH (Jordan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that in some countries in his Region between half and two thirds of the burden of diseases such as diarrhoeal diseases, measles, malaria and lower respiratory tract infections among children under the age of five could be attributed to undernutrition in infancy and early childhood. The Global Strategy for Infant and Young Child Feeding had been successful in drawing the world's attention to the impact that feeding practices had on the nutritional status, growth, development and survival of infants and children.

In several Member States of the Region, the goal of halving levels of undernutrition in young children was unlikely to be met by 2015. It was therefore essential that support continued to be provided to Member States in order to keep the question of adequate nutrition for infants and young children high on the political agenda. Adequate resources, both technical and financial, were needed in Member States in order to apply the Global Strategy to national circumstances. He recommended giving priority to promoting exclusive breastfeeding for the first six months of life, and to equipping mothers and other caregivers with the requisite knowledge about appropriate supplementary feeding. Technical and financial resources would also be required by Member States experiencing complex emergencies in order to improve their national capacities to feed infant and young children in exceptionally difficult circumstances.

Dr SADRIZADEH (Islamic Republic of Iran) supported the draft resolution. The Call for Action in the Innocenti Declaration 2005 on Infant and Young Child Feeding excellently encapsulated what was needed in order to promote breastfeeding. More studies confirmed that exclusive breastfeeding gave protection against a wide range of diseases and infections and even obesity. On the occasion of the twenty-fifth anniversary of the International Code of Marketing of Breast-milk Substitutes, he expressed support for the view that only through legislation would breastfeeding and adequate supplementary feeding receive adequate protection.

Dr HASSAN (Chad) said that a survey carried out in Chad in 2004 had shown that 37% of children under five were underweight, 13.5% were emaciated and 41% experienced stunted growth. Malnutrition accounted for 49% of deaths among children aged between three and five. In combatting malnutrition, Chad received support from its traditional partners such as WHO and UNICEF and,

through bilateral and multilateral cooperation from nongovernmental organizations and friendly countries.

Dr MADZIMA (Zimbabwe) said that her Government was committed to achieving the goals for implementing the Global Strategy for Infant and Young Child Feeding. Some 60% of the budget for implementing infant and young child nutrition strategies came from governments. Zimbabwe was one of the 32 countries to have incorporated the International Code of Marketing of Breast-milk Substitutes into domestic legislation. Although there was reason to celebrate the twenty-fifth anniversary of the Code, the need for technical support from WHO and its partners continued. Since the introduction of the Baby-friendly Hospital Initiative training and assessment tools developed by WHO and UNICEF, one hospital in her country had been awarded baby-friendly status, providing a basis for measuring the success of the Initiative. In 2004 Zimbabwe had introduced into the nursing curriculum a combined course on breastfeeding and infant feeding. Since then, more than 146 tutors had been trained and 1281 primary care nurses had graduated with infant-feeding counselling skills. In addition, her country had produced a protocol for the management of acute severe malnutrition, and more than 2000 health workers had since been trained to follow it. With support from UNICEF, Zimbabwe was piloting a ready-to-use therapeutic food at eight sites. She supported the draft resolution, but proposed replacing the word "implement" in paragraph 3 by "support".

Mr KAZENENE (Zambia) highlighted the health, cost and family planning advantages of breastfeeding. In a developing country like Zambia, the risk of death for infants who were not breastfed was 10 to 15 times greater in the first three to four months of life than for babies fed exclusively on breast milk. Encouraging, protecting and promoting breastfeeding was part of Zambia's national health policy. The International Code of Marketing of Breast-milk Substitutes had been incorporated into Zambia's domestic legislation – an act of investment in the nation's children.

Ms DLAMINI (Swaziland), speaking on behalf of the Member States of the African Region, said that, on the occasion of the twenty-fifth anniversary of the International Code of Marketing of Breast-milk Substitutes, many countries in Africa had incorporated all, or nearly all, the Code's provisions and resolutions. Many African countries were implementing the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding, and the Global Strategy for Infant and Young Child Feeding. She endorsed the Call for Action in the Innocenti Declaration 2005, which was a milestone in achieving better infant health. In view of the risks involved in formula feeding, and commercial interference with decisions by breastfeeding mothers, the International Code must be implemented and endorsed in both recipient and exporting countries. Some countries in the Region had revised their policies and guidelines on HIV and infant feeding. More than 8000 health workers had been trained in counselling on breastfeeding, HIV infection and infant feeding. Babies in the African Region were more vulnerable than anywhere else, and implementing the Code would help them to get the best possible start in life. She called upon all Member States to renew their commitment to the International Code and to all relevant subsequent resolutions. She encouraged partnership and collaboration among stakeholders, including organizations of the United Nations system, the public and private sector and civil society, in order to mobilize all financial resources and rapidly scale up infant and young child feeding activities at national, regional and community levels.

Mr GAUDÊNCIO (BRAZIL) recalled that Brazil had been among the first countries to incorporate the International Code of Marketing of Breast-milk Substitutes into law. He urged other Member States to follow suit. The Code had made a significant difference; slowly but surely, rates of exclusive breastfeeding had risen. Brazil had endorsed the 1990 and 2005 Innocenti Declarations, and endorsed the draft resolution.

Ms GONZÁLEZ MOREL (Mexico) said that Mexico had implemented various health strategies and policies within the framework of the Global Strategy for Infant and Young Child Feeding. The country's child health-care programmes included care for pregnant women, the promotion of exclusive

breastfeeding until the age of six months, and proper weaning and incorporation of the family diet into feeding at the age of one year. Mexico had also set official standards for basic health services, nutritional health promotion and training, and child health, which latter highlighted the importance of correct feeding for infants. Guidelines also existed for population groups suffering from malnutrition, overweight and obesity. Official standards also governed breast-milk substitutes. Mexico was interested in the Secretariat's work on an international growth reference for school-age children and adolescents. She emphasized the increased prevalence of overweight and obesity in those age groups.

She supported the draft resolution, but sought more emphasis in the fifth preambular paragraph on the conservation, preparation and handling of breast-milk substitutes than on concerns about their intrinsic contamination.

Dr MUÑOZ (Uruguay) commended the quadrennial report, and said that implementation of the Global Strategy for Infant and Young Child Feeding was crucial to the survival of her country, where 50% of children were born below the poverty line. By adopting the Global Strategy, Uruguay aimed to improve feeding for the relevant age groups and the quality and control of care in pregnancy and childbirth. Flour had been fortified with folic acid and iron, because half the country's children under the age of two born into poor households suffered from iron-deficiency anaemia. The problem of teenage pregnancies had serious implications for infant and young child feeding since it was mostly teenage mothers who gave up breastfeeding during the first few months, and training had therefore begun for medical staff, midwives, nurses and social workers in health care for adolescents. Teenage parents were being educated in order to delay a second pregnancy and to promote exclusive breastfeeding for six months (compulsory for all working women in Uruguay); home visits were made in order to check the baby's health; and their educational, social and vocational integration was fostered.

Dr MATHESON (New Zealand), confirming that breastfeeding was the best way to feed infants, said that his country was implementing the International Code of Marketing of Breast-milk Substitutes; actions included the Baby-friendly Hospital Initiative and the establishment of a national breastfeeding committee.

He supported the draft resolution and proposed the insertion in the second preambular paragraph of a reference to resolution WHA58.32. In paragraph 2 he proposed the replacement of the word "ENDORSES" by the word "WELCOMES", which was consistent with the Health Assembly's response to the 1990 Innocenti Declaration in resolution WHA44.33. In paragraph 3 the word "implement" should be replaced by the words "act on", and the words "related Health Assembly resolutions" by the words "relevant Health Assembly resolutions" (and similarly in paragraph 5). The key message to send to donors was that the area of work in question was a priority; to that end, he proposed that in paragraph 4 the word "increase" be replaced by the word "direct" and that for greater clarity the words "donor arrangements" be inserted after the word "bilateral".

Ms MOENG (South Africa) welcomed the report and supported the draft resolution, as amended by Zimbabwe. She confirmed the importance of commitment to the International Code. Appropriate infant feeding contributed to improved child-survival rates, and was a basis for the attainment of children's rights. WHO had established several new child survival strategies, summarized in the Global Strategy for Infant and Young Child Feeding, and she expressed concern about endorsing those strategies in view of the limited resources available. Greater emphasis should be placed on strengthening existing strategies. The mode of infant feeding for mothers choosing alternative feeding was a challenge; her country was committed to supporting research on the practical implementation of cup feeding in order to avoid bottle-feeding. Cups were safer than bottles, especially in conditions of poor sanitation and drinking-water quality. She looked forward to the first set of new child-growth standards, which established the breastfed infant as the normative model for growth. That should provide a true reflection of the growth status of children in Africa, most of whom were breastfed.

South Africa had implemented several strategies to counter micronutrient deficiencies. Folic acid supplement was provided to all pregnant women during the first three months of pregnancy, but

the timely provision of that supplement remained a challenge since most women were late in registering for antenatal care. The number of baby-friendly health facilities had been increased, but exclusive breastfeeding rates were still relatively low, and population-based approaches therefore needed to be strengthened. Her country had adopted the WHO/UNICEF recommendation on the provision of zinc supplement for the treatment of acute and persistent diarrhoea in young children. It had reviewed the guidelines for integrated management of childhood illness in order to ensure that zinc was part of the treatment protocol. Consultations were well advanced on drawing up regulations on foodstuffs for infants and young children, which would complement the country's infant and young child feeding policy and guidelines.

Dr OTTO (Palau) expressed satisfaction that the goal of reducing the 1990 levels of underweight by 50% was expected to be reached in eastern and south-eastern Asia. The proposed resolution would help other regions to reach that goal, as well as the fourth Millennium Development Goal to reduce child mortality; a key element was the reference to the Innocenti Declaration 2005 and its Call for Action. The relatively slow increase in the global rate of exclusive breastfeeding among infants less than six months old between 1990 and 2001 was discouraging as breastfeeding was the single most effective public health measure for increasing the survival and improving the quality of life of infants and children, especially when compared with the near doubling of the annual turnover of the breastfeeding substitutes market.

Breastfeeding would be the norm for WHO's first set of new child-growth standards, and could help to counter the increase in childhood obesity, which was largely due to a diet that had become increasingly saturated with unhealthy, but highly marketed, food products. In his speech to the Health Assembly His Royal Highness Prince Charles had suggested that health interventions should be judged on the criteria of whether they were "human-efficient" and encouraged better physical and mental health, satisfaction with life; breastfeeding fully met those criteria.

He announced that the International Code had just been incorporated into domestic legislation in Palau. He thanked the Regional Office for the Western Pacific, UNICEF and other partners for their continuous support in helping Member States to implement the International Code and the Global Strategy for Infant and Young Child Feeding. The Code was often misunderstood as a tool for pushing breastfeeding at all costs, but that was not true; once implemented, it allowed mothers to decide for themselves what was best for their babies. Freedom of choice by removing commercial pressure was the main goal. He supported the amendments to the draft resolution proposed by New Zealand.

Ms RIMESTAD (Norway), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, urged further implementation of the Global Strategy for Infant and Young Child Feeding at the national level. The prevalence of childhood undernutrition, particularly in Africa, was a cause for concern. The importance of breastfeeding had been identified in reducing child mortality and should be promoted. The twenty-fifth anniversary of the International Code of Marketing of Breast-milk Substitutes should revitalize the Code in order to protect breastfeeding and to improve infant feeding and health. Resources were needed for implementation of the new International Growth Standards for Infants and Young Children. Activities to promote, support and protect breastfeeding should be linked to the healthy growth of children. The Baby-friendly Hospital Initiative was a most effective measure to support breastfeeding, and it could be expanded to include neonatal intensive care units and child health clinics at the international level. Priority should also be given to activities relating to breastfeeding and HIV/AIDS.

The Nordic countries would continue their national efforts to improve child nutrition and health, and would further collaborate in that regard with the Secretariat. They supported the draft resolution, but considered that it should have been submitted to the Executive Board before the Health Assembly.

Dr PUANGPEN CHANPRASERT (Thailand) said that the problems of protein-energy and micronutrient malnutrition, vitamin and mineral deficiencies still had to be resolved in some regions, and the implementation of the Global Strategy for Infant and Young Child Feeding should be continued. Although the number of baby-friendly maternity facilities wordwide had increased, the rate

of exclusive breastfeeding had risen only minimally. Policies to promote breastfeeding should therefore be continued, and complementary feeding from six months encouraged in order to reduce malnutrition. In her country all government hospitals were baby-friendly, and a comprehensive review of the national breastfeeding programme was being undertaken with a view to increasing it effectiveness.

With reference to paragraph 2 of the draft resolution, she endorsed the Call for Action made in the Innocenti Declaration 2005. In paragraph 3 she proposed that the words ", promote and support" be added after "to protect".

Ms VALDEZ (United States of America) said that malnutrition was responsible for more than 5.3 million deaths a year among children under five, and agreed that fetal and infant undernutrition contributed to the increasing risk of obesity. The global strategies for infant and young child feeding and on diet, physical activity and health provided sound frameworks for improving the nutrition of infants and children. Her Government remained committed to increasing breastfeeding rates throughout the country, and to promoting optimal breastfeeding practices. The guide to breastfeeding interventions for all States provided mothers with the information that best met their needs. The National Institutes of Health were leaders in research on breastfeeding, including studies on HIV and breastfeeding risk. In order to avoid confusion at the local level, the Director-General should make clear to Member States and health-care providers that the new International Growth Standards for Infants and Young Children represented an ideal, rather than a reference for growth in a real-world setting.

Because the Call for Action in the Innocenti Declaration 2005 was directed at a number of stakeholders outside the purview of governments, she suggested that the amendment proposed by New Zealand to paragraph 3 might be further refined by inserting "as appropriate" after "to act".

Dr AYDINLI (Turkey) said that at the end of 2005, as part of a national project aimed at lowest income groups, his Government had provided cash assistance to more than 700 000 children up to six years of age and to prospective mothers for primary health-care services. More than 300 hospitals had become baby-friendly. The breastfeeding rate was increasing, and the rate of exclusive breastfeeding stood at 21%. By the end of 2005, 1.6 million babies in Turkey had been given iron supplements as part of an iron-deficiency anaemia control project. About 750 000 babies had been given vitamin D supplements, and a programme in order to remedy iodine deficiency was aimed at the 31% of the population who were at risk of that condition.

Mr A.P. SINGH (India) welcomed the report. Through policy and legislation, India was doing its best to reduce malnutrition in children and to promote breastfeeding. It had some of the most stringent legislation of any country in order to protect breastfeeding from commercial influence, under which any health or nutrition claims on the labelling of foods for infants and young children were prohibited by law. Success was borne out by the declining infant mortality rates in the country. He reaffirmed the importance of the work of the Codex Alimentarius Commission in elaborating safety standards and guidelines on foods for infants and young children, and drew attention to the need for a participatory process in that regard.

He reaffirmed his commitment to the Global Strategy for Infant and Young Child Feeding, and supported the draft resolution.

Dr ZAMPALIGRE (Burkina Faso) said that protein-energy malnutrition and micronutrient malnutrition were major problems for the under-fives in Burkina Faso. Malnutrition rates were particularly high for children aged six to 23 months and those of single mothers. The situation was exacerbated by poor diet, lack of knowledge among field workers, the lack of training and experience of local health workers, insufficient funds, and a deprived social environment.

Parts of the country had experienced a food crisis in 2005, and steps taken to improve the situation had included: information on feeding in the context of HIV infection; publication of a nutritional guide for health professionals; vitamin A and iron supplementation; and promotion of

breastfeeding. Future activities would include a national policy for infant and young child feeding that took into account HIV/AIDS. WHO should continue to provide support to African countries in general, and Burkina Faso in particular, for monitoring the nutritional health of the population and especially children. She supported the draft resolution.

Dr ST JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, acknowledged the importance of breastfeeding. Policies for creating supportive environments for infant and young child feeding had been elaborated by the Caribbean Food and Nutrition Institute, and baby-friendly hospitals had been designated. Many of the countries had adopted the International Code of Marketing of Breast-milk Substitutes, and, in view of the regional prevalence of HIV/AIDS, had actively discouraged breastfeeding by HIV-positive mothers and provided them with replacement feeds as necessary. Feeding programmes that supported the nutritional needs of all schoolchildren, particularly those in vulnerable populations, were well established in the region, and the International Growth Standards for children under five were being implemented thanks to the support of PAHO. She supported the draft resolution.

Dr MASSÉ (Canada) said that the International Code of Marketing of Breast-milk Substitutes should be adapted to suit political, economic and social conditions in particular countries. He supported the draft resolution, but some text required clarification. For example, the fifth preambular paragraph, as currently worded, implied that breast-milk substitute products were intrinsically unsafe and that the risk stemmed solely from the manufacturing process. In the case of a dehydrated product it was not possible to produce powdered formulae without microorganisms at low levels, and the end-user as well as the manufacturer had to therefore exercise good hygienic practices. He suggested replacing the phrase "and concerns about intrinsic contamination of powdered infant formula" by "recognizing the need to provide guidance on the safe manufacturing, preparation, handling, and use of powdered infant formula where needed".

Dr KOKKINAKIS (Austria), speaking on behalf of the European Union and its Member States, welcomed the draft resolution, but proposed adding "the risks of" before "intrinsic contamination" in the fifth preambular paragraph; replacing "ENDORSES" in paragraph 2 with "WELCOMES," as suggested by New Zealand; and replacing "implement" in paragraph 3 with "support".

Ms MATA (Bolivarian Republic of Venezuela) said that her country, in line with the Millennium Development Goals, was giving priority to reduction of maternal and infant mortality. In 2006, it had launched a project aimed at pregnant women and the under-fives in the context of breastfeeding, complementary feeding, vaccination and education. Community involvement at the national level was one of the project's great successes. In order to promote breastfeeding, community facilities had been established that gave guidance to mothers. Some 17 establishments had been certified as baby- and mother-friendly. Since 2004, legislation had been introduced requiring the labelling of formulae and complementary foods in order to comply with the International Code of Marketing of Breast-milk Substitutes. Legislation had also been elaborated concerning the operation of breast-milk banks and facilities for wet-nursing that would enable more than 15 000 children in special situations to continue natural feeding. Maternity leave had been increased from four to six months, and working mothers were allowed two one-hour breaks instead of two half-hour breaks for breastfeeding. She strongly supported the draft resolution.

Ms ZHANG Lingli (China) said that, because low birth weight was an important public health problem, China aimed to achieve the goal of a 50% reduction in 1990 levels of underweight by 2015. It had always promoted breastfeeding and appropriate complementary feeding. A multifaceted approach had been adopted for improving infant and young child nutrition, with emphasis on rural areas. A national study was being undertaken into low birth weight and vitamin A and iron deficiency. Since 1995, China had been implementing the International Code of Marketing of Breast-milk Substitutes. In 2005 it had organized a joint seminar with WHO and UNICEF on implementation of

the Code and in order to review regulations governing the production of breast-milk substitutes in China. She urged WHO to strengthen its support to developing countries in their efforts to achieve the Millennium Development Goals.

Mr CHO Do-yeon (Republic of Korea) said that his Government was extending a special supplementary nutrition programme for women, infants and children throughout the country. Prevalence of anaemia had decreased with a considerable increase in breastfeeding. He welcomed WHO's efforts to promote and protect the health of infants and young children, and endorsed the draft resolution as amended by Austria.

Dr NODA (Japan) said that exclusive breastfeeding was a cheap and effective way of reducing infant morbidity and mortality, and should be encouraged if the Millennium Development Goals were to be achieved. National action plans should implement the Global Strategy for Infant and Young Child Feeding, particularly in countries with high rates of infant mortality. He endorsed the Baby-friendly Hospital Initiative. As both child health and maternal health programmes would be required for the promotion of exclusive breastfeeding, those should be discussed by the Global Partnership for Maternal, Newborn and Child Health established in 2005.

Although Japan had been promoting breastfeeding since 1975, it understood the importance of the International Code of Marketing of Breast-milk Substitutes in the attainment of the Millennium Development Goals. The draft resolution should take into account differences in health policy among Member States, and he therefore supported the amendment put forward by the delegate of the United States of America.

Dr KAGGWA (Uganda) said that the nutritional status of the general population in Uganda was still poor; 28% and 52% of children and women respectively had vitamin A deficiency, and 65% of children and 30% of women were suffering from anaemia. Various strategies were being implemented. In the area of protein-energy malnutrition, growth promotion and monitoring had been initiated. For micronutrient malnutrition, some industries, including those processing of wheat and maize flour, had begun to fortify their products, and Uganda had hosted a regional meeting on sustainable partnerships for food fortification in 2005. Programmes for nutrition in emergencies and for the management of severe malnutrition were being implemented, and the level of acute malnutrition had fallen overall from 34% in 2002 to 4% in 2005.

The Global Strategy for Infant and Young Child Feeding had been adopted in Uganda and incorporated into the five-year health sector strategy. Infant and young child feeding was being expanded, and all units for the prevention of mother-to-child transmission of HIV had received guidance on feeding by HIV-infected mothers. About 100 health facilities with maternity services were implementing the Baby-friendly Hospital Initiative, and 15 had recently been awarded "baby-friendly" status. The regulations for the marketing of infant and young child foods that had become law in 1998 would be revised in order to take into account HIV/AIDS and the International Code of Marketing of Breast-milk Substitutes.

Challenges included improving the interface between health centres and the community, and introducing sustainable feeding options for the children of HIV-positive mothers. Resources should be mobilized for expansion of infant and young child feeding programmes at all levels. The capacity of recognized community structures, such as village health teams, should be strengthened. Research into feeding options for HIV-positive mothers should be prioritized. He endorsed the draft resolution.

Ms PÉREZ ALVAREZ (Cuba) supported the draft resolution. Despite having been blockaded during almost half a century her country had maintained its compliance with the standards and recommendations of the International Code of Marketing of Breast-milk Substitutes and the Global Strategy for Infant and Young Child Feeding. The Code of Practice for the preparation of baby and infant foods was being revised, and maternal breastfeeding up to the first six months of life was being prioritized, as was provision of safe complementary foods and meeting the nutritional needs of high-risk children.

The Baby-friendly Hospital Initiative should be supported and extended in order to include primary health care. WHO should assist countries and regions in states of emergency, especially African countries with high levels of malnutrition and infants and children at serious risk, notably due to HIV/AIDS and other childhood illnesses. Low birth weight should continue to be studied, and guidelines for its prevention and control should be prepared.

Dr CHUI SOI LEK (Malaysia) said that his country emphasized the health of infants and young children, promoting breastfeeding and taking national measures to implement the International Code of Marketing of Breast-milk Substitutes, including revision of the 1979 Code of Ethics for Infant Food Products so as to minimize the endorsement by medical and health professionals of commercially-produced foods, such as infant foods. Malaysia maintained its firm stand against the unethical promotion of commercial infant food formulae in competition with breast milk. Efforts were currently being made to provide a minimum of 12 weeks maternity leave, to replace the current five weeks. All Government hospitals complied with the Baby-friendly Hospital Initiative, and private health facilities were beginning to do so. Legal requirements had been introduced governing infant food formulae and food products for young children, including provisions on labelling. Malaysia fully supported the draft resolution.

Dr CHAOUKI (Morocco) welcomed the report and supported the draft resolution. His country had rates of 52% for early breastfeeding and about 32% for exclusive breastfeeding up to the age of six months. A national plan for the promotion of breastfeeding included audiovisual aids, campaigns to raise public awareness, intersectoral cooperation, and incorporation of the subject into training for health professionals. Other measures included the elaboration of a national code for marketing infant feeding products, the extension of maternity leave from 60 to 90 days, and the provision of a rest period of one hour per day for breastfeeding working mothers. Figures for low birth weight were 10%, slow growth rate around 18%, and acute malnutrition in children under five years of age 9.3%; the prevalence rates for vitamin A deficiency were 40%, iron deficiency 30%, iodine deficiency 22% and vitamin D deficiency 2.5%. Recommendations on infant and young child feeding had been incorporated into care of childhood illnesses.

Dr VILLAVERDE (Philippines) reaffirmed his country's commitment to the Global Strategy for Infant and Young Child Feeding. It had recently revised and improved the Philippine Milk Code. He supported the draft resolution, which would contribute to the attainment of the Millennium Development Goal of reducing infant and child mortality.

Dr GASHUT (Libyan Arab Jamahiriya) commended the report, and emphasized the positive effects of breastfeeding on the health of children under five years of age. She endorsed the draft resolution as amended by Austria.

Mr JALLOW (Gambia) supported the statement by the delegate of Palau. Breastfeeding was a most cost-effective intervention for saving the lives of infants and young children, and was prioritized in Gambia's national health and nutrition policies. The Baby-friendly Hospital Initiative was being implemented. Between 1988 and 2000 the exclusive breastfeeding rate had doubled to 35%, and the current rate for infants under six months was 46%. Gambia had a national code on the marketing of breast-milk substitutes, and was one of the few countries in sub-Saharan Africa in which a downward trend in child malnutrition had been recorded. Gambia thanked WHO, UNICEF, the World Bank and other development partners for support.

Dr MASSÉ (Canada) accepted the amendment to the the fifth preambular paragraph of the draft resolution proposed by Austria. He therefore withdrew Canada's amendment in that regard.

Mrs ALABI (Ghana) emphasized breastfeeding's contribution towards the fourth Millennium Development Goal. Studies in her country indicated that, if begun in the first hour after birth,

breastfeeding could significantly reduce neonatal deaths. Ghana applied the International Code of Marketing of Breast-milk Substitutes. She supported statements made by the delegates of Swaziland and Palau, and strongly supported the draft resolution.

Ms ARENDT LEHNERS (International Lactation Consultation Association), speaking at the invitation of the CHAIRMAN, said that the Association had worked with WHO and UNICEF on the Innocenti Declaration 2005 on Infant and Young Child Feeding, which she urged delegates to put into practice. Progress since the 1990 Innocenti Declaration showed that major strides towards achieving Millennium Development Goals could be made if babies were exclusively breastfed for six months and if breastfeeding continued for two years and beyond, with appropriate complementary food.

Many governments had incorporated the International Code of Marketing on Breast-milk Substitutes into their legislation; she called on those that had not to implement the Code and the relevant Health Assembly resolutions in their entirety.

Dr BRONNER (International Special Dietary Food Industry), speaking at the invitation of the CHAIRMAN, said that her organization had played a part in the development of the International Code of Marketing of Breast-milk Substitutes. The infant food industry recognized the twenty-fifth anniversary of the Code as a milestone, and was cooperating with implementation at country level. It was promoting transparent monitoring and reporting and establishing monitoring agencies under government authority. The number of governments taking up the task of monitoring and implementation had grown over the past 25 years. Manufacturers had made significant progress in improving marketing practices and helping to ensure the proper use of breast-milk substitutes. The industry reiterated its support for the Global Strategy on Infant and Young Child Feeding, and commended the efforts of governments and other stakeholders to implement it. It would continue its research with a view to producing food designed to meet the needs of infants and young children in accordance with approved scientific criteria.

Dr Mazzetti Soler took the Chair.

Ms ALLAIN (Consumers International), speaking at the invitation of the CHAIRMAN, said that records showed that, 25 years after adoption of the International Code of Marketing of Breast-milk Substitutes, only 32 countries had enacted legislation incorporating its provisions, 44 had laws which only partially controlled the marketing of such substitutes, and a further 18 had a voluntary policy lacking enforcement mechanisms. The International Code Documentation Centre would continue to provide support to countries in drafting legislation and in strengthening existing laws. Although the record on Code implementation was relatively good, enforcement was often lacking, and spot-check monitoring revealed violations. The annual turnover of the baby food market had grown to more than US$ 20 000 million. Companies paid lip service to the Code but constantly found new ways to win customers, spending an annual average of US$ 30 per baby on product promotion while government spending on promoting breastfeeding was just US$ 0.21 per baby. Only legislation to curb commercial promotion of substitutes could give breastfeeding a fair chance.

She stressed that failure to breastfeed entailed certain risks. According to UNICEF, six million lives were saved every year by improved breastfeeding, which also protected against obesity. She urged Member States to adopt the Code, which was the only way to protect the world's most vulnerable citizens.

Ms BAILLIE (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pediatric Association, the International Union of Nutritional Sciences, the International Diabetes Federation and the World Heart Foundation, which together had formed the Global Prevention Alliance, welcomed WHO's international growth standards for infants and young children, which provided a powerful indicator for minimizing early development of childhood obesity. Obesity must not be allowed to overtake a further generation while methods for measuring children's obesity levels were being refined. A report and forecasts made public by her

Association's International Obesity Task Force had highlighted the scale of childhood obesity, indicating that the epidemic was gathering pace. The adoption of WHO's international growth standards must, therefore, be accompanied by vigorous implementation of a strategy to ensure that the world's young were not pushed even faster along the path to obesity and its associated diseases.

Dr LE GALÈS-CAMUS (Assistant Director-General) acknowledged the support given by countries and organizations to the project that had led to the recently published WHO child growth standards.[1] Those standards, which made breastfeeding a biological norm, showed that economic, sanitary and social conditions were more responsible for variations in growth than, for example, genetic factors. They provided an exceptional instrument for monitoring growth among children worldwide, and made possible the early detection of any anomaly, together with the application and subsequent evaluation of appropriate interventions. The standards would be all the more useful given the double burden of malnutrition and childhood obesity faced by a growing number of countries.

Mr AITKEN (Adviser to the Director-General) said that the Secretariat had not yet issued a document detailing the financial implications of the draft resolution under consideration. The total cost over its life-cycle was US$ 650 000; and, of that cost, US$ 200 000 could be subsumed under existing programmed activities. The balance would therefore have to be found from other sources.

Dr ISLAM (Secretary) said that, following the amendment proposed by the delegate of New Zealand, the second preambular paragraph would read: "Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA47.5, WHA49.15, WHA54.2 and WHA58.32 on infant and young child nutrition, appropriate feeding practices and related questions;". Following the amendment by the delegate of Austria, the last preambular paragraph would read: "Mindful that 2006 marks the twenty-fifth anniversary of the adoption of the International Code of Marketing of Breast-milk Substitutes and recognizing its increased relevance in the wake of the HIV/AIDS pandemic, rising frequency of complex human and natural emergencies, and concerns about the risk of intrinsic contamination of powdered infant formula;". The beginning of paragraph 2 would read: "WELCOMES in its entirety the Call for Action made in the Innocenti Declaration 2005 on Infant and Young Child Feeding as a significant step …".

Dr MATHESON (New Zealand) said that, following discussion between interested delegates, it was proposed that paragraph 3 should read: "URGES Member States to support action on this Call for Action and, in particular, to renew their commitment to policies and programmes related to the implementation of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions and to the revitalization of the Baby-Friendly Hospital Initiative to protect, promote and support breastfeeding;".

Dr ISLAM (Secretary) said that paragraph 4 would read: "CALLS on multilateral and bilateral donor arrangements and international financial institutions to direct financial resources for Member States to carry out these efforts;". Following an amendment by the delegate of New Zealand, paragraph 5 would read: "REQUESTS the Director-General to mobilize technical support for Member States in the implementation and independent monitoring of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant Health Assembly resolutions."

[1] *WHO child growth standard: length/height-for-age, weight-for-age, weight-for-length, weight-for-height and body mass index-for-age: methods and development.* Geneva, World Health Organization, 2006.

Ms VALDEZ (United States of America) said that she had understood that the proposal by the delegate of New Zealand for paragraph 2 had been to substitute "WELCOMES" for "ENDORSES in its entirety".

Dr MATHESON (New Zealand) confirmed that that was the case.

Mrs ALABI (Ghana) disagreed with the wording: "URGES Member States to support …" in paragraph 3. Something more than support would be needed if the resolution was to be effective. In her country, international and global trade made it difficult to implement the International Code. It was not enough for the Code to be implemented in 32 countries: every country should be able to implement it. She suggested using "to act upon" instead of "to support".

Dr MATHESON (New Zealand) said that various different wordings had been proposed for paragraph 3, including "to implement", "to support", "to act on" and "to act on, as appropriate". The proposed compromise solution had been "to support action on" so that the beginning of the paragraph would read: "URGES Member States to support action on this Call for Action …".

Mrs ALABI (Ghana) commented that, in a small economy like Ghana's, when imported products arrived that did not meet official standards, it was difficult to implement the International Code because that would create artificial shortages for children in need. The wording should impose a moral obligation on such countries to implement the International Code themselves. For that reason, "to act upon" was preferable to "to support".

Ms VALDEZ (United States of America) favoured a compromise solution, since the Innocenti Declaration 2005 also made recommendations to a wide range of stakeholders, including industry, financial institutions and nongovernmental organizations. The use of "to act upon" would not therefore be appropriate in respect of the recommendations addressed to stakeholders outside government.

Mrs ALABI (Ghana) pointed out that the report had stated that the International Code supported other initiatives, including the Global Strategy for Infant and Young Child Feeding, in order to achieve Millennium Development Goal 4. She questioned whether the current choice of words had really been made in the interests of children and infants or whether there were other interests in play. Based on her country's experiences, she would still support the use of "to act upon", where necessary.

Mr AITKEN (Adviser to the Director-General), clarifying the position, said that the issue hinged on whether Ghana felt that all recommendations in the Innocenti Declaration should be acted upon by governments, or only those recommendations directed towards governments. The United States' view was that "to act upon" was not relevant for the whole Declaration. The Committee therefore needed to find wording that would specify that the paragraphs directed towards governments should be acted upon, while the other paragraphs should be supported.

The CHAIRMAN suggested that the delegations of Ghana, New Zealand and the United States of America, together with any other delegations wishing to participate, should meet in order to seek a wording of the text that was acceptable to all.

It was so agreed.

(For approval of the draft resolution, see summary record of the tenth meeting.)

The meeting rose at 18:25.

TENTH MEETING

Friday, 26 May 2006, at 18:30

Chairman: Dr P. MAZZETTI SOLER (Peru)
later: Dr A. RAMADOSS (India)
later: Dr P. MAZZETTI SOLER (Peru)

TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

WHO's contribution to implementation of the strategy for child and adolescent health and development: Item 11.9 of the Agenda (Document A59/14)

Ms VALLIMIES-PATOMÄKI (Finland) said that the strategy for child and adolescent health and development, together with other programmes concerning children's health, had provided needed support and guidelines. Although in some countries development had stopped or even regressed, the situation could be changed. Work on translating global and regional policy recommendations into national strategies and action plans should be accelerated. Investing in child and adolescent health was a cost-effective way to secure the future well-being of nations. That required strong commitment from political leaders and should be identified as a strategic investment in national budgets.

All available means should be used in order to reduce child mortality, including promotion of breastfeeding, particularly given new evidence that breastfeeding in the first hour of life could save almost one million babies' lives per year. Emphasis should be given to access to maternal care and skilled birth attendants.

More should be done in all sectors of society in order to prevent childhood obesity, especially in developed countries, and early contact of children with care services should be promoted all over the world. Stronger focus was needed on adolescents' health, including sexual and reproductive health, by using age-specific information, counselling and services that were relevant to specific age groups.

Dr Ramadoss took the Chair.

Mr RUÍZ MATUS (Mexico) said that, in accordance with the commitments made at the United Nations General Assembly special session on children, Mexico had drawn up a programme of action on childhood and adolescence for 2002–2010. That established the principles and actions of the Mexican Government for children and adolescents to grow up in an environment of security and equality. The programmes for adolescent health care, child heath care and an even start in life involved preventive measures, early detection of birth defects, and health promotion, all with the active participation of the social and private sectors.

Mexico's universal immunization programme had attained more than 94% coverage of one-year-olds since 2000, with a target of 95% to 96% for 2006. Since 2004, the immunization programme had included vaccination with 11 immunogens (giving protection against, for instance, hepatitis B, invasive *Haemophilus influenzae* infections, measles, rubella, mumps and influenza). Since the beginning of 2006, it had included vaccinations against invasive bacterial pneumonia, targeting those communities with the lowest human development index in the country. Vaccination against rotavirus was also included for more than 70% of the indigenous population. His Government had also created a national council for the prevention and treatment of cancer in children and adolescents. Although antenatal and perinatal care had improved, maternal mortality remained a serious concern.

Regarding adolescent health, significant progress had been made in promoting safer sexual behaviour and the law had been amended in order to facilitate access to family planning methods, including emergency contraception. Emphasis was being placed on healthy lifestyles, with respect for differences in gender, culture and access to services. The principal aim was to reduce the number of teenage pregnancies and prevent accidents, still the primary cause of death in that age group.

An item should be added to the Health Assembly's agenda on the establishment of direct strategies to combat childhood and adolescent obesity, including the participation of the social and education sectors and food producers, as part of a long-term strategy to control chronic degenerative illnesses. The promotion of food education should be included in the Global Strategy for Infant and Young Child Feeding, using community resources and low-cost nutrition in order to improve the standard of living and focusing on gender, rights, and health promotion for adolescents. Universal immunization schemes for children and adolescents could be broadened. Cooperation with other organizations of the United Nations system should be increased in order to achieve the Millennium Development Goals.

Mrs GUEZZAR (Morocco) said that the health strategy in Morocco for child and adolescent development focused on two groups: children, and adolescents and young people. Almost half of infant deaths were caused by infectious diseases, particularly by acute respiratory infections and diarrhoeal illnesses. National surveys had found many shortfalls in primary health care for children. An integrated strategy had been put in place in almost all provinces of Morocco in order to upgrade the skills of health-care professionals, reorganize services, and improve family and community practices. Clinical guidelines had been extended in order to cover neonates under one week old and healthy children in systematic examinations and health-care promotion activities. In 2004 Morocco had joined the Child Health Policy Initiative of the Regional Office for the Eastern Mediterranean.

The more than six million adolescents and young people aged between 15 and 24 in Morocco constituted 21% of the population. To respond to their specific health-care needs, Morocco had a school and university health programme which detected and treated contagious diseases, remedied sensory and speech difficulties, promoted healthy behaviour and dealt with psychosocial problems. In order to approach adolescent health holistically, consultation centres had been set up with the support of UNFPA in several provinces.

Mr GAUDÊNCIO (Brazil) praised the Secretariat's work on applying the strategy for child and adolescent health and development, but emphasized both health promotion in order to reduce inequality and the involvement of families to ensure that actions were comprehensive. In addition, more detailed information on external events such as homicide, violence or sexual harassment were needed so that work could be focused. It was important for young people to participate in formulating strategies and for countries to share their experiences on the issue.

Dr PUANGPEN CHANPRASERT (Thailand) said that Thailand had implemented the seven priorities for action through projects including food safety, exercise for health, mental well-being, countering drug and substance abuse, and environmental health. The health movement was facilitated by the Health Promotion Fund, generated from a 2% excise tax on tobacco and alcohol. The Healthy Thailand programme recognized that achieving its goal required collaboration from a variety of sectors, including communities, civil society, government and nongovernmental organizations.

Mr MARTIN (Switzerland) praised the recognition of children and adolescents as "basic and fundamental resources for human, social and economic development". He fully supported the strategy and acknowledged progress in the seven priority areas. Good maternal health was essential for improving the outcome of pregnancy and neonatal health. As pregnancy was the main cause of death among girls aged 15 to 19, an effective strategy would combine health services in pregnancy with youth-friendly and gender-sensitive prevention measures targeting early adolescence. He welcomed the workshops that had been held for programme managers on how to strengthen the neonatal health component of maternal and child health programmes (Bangkok 2005) and community practices for

newborn and child health (Maputo 2005). Nutrition was essential to health promotion in schools; the aims should not solely be "to reduce morbidity and mortality in pregnancy" but rather to contribute to the physical and mental health of all individuals, both male and female, pregnant or not. It was positive that HIV/AIDS had been covered by the strategy in order to improve both the performance of health workers and community-based services. He fully supported WHO's efforts to increase young people's information on HIV/AIDS and broaden their access to health services.

Young people were responsible actors rather than beneficiaries and should be involved in developing material for them, in which field Switzerland had some good experiences. Non-formal education, such as accompanied peer-to-peer structures and older sibling systems, also were effective methods of youth sensitization and training.

Mr NESVÅG (Norway) commended WHO's sharper focus on child health and especially welcomed the key messages that child, neonatal and maternal health needed to be seen as a whole and that strengthening health systems was essential for reducing child mortality. His Government was increasing its support to global child health. As well as working towards all the Millennium Development Goals, reducing child mortality by two-thirds by 2015 was seen as a litmus test of Norway's determination to work differently and achieve results. Norway would increase its advocacy for child survival and work with some large countries that were enhancing efforts to reduce child mortality.

Dr MESSELE (Ethiopia), speaking on behalf of the Member States in the African Region, noted progress and commended the Secretariat's action to strengthen the neonatal component of maternal and child health programmes. About one quarter of the deaths of children under five in Africa in 2004 had neonatal causes. Newborn survival interventions at community and health-facility level should be incorporated into national child survival and reproductive health strategies. Despite improvements in child survival over the past 20 years, more than 10 million children under five years old still died every year. The Tripoli Declaration on Child Survival in July 2005 had recognized the need to accelerate action. The African Union had requested WHO to elaborate a regional child survival strategy with guidelines for implementation; that work should be accelerated. She asked the Secretariat to provide support for national child-survival strategies and implementation plans, and for a report to the next Health Assembly on progress in terms of key indicators at country level towards the Millennium Development Goals. Child survival had to be part of a country's health-sector plans, including poverty-reduction strategies. Ethiopia's Health Sector Development Programme III and Plan for Accelerated and Sustainable Development to end Poverty included the national child-survival strategy.

She also urged the Secretariat to continue its provision of support to countries for cost-effective interventions. She emphasized human and financial resources and asked what was being done in order to mobilize additional resources for neonatal health. Adolescent health remained a neglected area, and children between the ages of six and nine were not covered in any guidelines or policies; the needs of that age group should be supported.

Given the increasing use of highly effective antimalarial therapies, she pressed the Secretariat to encourage pharmaceutical companies to expand production capacity in order to increase availability and accessibility of both generic and brand antimalarials at country level.

Dr DLAMINI (South Africa) welcomed the increasing global attention paid to maternal, child and adolescent health. South Africa had adopted several of WHO's strategies, such as those on integrated management of childhood illness and reaching every district, which were improving care. Disease-specific morbidity and mortality had been reduced and South Africa had been nominated for poliomyelitis-free certification in 2008. World Health Day 2005, with its theme "Make every mother and child count", had been an opportune platform for child and adolescent health promotion. South Africa had an overall child health policy for maternal, newborn and child health and was working hard to reduce its current infant mortality rate of 43/1000 live births. A special nutrition unit had been created in order to coordinate nutrition activities. According to the National Youth Risk Behaviour

Survey in 2002, childhood obesity was common; continued engagement in rigorous healthy lifestyle campaigns was therefore needed in order to reverse the trend. Food fortification had significantly reduced micronutrient deficiency in children. Work was in hand to improve the immunization coverage rate from the current 81%. Health workers were being trained in the provision of youth-friendly services in order to combat drug and alcohol abuse in adolescents.

South Africa had recently hosted the 8th World Conference on Injury Prevention and Safety Promotion (Durban, 2–5 April 2006), and was committed to strengthening provision of maternal, newborn, child and adolescent interventions through the health system.

Mr A.P. SINGH (India) expressed his appreciation of the Secretariat's work on implementing the strategy for child and adolescent health as an important means of achieving the Millennium Development Goals. He noted the emphasis of *The world health report 2005* on "continuum of care" and "evidence-based strategies" for reducing infant and maternal mortality.[1] He recognized the progress in the seven priority areas but drew attention to the need to promote, more prominently and with more resources, the various "low-tech and low-cost interventions" referred to in the strategic directions. In India neonatal mortality accounted for nearly two-thirds of infant mortality. Early spectacular reductions in child mortality through such interventions as immunization had levelled off. Newborn health was inseparable from maternal health. Skilled attendance at delivery and emergency obstetric care were of great benefit to neonatal survival and health and, along with integrated management of neonatal and childhood illnesses, were the key components of India's National Rural Health Mission, which placed child health, maternal health and adolescent health in a continuum of care. The Secretariat should promote the easier, less expensive, evidence-based strategies. Drying and wrapping neonates at birth could be done more readily than resuscitation with a bag and mask; kangaroo-mother care was more effective than incubator-based care; and amoxicillin treatment was easier than treating infants with gentamicin injections. Promoting clean delivery with kits and exclusive breastfeeding should be given priority over creating neonatal units where resources are scarce. The National Rural Health Mission and its critical grassroots exponent, the Accredited Social Health Activist, were efforts in that direction.

Ms ZHANG Lingli (China) commented that, guided by WHO's strategy, many governments were striving to reduce child mortality and eliminate extreme poverty and hunger, improve maternal care, promote communicable disease prevention and provide treatment. Her Government would give priority to maternal and child health. It had promoted women and child development, introducing indicators on women's and children's health levels. Breastfeeding was strongly advocated and the legal rights of pregnant women, including maternal leave and time for breastfeeding, were protected by law. China had 7329 baby-friendly hospitals and it promoted the prevention of infant and child anaemia, a strengthened immunization plan and the prevention of communicable diseases. Her Government was enhancing the care service for women and children, improving efficiency and coverage in order to ensure the safety of children and infants. The question of resistance to monotherapies for malaria and the use of artemisinin-based combination therapies needed to be further studied. Since developing countries could not afford some of the expensive medicines on offer, use of the monotherapies should continue. The Chinese Government would go on working to reduce the mortality of children under five years of age.

Dr NODA (Japan) expressed appreciation of WHO's contribution to achieving the Millennium Development Goal, including the strategy for child and adolescent health and development and the emphasis on the continuum of care for the mother, neonatal and child and the integration of programmes. Japan used a maternal and child health handbook as a tool for providing continuing care for mother and child; that had been adopted in developing countries. The effective integration of

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

mother and child programmes into other programmes, such as the Expanded Programme of Immunization, had started and Japan was ready to promote that area in cooperation with WHO. Cooperation and coordination under the leadership of WHO in various donor programmes concerning the integration of intervention was greatly needed.

He asked for clarification of the Secretariat's perspective on the integrated management of childhood illness, which had not been extended from the pilot programme to national coverage. The current issue was how to deliver interventions on mother, newborn and child health to more people, and strengthen national health systems. How would coverage be expanded? Moreover, although there was an acknowledged need for adding an HIV/AIDS component, that move might overtax the programme.

Dr OTTO (Palau) commended the documentation on children and adolescents and on promoting psychosocial development and mental health, which was an increasing problem in Palau. More information on tobacco use among children and adolescents would have been desirable as it was a problem in Palau and many other countries. Following a situation analysis on children, Palau had developed a national youth policy.

Dr MAJARA (Lesotho) said that an emergency obstetric assessment in March 2005 had revealed that the country's facilities for emergency surgical care were inadequate. His country had developed a multisectoral plan for the reduction of maternal and newborn deaths. All 10 district hospitals provided youth and adolescent services, and facilities would be made available at health centres. Lesotho was implementing the child-survival programme, and was providing free primary education with free meals, which encouraged children to attend school. It attached great importance to children and adolescents, as they were the future of the country.

Dr LEVENTHAL (Israel), commenting that the report overlapped with the documents on infant and young child nutrition and essential health research and development,[1] for example on HIV/AIDS and nutrition, suggested that one document should encompass all matters concerning child health.

Mrs PHUMAPHI (Assistant Director-General) observed that the area of work contributed to attainment of Millennium Development Goals 3, 4, 5 and 6. Responding to the previous speaker she said that all the programmes responsible for the three reports worked closely together, using joint strategies and work plans. The three reports had been produced, as requested, in response to specific resolutions made by the governing bodies.

She welcomed the endorsement of the concepts of the continuum of care, working within health-systems formats, the contribution of communities and the focus on low-cost low-tech interventions. She acknowledged the success of India's National Rural Health Mission and had noted that the same concept was currently being introduced in Ethiopia with the health extension worker programme. There should be increased focus on adolescent health. At the XVI International AIDS Conference (Toronto, Canada, 13–18 August 2006) the Secretariat would present the results of the "Ready Steady Go" programme on how to tackle adolescent HIV/AIDS. With regard to the strategies for child and adolescent health in Africa, WHO was working together with UNICEF and the World Bank. A draft strategy had been completed and was being submitted to the African Union and the Regional Committee for Africa. The Partnership for Maternal, Newborn and Child Health had recently endorsed both the strategy for child survival and the plan for maternal mortality reduction in Africa. The Secretariat would examine the development of programmes in order to increase the focus on six- to nine-year olds.

The Integrated Management of Childhood Illness initiative, which had, for example, reduced infant and child mortality by 13% in the United Republic of Tanzania, was a useful approach; 70% of

[1] Documents A59/13 and A59/17.

all districts in 11 countries had initiated training and more than 21 countries had national coverage of 51%. There was a long way to go but with the possibility of preventing 11 million deaths every year the effort was worthwhile. Some countries were increasing investment and scaling up activities and she thanked donor countries, such as Norway, that were sharpening their focus on child survival. More advocacy was required.

The Committee noted the report.

Infant and young child nutrition: quadrennial report: Item 11.8 of the Agenda (Document A59/13) (continued from the ninth meeting)

The CHAIRMAN recalled that an informal drafting group had met.

Dr OTTO (Palau) read out the proposed changes to paragraph 3 of the draft resolution. The first sentence should read "URGES Member States to support action on this Call for Action…". He recalled that the 1990 Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding called for governments to assist in all actions in that area.

The draft resolution was approved.[1]

International trade and health: Item 11.10 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R5, and A59/15)

Dr HANSEN-KOENIG (representative of the Executive Board) recalled that at its 116th session in May 2005 the Executive Board had examined a report on international trade and health.[2] A draft resolution had been proposed but Board members had decided to defer further consideration until the 117th session in January 2006.[3] At that session, members adopted resolution EB117.R5 which recommended to the Health Assembly a draft resolution that urged Member States to cooperate constructively in order to ensure coherence in their health and trade policies and requested the Director-General to continue to generate and exchange data on links between trade and health.

Dr ABDESSALEM (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the opening up of health sectors would create new opportunities and challenges for health systems, which would benefit from information technology applications, with greater accessibility of up-to-date biomedical technology and skills. There were concerns that free trade might restrict access to essential health services, exacerbate the existing brain drain of qualified professionals from the Region, and diminish overall equity with respect to health care. The Regional Office for the Eastern Mediterranean and the Canadian International Development Research Centre had undertaken a joint study on the influence of trade on the efficient and equitable provision of health services.

Most countries had taken a conservative approach to the liberalization of trade in health services. One reason was the difficulty of gauging the impact of globalization on the health services sector in terms of efficiency, access and equity. Trade liberalization need not mean the absence of government regulatory control. Without regulatory measures to ensure equality and accessibility, gains from trade might not accrue equally to all. Policy-makers had to ensure that gains from trade did not create dual health-care systems or create shortages that threatened the sustainability of essential health

[1] Transmitted to the plenary in the Committee's fifth report and adopted as resolution WHA59.21.

[2] Document EB116/4.

[3] Document EB116/2005/REC/1, summary record of the third meeting, section 2.

services. The Secretariat and policy-makers in Member States had to respond to the following challenges. Data on trade in health services in the Region were sparse, constraining evaluation of the impact of liberalization. Communication between health and trade officials on issues regarding trade and health had not been systematic; coherence between policies in both sectors was instrumental to successful negotiation. Therefore, gathering evidence on the potential implications of the General Agreement on Trade in Services for trade in health services should be continued and reinforced, and the Secretariat's support was essential to Member States. There was need for improved understanding and policy coherence between health and trade officials of national governments so that during trade negotiations no agreements were made that compromised the overall goal of better health, especially for the poor and vulnerable. Health ministries should build capacities around trade in health services specifically and establish units on all such trade. Countries should adopt a conservative approach before opening up the health sector to international trade as many of the commitments under the Agreement were not easily reversible.

Dr Mazzetti Soler resumed the Chair.

Dr BOR (Turkey) affirmed the need for information about the implications of international trade and trade agreements for health policy nationally, regionally and globally. She supported the statements to be made by the European Commission, since the effects of international trade and trade agreements on public health assets were likely to be encountered in transit countries like Turkey. The problems they faced should be taken into consideration. She therefore proposed the addition of a phrase at the end of paragraph 1(5) of draft resolution: "taking also the special problems of transit countries into consideration".

Dr PUANGPEN CHANPRASERT (Thailand) observed that international trade could improve the efficient use of scarce resources. However, with increasing links between trade and health, coupled with any failure in the functioning of the market or government, trade could distort health systems and deprive some segments of the population, especially the poor, of equitable access to an affordable health service. The draft resolution, which she endorsed, provided approaches that would enable countries to cope and established the framework for WHO's action.

Ms PÉREZ ALVAREZ (Cuba), recalling the report to the Board at its 116th session,[1] said that significant advances could be seen in areas such as pharmaceuticals, intellectual property and the food trade, and in the impact of the International Health Regulations (2005) and the WHO Framework Convention on Tobacco Control. It had also identified four multilateral trade agreements of WTO that were of particular importance to WHO's work and noted that informed and evidence-based approaches were needed in order to liberalize health services for greater access, affordable, and effective services. That ought to be in accord with the legal responsibility of the State toward its citizens.

Unfortunately, the intention of the Doha Declaration on the TRIPS Agreement and Public Health had not been fulfilled; developing countries still faced economic and trade disadvantages. He called urgently for compliance with the terms agreed in the Doha Declaration, pointing out that the arbitrary application of supposed free trade had only deepened inequalities, enlarging the zones affected by poverty. The concept of free trade had been manipulated by the use of unilateral coercive measures to block unfettered commercial exchange between nations and which undermined the human right to health. He denounced the genocidal blockade imposed by the United States of America on his country for nearly half a century.

[1] Document EB116/4.

The overriding issue was not trade or health, but to ensure that trade benefited health. Cuba called for urgent reform and reinforcement of the multilateral trade system so as to ensure that development and the right to health took precedence in any multilateral trade negotiations.

Dr FRIZA (Austria), pointing out that in the European Union the subject under discussion fell chiefly under the competence of the European Community, requested that the European Commission should be asked to speak.

The CHAIRMAN, seeing no objection to such a procedure, gave the floor to the European Commission.

Mr FAHY (European Commission), speaking on behalf of the European Union and its Member States, said that the acceding countries Bulgaria and Romania, the candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, and the countries of the Stabilisation and Association Process and potential candidates, Bosnia and Herzegovina and Serbia and Montenegro aligned themselves with his statement. He welcomed the proposed resolution, agreeing with the importance of ensuring coherent policies on trade and health. The Secretariat should continue to provide support to Member States for building a knowledge base and better understanding the public health implications of bilateral and multilateral trade agreements.

The treaties establishing the European Community required policy coherence and that protection of health should be ensured in all Community policies. Similarly, the treaties establishing WTO also stated the need for trade policy to integrate policies designed to protect public health. The European Community and its Member States had worked hard to ensure that those principles were reflected in practice. A recent example of adaptation of trade rules to the requirements of public health was the adoption by the WTO General Council of a decision to amend the TRIPS agreement, with the aim of supplying countries that lacked pharmaceutical production facilities with affordable medicines.[1] The European Community was already implementing that decision through a Council Regulation adopted on 27 April 2006.

Dr PILLAY (South Africa) commented on the difficulty in achieving a balance between trade objectives and health. Trade agreements between developed and developing nations had proliferated, and some of their provisions might pose public health problems. Trade negotiators should include representatives from health ministries in order to identify clauses that might adversely affect health. Establishing an office at national level responsible for monitoring and evaluating international trade agreements and health would be beneficial. The draft resolution placed a major responsibility on the Director-General, who was required to provide support to Member States in assessing the impact of such trade agreements. That might entail the establishment of an expert advisory panel. Given the large number of trade negotiations in progress, adopting the draft resolution should be a priority.

Ms VALDEZ (United States of America) said that document EB116/4 had summarized the many contexts in which the Secretariat dealt with international trade and health. She requested the Secretariat to publish the terms of reference of its "technical working group on globalization, trade and health", referred to therein and to provide information on the affiliations and expertise of the "various resource groups of outside experts" guiding that working group. She cautioned the Secretariat on its technical competency to advise Member States accurately on the potential implications of trade rules from a public health perspective. Any information on best practices in trade negotiations that WHO provided had to be unbiased and evidence-based and had to be cleared with WTO and WIPO. To the extent that such work did fall within the Secretariat's mission, mandate and expertise, it must provide the Member States with information that was accurate and fairly represented the different views of

[1] Decision WT/L/641, 6 December 2005.

Members. WHO's recent documentation on remuneration guidelines for non-voluntary use of a patent on medical technologies illustrated that point.[1] The United States supported the draft resolution in its current form.

She objected to the outrageous attacks made on her Government by the delegate of Cuba. They were unfortunate, had nothing to do with the public health issues under discussion, and were completely unacceptable to her Government.

Dr PADILLA (Bolivarian Republic of Venezuela) said that national public health must come before the rights deriving from free trade. In reality, the situation was far from that ideal, with enormous social gaps being progressively accentuated by the trade models prevailing in the world. His country promoted trade policies based on cooperation, solidarity and complementarity that took account of the needs of the most excluded and disadvantaged populations and rejected free trade agreements that conflicted with those principles, created inequalities and worsened poverty. It also promoted the production of generic medicines at reduced cost, guaranteeing access to essential medicines, in particular, universal and cost-free access to antiretroviral therapies. That had involved a major investment, because of patent protection of, and monopolies on, such medicines. In Venezuela, multinational companies had sued various laboratories and even the Ministry of Health. Those suits had impeded the circulation of 14 generic products for more than a year, with the consequent economic harm for patients and the State, which had been forced to pay monopoly prices to the disadvantage of its own health plans.

He called on Member States to pursue "lowest price possible" agreements in trade negotiations. Observer status on two WTO committees and ad hoc observer status at two of WTO's Councils was insufficient: WHO should be a full participant in discussions linked with health.

His country had adopted the flexibilities provided for in the TRIPS agreement, but they were not sufficient to overcome the patent-related obstacles that prevented access to medicines. Goodwill was needed on the part of the developed countries in supporting their implementation. There was at present strong pressure from the Government of the United States of America, through free trade agreements, to ignore those flexibilities and to impose the additional commitments to the TRIPS agreement (TRIPS-plus).

Another aspect of international trade that impaired health-care programmes in poor countries was the international migration of health personnel. Member States should adopt energetic measures to counter that problem.

The draft resolution should be amplified with a further provision along the lines of requesting the Director-General "to establish in the near future an intergovernmental working group representative of the six regions of WHO, assigned the task of analysing the potential difficulties that trade and trade agreements might represent for health; and to submit an interim report to the Sixtieth World Health Assembly and a final report, including specific proposals, to the Executive Board at its 119th session".

Mr BHUSHAN (India) said that assessing and responding to the health impact of trade agreements were challenges for health ministries. Trade and health policies could be harmoniously aligned only if adequate information on international trade agreements was available to the health ministries and a multistakeholder dialogue was initiated at national level. National ability to make full use of the provisions and flexibilities provided for in international trade agreements was also crucial. He therefore proposed insertion of the world "multistakeholder" between the words "promote" and "dialogue" in paragraph 1(1) and a new subparagraph in paragraph (1): "to reflect all the flexibilities permitted under international trade agreements in national laws to address public health concerns".

[1] Document WHO/TCM/2005.1.

Ms NOGUIERA GUEBEL (Brazil), supporting the draft resolution, recalled the importance of bilateral trade agreements and the need to take into account the flexibilities contained in the TRIPS agreement and the Doha Declaration on the TRIPS Agreement and Public Health, in order to protect public health and promote access to medicines for all.

Dr COOMBS (Jamaica), speaking on behalf of the member countries of the Caribbean Community, said that the implications of globalization and the liberalization of trade for public health included: faster cross-border spread of infectious diseases; new efforts to increase patent protection, which could raise the costs of vital medicines; the impact of fast food chains on national food security; and the effect of trade in health services, such as offshore medical and nursing schools, on national health systems. The Caribbean was a region whose countries' economies greatly depended on tourism and its accompanying movement of large numbers of persons, which carried its own health risks. Some States had also been exploring health tourism as a possible economic activity. The Caribbean Community had established a single market and economy which set the basis for intraregional trade and the free movement of persons; consequences at the subregional level would be similar. The Caribbean countries endorsed the need for dialogue at the national level; intersectoral committees had already been established for that purpose.

Mr ANDOM (Eritrea), speaking on behalf of Member States of the African Region, noted that 80% of the countries in that Region were members of WTO and thus signatories to multilateral trade agreements. Such agreements had the potential to create both opportunities and risks to public health, especially in the African context where there was often little awareness of the implications for public health, or the capacity within health systems to deal with such implications. Those constraints limited the capability of national authorities to negotiate effectively at WTO meetings in order to maximize health-related benefits, particularly since such negotiations were usually led by trade ministries, which often collaborated insufficiently with the health sector in developing country positions. In order to expand such capacity, the African countries had selected the issues of poverty, trade and health as a priority for the fifty-sixth session of the Regional Committee for Africa, and a regional workshop on trade in health services was planned for 2006. Additionally, several countries in the Region were considering or making amendments to legislation relating to intellectual property rights and international trade.

African countries needed to position themselves strategically for competitive advantage by building or strengthening national knowledge bases and capabilities, in order to understand and maximize the public health benefits in all multilateral trade agreements, and to achieve greater policy coherence between trade and health policies, thereby minimizing health risks to poor and vulnerable populations. The Region's health ministries would need technical assistance from WHO and other international agencies to meet those challenges.

Dr MOETI (Botswana) said that the development of capacity to maximize the health benefits of globalization of international trade while minimizing the potential negative impacts was a major challenge for Botswana and other African countries. Member States should be encouraged to work with trade ministries, international organizations, and other stakeholders in order to build relevant expertise. Botswana was amending its intellectual property legislation in order to improve its ability to take advantage of the flexibilities under the TRIPS agreement, and would welcome WHO's support in developing the necessary capacity. Botswana supported the draft resolution.

Ms IMAI (Japan), emphasizing the importance of ensuring policy coherence between trade and health sectors, supported the draft resolution and urged continuing support to Member States from the Secretariat in collaboration with relevant international organizations.

Ms GILDERS (Canada) commended WHO's work in fostering at the global and national levels a better understanding of the complex relationship between international trade and health and building the evidence base. Canada recognized the importance of strengthening capacities in health ministries

so that health policies received due consideration in trade negotiations. She supported the draft resolution.

Dr GAO Weizhong (China) welcomed the draft resolution and emphasized that China had established an administrative bureau for trade and health. Collaboration between WHO and WTO should continue, and the impact of trade negotiations on health should continue to be assessed.

Mr SAWERS (Australia) urged adoption of the draft resolution as recommended by the Executive Board, emphasizing the need for coherent trade and health policies in order to maximize the positive effects of trade liberalization on health outcomes. The implications of international trade relationships on health and health policy should be properly understood and that there should be coherence between domestic and international policy objectives. WHO, WTO and WIPO should assist in achieving that goal within their competencies.

Ms PÉREZ ALVAREZ (Cuba), responding to the use of the words "attacks", "unfortunate" and "unacceptable" by the delegate of the United States of America, retorted that the blockade imposed on Cuba was unacceptable. It had prevented the Cuban health system from benefiting from technological advances by prohibiting the sale to Cuba of medicines, equipment and consumables available exclusively from companies based in the United States, and had made the Cuban health system more costly by forcing Cuba to purchase more expensive products from markets in Asia and Europe. She regarded as unfortunate the United States' delegation's unwillingness to recognize the disapproval of an illegal and genocidal policy to which 182 countries had expressed their opposition in 2005. She regarded as attacks the actions and measures that has seriously affected the Cuban people's right to health, even though the Cuban people had supported the North American people's right to health by offering without charge the assistance of 1518 Cuban doctors in the wake of hurricane Katrina.

Dr OTTO (Palau), supporting the draft resolution, asked whether it would cover commodities such as tobacco which had no health benefits.

Dr WASUNNA (Kenya) supported the draft resolution.

Ms RIETSEMA (Medicus Mundi International), speaking at the invitation of the CHAIRMAN, emphasized the right to health and said that trade rules should not be allowed to compromise that right or limit the ability of countries to regulate in the interest of public health. Ex ante health impact assessments of trade agreements were therefore crucial. Furthermore, the draft resolution should state explicitly that health should never be compromised in the interests of trade.

Given that the right to health imposed legal obligations on Member States, she proposed adding a new preambular paragraph: "Mindful of the legal obligations of Member States to ensure that trade rules and policies are consistent with human rights, including the right to health;". Additional resources would undoubtedly be required for the biennium 2008–2009 for the successful implementation of the draft resolution. It was disappointing to note that WHO's request for observer status at the WTO General Council had not been considered and she urged WHO to take action to rectify that situation.

Dr NOEHRENBERG (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that an often overlooked but essential issue in the discussion about trade and health was the negative impact that taxes and tariffs on pharmaceuticals and medical devices had on public health, an issue that had been highlighted by the WHO Commission on Intellectual Property Rights, Innovation and Public Health. Almost US$ 33 000 million of trade in pharmaceuticals was still subject to duty, predominately by developing countries. Given that that regressive tax on medicines targeted the poor and the sick, developing countries must make widespread changes to their domestic taxes, tariffs and regulatory structures. They could easily afford the revenue losses that would result from waiving the taxes on

pharmaceuticals, as they only accounted for around 1% of public health-care expenditure. However, tariff reductions would have a far greater impact on patients who were rarely protected by efficient health-insurance systems. Lower tariffs would have an even greater impact on the final price because tariffs were only the first in a series of added charges. Domestic industries protected by high tariffs did not lower the cost of pharmaceuticals; their prices were lower only in comparison to artificially inflated import prices. However, tariffs did jeopardize optimal price efficiency and high quality standards. The Secretariat should therefore continue its research in that field, and countries should improve access to medicines be eliminating tariffs on medicines and medical devices. Member States should, furthermore, support the action proposed by a number of countries in WTO.

Mr BENTON (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of the International confederation of Midwives, the International Council of Nurses, the International Pharmaceutical Federation, the World Dental Federation and the World Medical Association, said that access to health services, employment opportunities for health personnel, and professional regulations that protected the public were of particular interest and relevance to health professionals. He supported the need for different ministries to work together, and the emphasis placed on national dialogue in the draft resolution. The dialogue would be enhanced by including health professionals from the outset though the involvement of nongovernmental organizations.

Trade in health services, such as health tourism and tele-consulting, could raise significant ethical dilemmas for professionals. The impact of the agreements involved was often only recognized once they were in place and it was therefore imperative that key stakeholders should engage professionals at national and global levels at a much earlier stage.

The organizations he presented and their member associations already worked strategically with others in health care in order to influence international trade agreements, and felt that governments should more regularly involve professionals at a formative stage in discussion. He supported the draft resolution and urged the Secretariat and Member States to encourage health professional organizations to explore the links between international trade and health so that the consequences for patients and health systems were better understood and addressed.

Mrs WEBER-MOSDORF (Assistant Director-General) welcomed the strong support for the draft resolution and said that delegates' comments had been noted. The information requested would be provided.

Responding to the delegate of Palau, she confirmed that the draft resolution addressed all aspects of trade related to health. She acknowledged the importance of its objectives in order to promote an effective health dimension in economic and trade policies. It would enable Member States that had requested assistance to be given support in recognizing and acting on the public health implications of trade rules and trade agreements. WHO worked closely with relevant international organizations such as WTO and the World Bank in order to achieve greater coherence between trade and health.

In response to a point of order raised by Mr HOHMAN (United States of America), the CHAIRMAN proposed that consideration of the draft resolution should be postponed so that a revised text could be made available.

It was so agreed.

(For approval of the draft resolution, see summary record of the eleventh meeting, section 2.)

International migration of health personnel: a challenge for health systems in developing countries: Item 11.12 of the Agenda (Document A59/18)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegation of Thailand, which read:

The Fifty-ninth World Health Assembly,

Recognizing the centrality of human resources for health for the effective operation of country health systems as highlighted in *The world health report 2006*;[1]

Recognizing that an adequate health workforce is defined as a minimum of 2.3 doctors, nurses and midwives per 1000 people, balanced in such a way as to reach 80% or more of the population with skilled birth attendance and childhood immunization, and that 57 countries fall below this threshold;

Recognizing that more than 4 million additional workers need to be trained to fill the health-worker gap in those countries;

Recognizing that these health-worker shortages are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

Aware that the Global Health Workforce Alliance, a new partnership whose secretariat is at WHO, has launched a Fast Track Training Initiative for the health workforce, which is aimed at achieving a rapid increase in the number of qualified health workers in countries experiencing shortages through partnerships between industrialized and developing countries;

Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;

Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of the population;

Concerned that many countries lack the financial means, facilities and sufficient educators to train an adequate health workforce;

1. URGES Member States to confirm their commitment to the training of the health workforce by:

(1) endorsing the Fast Track Training Initiative;

(2) providing support for the revitalization of institutions that train the health workforce, meaning they must be in good repair, accessible to students and rapidly able to increase matriculation by offering shift training - so-called 24/7 education;

(3) promoting training in accredited institutions of a full spectrum of quality professionals, including community health workers, public health workers and paraprofessionals;

(4) encouraging direct financial support by global health partners, meaning bilateral donors, priority disease and intervention partnerships and global funds for health training institutions according to the prescription in *The world health report 2006* that of all new donor contributions for health, 50% should be dedicated to strengthening health systems, and 50% should be dedicated to the health workforce;

(5) endorsing the concept of training partnerships between schools in industrialized and developing countries involving exchanges of faculty and students;

(6) promoting the creation of planning teams in each country facing health-worker shortages, drawing on the top leadership of the major schools, whose task would be to formulate a comprehensive national strategy for the health workforce;

[1] *The world health report 2006: Working together for health*. Geneva, World Health Organization, 2006.

(7) providing support to innovative approaches to teaching in developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

2. REQUESTS the Director-General:
(1) to encourage Member States to participate fully in the Fast Track Training Initiative;
(2) to provide support to Member States in their efforts to revitalize health training institutions and rapidly to increase matriculation of students;
(3) to provide support to Member States in building up the training of doctors, nurses, midwives and other health workers, including community health workers, paraprofessionals and public health workers;
(4) to encourage global health partners, meaning bilateral donors, priority disease and intervention partnerships and global funds, to provide direct financial support to health training institutions;
(5) to encourage Member States to engage in training partnerships intended to improve the quality of health-professional education in developing countries;
(6) to encourage and provide support to Member States in development of health-workforce planning teams and use of innovative approaches to teaching in developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;
(7) to report to the Sixty-third World Health Assembly in 2010 on progress made in the implementation of this resolution.

The associated administrative and financial implications were as follows:

1. Resolution Fast Track Training Initiative for the health workforce

2. Linkage to programme budget

Area of work	**Expected result**
Human resources for health	Practical guidance and tools to ensure quality of education and training and its relevance to needs available to countries and used in targeted countries

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

The resolution is consistent with the expected result and focuses on ensuring that Member States have the capacity to scale up training and education efforts for the health workforce.

The indicator, baseline and targets may need to be revised to reflect more specifically changes in the capacity of Member States to implement the Fast Track Training Initiative for the health workforce.

3. Financial implications

(a) Total estimated cost for implementation over the "life-cycle" of the resolution (estimated to the nearest US$ 10 000, including staff and activities) US$ 18 052 000

(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US$ 10 000, including staff and activities) US$ 9 284 000

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

About US$ 3 184 000 of the proposed expenditure can be absorbed; additional funding of

US$ 6 100 000 is therefore required.

4. **Administrative implications**

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

Work will be undertaken at WHO country level, additional capacity will be required at the regional and headquarters levels to support the WHO Representatives' offices. All WHO regions will be covered, with special emphasis on building training capacity in the African Region.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

No additional staffing will be required at country level as the skills of existing staff will be upgraded.

Six staff members (100% full-time equivalent) will be required at regional level, together with one staff member (100% full-time equivalent) at headquarters.

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

Implementation in a limited number of countries will begin in the current biennium. An evaluation is expected to be undertaken in early 2010.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that the aim of the text was to solve the chronic shortage of human resources through the support of developed countries. In the course of informal discussions with 11 Member States, the following proposed amendments had been agreed. The title should be changed to "Rapid scale-up of health workforce production" and the second and third preambular paragraphs should be deleted. The fifth preambular paragraph should read: "Aware of alliances aiming at achieving a rapid increase in the number of qualified health workforce in countries experiencing shortages through partnerships between industrialized and developing countries." A footnote should be added relating to "alliances" to read "For example, the Global Health Workforce Alliance, whose Secretariat is at WHO". Two new preambular paragraphs should be added that would read: "Mindful of the need for a comprehensive national policy and plan on human resources for health and that production is one of its elements;" and "Recognizing the importance of achieving the goals of self-sufficiency in health workforce development".

In paragraph 1, the word "confirm" should be replaced by "affirm" and "the health workforce" should be replaced by "more health workers". Paragraph 1(1) should be deleted. Paragraph 1(2) should be replaced by paragraph 1(4) of resolution WHA57.19, which read: "to establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin". In paragraph 1(3), the word "including" should be replaced by "and also". In paragraph 1(4), the entire text following "health training institutions" should be replaced by "in developing countries". In paragraph 1(5), "endorsing" should be replaced by "promoting", and in paragraph 1(6) "top leadership of the major schools" should be replaced by "wider stakeholders including professional bodies, the public and private sectors". In paragraph 1(7), "providing support to" should be replaced by "using", and "developed and" should be inserted before "developing countries".

Paragraph 2(1) should be deleted and paragraph 2(2) amended to read "to provide technical support to Member States, as needed, in their efforts to revitalize health training institutions and rapidly to increase the health workforce". Paragraph 2(3) should be deleted and paragraph 2(4) amended to read "to encourage global health partners to support health training institutions". In paragraph 2(6), "provide support to" should be replaced by "to support".

A revised text should be circulated.

Ms MATA (Bolivarian Republic of Venezuela) stated that every person had the irrefutable right to leave their country of origin temporarily or permanently. However, the trend could cause a loss of ethical values in her country as Venezuelan doctors and nurses were trained in the ethical values and social responsibility that were fundamental to her country's economic model. A cornerstone of that responsibility was the inalienable right to life held by all, as enshrined in the country's Constitution. She nevertheless supported the document as it highlighted the importance of the theme.

Dr WINT (Jamaica) said that the issue of human resources for health and in particular the continued high level of migration of highly trained and experienced personnel from the developing to the developed countries had become a recurrent agenda item. *The world health report 2006* and the Secretariat's report were important contributions. Some Caribbean countries had lost half their senior nursing personnel, and efforts to expand the training of such personnel were severely hampered by a lack of financial resources. Recipient countries should develop partnerships with donor countries in an effort to improve the management of the migration by supporting scaled-up training programmes. Nursing schools in Jamaica were full to capacity and turned away hundreds of suitable candidates every year. A special initiative was called for to find urgent solutions to the problem.

Dr MIYOSHI (Japan) said that the international migration of health personnel was an important and urgent problem that deserved examination in *The world health report 2006*. Each problem should be tackled individually, and health workforces should be considered in terms of their life span within the health system as a whole.

Japan had secured its entire health workforce with no international migration, thanks to careful human resource development and distribution, taking into account the balance of supply and demand. The quantity and quality of the health workforce had also been secured through investment in infrastructure, life-time education and a reemployment policy. Japan wished to share its experience in those areas with other countries through international cooperation. As a result of its emphasis on human resource development, outstanding outcomes had been achieved in the health sector. In order to improve the effectiveness and sustainability of its efforts, Japan wished to continue its policy of active cooperation on that issue. He supported the draft resolution as revised.

Mr RAKUOM (Kenya), acknowledging the complexity of the matter, said that Kenya had no intention of forcibly preventing the migration of its health workers. It had set up an international employment office which supported Kenyans who wanted to work abroad, not because it had an excess of workers, but because it respected the right of health workers to choose where they worked and as a way of responding to the unemployment of health workers in Kenya created by outside factors. Some 600 health workers left Kenya each year to take up employment abroad, most of them highly trained and experienced nurses and doctors, creating a problem in training younger nurses and doctors and sustaining good standards of health-care delivery. Kenya needed 47 000 nurses within the next five years, compared with the current figure of 16 000 employed in the public service. The argument that health workers remitted income to their country of origin overlooked the consequent decline in the quality of health care, the loss of mothers and children and the shortage of skilled manpower. If current trends continued, migration would soon become a social determinant of health. Low-income countries would not have the capacity to meet the Millennium Development Goals unless that problem was tackled vigorously. Kenya therefore supported the proposals in the report, which should be a basis for enabling the countries adversely affected by health-worker migration to increase skilled staffing levels, to work towards achieving their Millennium Development Goals and to improve the quality of health-care delivery.

Mr MAHI (Algeria), speaking on behalf of the Member States of the African Region, said that management of the international migration of health personnel was a major source of human-resource crisis management in developing countries. According to *The world health report 2006*, 57 countries were currently experiencing workforce shortages, the situation being most acute in sub-Saharan Africa. The African Region bore 24% of the global morbidity burden, but accounted for only 3% of

health personnel and less than 1% of health expenditure. That report also highlighted the dramatic effects of the exodus of qualified health workers from Africa which placed it at the epicentre of the global health-resources crisis. Meanwhile, its requirements in that area remained largely unsatisfied. That crisis would worsen considerably in the years to come.

Resolution WHA57.19 urged adequate responses to the international migration of health personnel. The Secretariat should continue implementing the actions initiated since the adoption of that resolution (as described in document A59/18), in cooperation with Member States and all the partners concerned, including the development agencies. Of particular importance was a feasibility study on the cost and relevance of an international instrument on the international recruitment of health personnel. It should also continue its research into compensation systems for developing countries that had experienced losses of trained health personnel.

The Sixth African Union Summit (Khartoum, 16–24 January 2006) had prioritized the matter, and the African Union was discussing the adoption of a common position. The New Partnership for Africa's Development was planning to upgrade human resources in Africa.

The CHAIRMAN said that she was obliged to interrupt the statement by the Algerian delegate because the Committee had exceeded the time allotted for interpretation. The delegate could continue his statement the following day. She proposed that a revised text of the draft resolution should be prepared for consideration the following day.

Mr SAWERS (Australia) said that, under Rule 52 of the Rules of Procedure of the World Health Assembly, proposals and amendments normally needed to be circulated two days in advance of their consideration, to allow delegates time to consult their capitals before proceeding with negotiations. Not all delegates had participated in the informal consultation.

Ms MOURAIN-SCHUT (Office of the Legal Counsel) confirmed that Rule 52 applied in the current circumstances, but, if the Committee was willing to waive the two-day rule, it could proceed to consider the draft resolution.

Dr TILLICH (Austria), speaking on behalf of the European Union and its Member States, supported the Australian statement. In view of its importance, the matter should be discussed further by the Executive Board in January 2007.

Ms MOURAIN-SCHUT (Office of the Legal Counsel) said that, if there was an objection to waiving the two-day rule, the Chairman could propose to defer the matter to the next Health Assembly through the Executive Board at its 118th session.

Dr TSHABALALA-MSIMANG (South Africa) asked whether consideration of the matter was to be deferred until January 2007 or until the next Health Assembly.

Mr AITKEN (Adviser to the Director-General) said that the proposal that had been made was to consider a draft resolution submitted outside the normal time frame. The Chairman had asked the Committee if it was prepared to do so, but Australia had raised an objection. One option, in order to avoid a vote, was to defer the item to the next Health Assembly through the Executive Board. The alternative was for the Committee to decide, either by means of a vote or by a consensus achieved overnight, whether it would consider the item.

Mr SAWERS (Australia) said that an issue of principle was at stake. The draft resolution had been presented very late in the proceedings and delegations had not had time to consult their capitals. It had been suggested that a conference document should be amended on the basis of informal negotiations conducted without the participation of many delegates, including his own. As a matter of fairness, all delegates should have an opportunity to consider the matter. However, he would not stand

in the way of a consensus on the proposal to discuss the resolution in the Committee the following day, if such a consensus was achievable.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), stressing the importance of the topic for developing countries, which bore the brunt of the consequences of health personnel migration, said that he hoped that a consensus could be reached on resuming consideration of the matter as quickly as possible, either the next day or at the 118th session of the Executive Board.

Dr NTABA (Malawi) thanked the Australian delegate for its willingness not to stand in the way of a consensus on the continued consideration of the matter, in view of its vital importance to developing countries.

Dr TSHABALALA-MSIMANG (South Africa) said that a decision should be taken as quickly as possible by consensus. As she understood it, an emergency session of the Health Assembly was likely to be convened in the near future. Consideration of the item could not be delayed until the next regular session of the Health Assembly in 2007, and the topic should therefore be examined by the Executive Board, the following week, as a matter of priority.

Mr AITKEN (Adviser to the Director-General) said that a revised text would be produced overnight, containing the amendments put forward, for consideration by the Committee the following morning.

It was so agreed.

(For approval of the draft resolution, see summary record of the eleventh meeting, section 2.)

The meeting rose at 21:15.

ELEVENTH MEETING

Saturday, 27 May 2006, at 09:20

Chairman: Dr P. MAZZETTI SOLER (Peru)
later: Dr K. LEPPO (Finland)
later: Dr A. RAMADOSS (India)

1. FOURTH AND FIFTH REPORTS OF COMMITTEE A (Documents A59/52 and A59/53)

Dr CISSÉ (Guinea), Rapporteur, read out the draft fourth report of Committee A contained in document A59/52.

The report was adopted.[1]

Dr CISSÉ (Guinea), Rapporteur, read out the draft fifth report of Committee A contained in document A59/53.

The report was adopted.[2]

2. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (continued)

International migration of health personnel: a challenge for health systems in developing countries: Item 11.12 of the Agenda (Document A59/18) (continued from the tenth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution incorporating amendments proposed in the tenth meeting, reading:

> The Fifty-ninth World Health Assembly,
>
> Recognizing the centrality of human resources for health for the effective operation of country health systems as highlighted in *The world health report 2006;*[3]
>
> Recognizing that these health-workers shortages are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;
>
> Aware of alliances[4] aiming at achieving a rapid increase in the number of qualified health workers in countries experiencing shortages through partnerships between industrialized and developing countries;

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[1] See page 257.

[2] See page 258.

[3] *The world health report 2006: Working together for health*. Geneva, World Health Organization, 2006.

[4] For example, the Global Health Workforce Alliance, whose Secretariat is at WHO.

Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;

Concerned that in many countries, notably those in sub-Saharan Africa, there is inadequate capacity to train sufficient health workers for adequate coverage of the population;

Concerned that many countries lack the financial means, facilities and sufficient educators to train an adequate health workforce;

Mindful of the need for a comprehensive national policy and plan on human resources for health, and that production is one of its elements;

Recognizing the importance of achieving the goals of self-sufficiency in health workforce development;

1. URGES Member States to affirm their commitment to the training of more health workers by:

(1) establishing mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin;

(2) promoting training in accredited institutions of a full spectrum of quality professionals, and also community health workers, public health workers and paraprofessionals;

(3) encouraging financial support by global health partners, including bilateral donors, priority disease and intervention partnerships, and global funds for health training institutions in developing countries;

(4) promoting the concept of training partnerships between schools in industrialized and developing countries involving exchanges of faculty and students;

(5) promoting the creation of planning teams in each country facing health-worker shortages, drawing on wider stakeholders, including professional bodies, the public and private sectors, whose task would be to formulate a comprehensive national strategy for the health workforce;

(6) using innovative approaches to teaching in developed and developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

2. REQUESTS the Director-General:

(1) to provide technical support to Member States, as needed, in their efforts to revitalize health training institutions and rapidly to increase the health workforce;

(2) to encourage global health partners to support health training institutions;

(3) to encourage Member States to engage in training partnerships intended to improve the quality of health-professional education in developing countries;

(4) to encourage and support Member States in development of health-workforce planning teams and use of innovative approaches to teaching in developing countries with state-of-the-art teaching materials and continuing education through the innovative use of information and communications technology;

(5) to report to the Sixty-third World Health Assembly in 2010 on progress made in the implementation of this resolution.

Mr MAHI (Algeria), speaking on behalf of the Member States of the African Region and resuming his intervention, noted that the report focused on the shortage of health workers in not only developing but developed countries. The problem for the developing world was that its health workforce was being drained by migration. New ways must be found of supporting such countries if the measures envisaged in the report were to be successful.

WHO should represent the interests of African countries at the forthcoming United Nations General Assembly's High Level Dialogue on International Migration and Development (New York,

14-15 September 2006) and incorporate the outcome of that dialogue into the management of the international migration of health workers.

Mr KAZENENE (Zambia) said that Zambia faced a massive shortage of human resources and an increasing attrition of its health workforce, largely due to migration to developed countries with better employment conditions. The crisis was acute in rural areas, where most health facilities were staffed by unskilled or unqualified personnel. In April 2006, his Government had abolished user fees in rural areas, which would result in an influx of new patients that would overburden the depleted health workforce. Migration was a major obstacle to achieving the health-related Millennium Development Goals. Staffing shortages had led to severe imbalances in terms of numbers, skills and geographical distribution, and to increased workloads, low motivation and a deterioration of services.

His Government's strategic plan included a rural retention scheme, which had already attracted 79 more doctors to rural areas. The challenges facing his country included: inadequate data on the health workforce; insufficient financial resources for implementation of the strategic plan; the adverse effects of migration; the need for capacity-building; and the need for evidence-based approaches to the problem of HIV/AIDS, which had a great impact on the country's human resources for health. He urged partners that were supporting specific programmes to consider earmarking financial resources for the recruitment, retention and development of health staff.

He supported fast-track training for the health workforce, provided that it took account of other concerns, such as infrastructure development, the need to produce lecturers, tutors and other crucial cadres, and financial implications.

Ms UUSIKU (Namibia) said that, although in Namibia migration of health personnel was not a major problem, her Government had introduced various incentives in order to retain the health workforce, such as improved pay and working conditions and benefits such as paid leave of absence and study leave with full pay. In order to strengthen human resources development, a study on perceptions of working conditions in both the public and the private health sector had been conducted in 2005. Its findings would guide further strategies designed to retain health personnel.

Mr MANINRAKA (Kiribati) noted the support given by WHO to countries of sub-Saharan Africa and to India in the management of health workforce migration problems. His country deserved the same kind of assistance; it had limited resources, its health administration costs were high because it comprised numerous scattered islands, and its remoteness meant that it attracted little foreign investment. Without help, his country could become one of the worst cases in the world in regard to provision of health services, especially if development partners and donors continued to cut back on their assistance.

Professor TLOU (Botswana) said that, for most health systems in Africa, the shortage of skilled human resources was a major challenge. With increasing globalization, the migration from developing to developed countries of health professionals, motivated to leave by low salaries and poor working conditions, had reached disturbing proportions. He appreciated the efforts of the international community in developing codes of practice and collaborative arrangements between countries in order to improve the ethics of international health-worker recruitment but such efforts had their limits. Developed and developing countries alike needed to accelerate domestic training of health workers, give greater priority to health workforce planning, and elaborate effective retention strategies if the harmful effects of migration on health systems in the developing world were to be reduced.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted that there had been some progress since the adoption of resolution WHA57.19 on the international migration of health personnel. The report suggested first that countries that exported health workers should be compensated, and secondly that recipient countries should increase their investment in training. It was difficult to see how a system of compensation could be applied. A better solution would be the promulgation of international

instruments, preferably binding in nature, in order to regulate conditions of recruitment for health personnel. He also advocated the negotiation of bilateral or multilateral intergovernmental agreements.

His Government had always prioritized human resources development for tackling health problems in Cuba and worldwide. A revolution in medical training was currently under way in Cuba whereby teaching had been decentralized to municipal level, permitting the creation of university polyclinics providing primary health care which were equipped to train doctors. That new approach made it possible to train large numbers of doctors and also to break with the traditional system of training in university faculties and hospitals, which required costly equipment and teaching staff. Such an approach might solve the problem of lack of health personnel in developing countries. Cuban medical teams were already training doctors overseas using those methodologies, thus obviating the need for medical students to travel abroad for training. He cited statistics on the large numbers of people trained in Cuba: since 1961, some 45 000 people, two thirds from sub-Saharan Africa. Cuba had also helped set up 11 medical schools in third-world countries, and currently had 305 professors teaching in 24 medical schools in 17 countries. That demonstrated how global solidarity and new forms of collaboration could help to alleviate the current global human resource crisis.

Mr SHARMA (India) said that migration of health workers could not be halted but could be better managed. Health professionals should be employed in other countries only on short-term contracts, after which they should have to return with their new skills. Human resources planning should be improved in all countries. International funding for the training infrastructure should be given to countries with the necessary technical competence and competitive advantages. The working conditions of health professionals in their home countries should be improved, although the gap in salaries between source and recipient countries was currently too wide to be bridged easily. A registry and database of health professionals should be created in every country.

Mr SAWERS (Australia) said that his Government recognized the impact of the migration of health personnel on developing countries and therefore complied with the Commonwealth Code of Practice for the International Recruitment of Health Workers. Using a range of initiatives, it aimed to increase the domestic supply of health workers and to improve their productivity. At international level, Australia had provided almost 1400 scholarships for overseas students for post-secondary studies in health between 2000 and 2004. In 2005, 25% of first-year medical students had been temporary residents, many of whom had returned to their country of origin on completion of their year's internship. In April 2006, it had increased funding for health, including health workforce development, in the Asia-Pacific region.

He suggested that paragraph 1(1) of the draft resolution should be amended to read: "giving consideration to the establishment of mechanisms…", since it was not yet clear what kind of mechanisms might be used.

Dr SANGALA (Malawi) said that his country faced a crisis in human resources for health. Over 60% of vacancies for nurses and over 90% of vacancies for physicians were currently unfilled. With the support of the partners, his Government had introduced a six-year emergency plan designed to recruit, train and retain more health workers by means of a pay scale more favourable than that of other public-sector workers. It was also trying to improve working conditions for health professionals and to ensure adequate medical supplies. He supported the draft resolution.

Dr GREGORICH-SCHEGA (Austria), speaking on behalf of the European Union and its Member States, said that the acceding countries Bulgaria and Romania, the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina and Serbia and Montenegro aligned themselves with her statement. The initiatives proposed in the report had been noted with interest. They included the development of incentives to encourage recruitment and retention of health workers, and policy consultations with Member States on the use of guidelines for ethically responsible recruitment.

She appreciated WHO's involvement in the debate on human resources for health. However, the report did not adequately examine financial aspects, such as ensuring reasonable levels of remuneration and social insurance for health workers. In view of the need to improve the position of the health workforce in the public sector, WHO's advocacy at international level and its participation in multisectoral dialogue at country level were crucial. Nor did the report reflect the impact of the HIV/AIDS epidemic on the health workforce and migration patterns. As that epidemic put workers at risk and increased their workload, she welcomed WHO's recent initiatives.

WHO should also take into account the part played by other organizations of the United Nations system and global health initiatives with regard to the brain drain in many countries. Many health workers used a job within the United Nations system as a stepping-stone to leaving their home country altogether. She welcomed the plans outlined in paragraph 24 of the report for collaboration with relevant international agencies.

In April 2006, the European Union had adopted a consensus statement for implementation of the European Union Strategy for Action on the Crisis in Human Resources for Health in Developing Countries. The strategy recognized that action to combat shortages of health workers must begin at national level, supplemented by efforts at regional and global levels. At country level, the European Union would support human resource strategies in the context of poverty-reduction programmes and health-sector policies. It would promote productive employment, decent working conditions, social protection and mobility. Dialogue with professional organizations, trade unions and research institutions could build consensus in order to train, support and retain a workforce able to meet health needs. The dialogue would focus on incentives in the form of increased training, improved working conditions and better career prospects. Human resources represented a long-term cost factor for health systems, and effective planning needed sustainable long-term financing.

At the regional level, the European Union would support the mapping, analysis and dialogue required for effective advocacy. As part of its Strategy for Africa, it would talk to regional communities about the human resource crisis and support linked to regional economic integration and the Economic Partnership Agreements. Migration to both developing and developed countries would be discussed, including ways of enabling source countries to replenish their human resources. This would strengthen human resources by means of regional agreements on skill-sharing and development. At the global level, greater efforts were needed in order to promote decent working conditions, invest in social protection and distribute the benefits of globalization more equitably. The European Union was committed to those goals.

The European Union would not oppose approval of the draft resolution, as amended by Australia.

Professor MWAKYUSA (United Republic of Tanzania) said that international migration of health workers hampered the efforts of developing countries to achieve the Millennium Development Goals. A survey conducted in his country in 2003 had shown that more than 200 health professionals, mainly physicians, had left the country in order to work elsewhere. Developing countries could never match the salaries offered by richer countries. A system of financial compensation for training costs would be difficult to arrange, and he therefore suggested that developed countries should help developing countries to increase their capacity for training health professionals, so that more staff would be available to work in their home country. He supported the draft resolution.

Dr AZIZ (Iraq) said that some 6500 health workers, including 1400 physicians, completed their training in his country every year. A further eight medical schools had been established, which would produce a further 500 trained health professionals per year. About 700 postgraduates qualified in various medical specialisms every year. The density of physicians in the country, only 6.5 per 10 000 population, was below the regional average and the shortage of nurses was more marked. The problem was exacerbated by the emigration of highly skilled health professionals, and had become acute over the previous three years. The migration of health professionals adversely affected health services, especially in remote areas. He supported the draft resolution.

Dr ABEYKOON (Sri Lanka) said that his country was affected by the migration of health professionals. An article in a leading medical journal had stated that 1.2% of physicians working in the United Kingdom of Great Britain and Northern Ireland and 1.1% of physicians in Australia came from Sri Lanka. Banning migration or adopting ad hoc solutions would not help the situation: migration must be carefully managed, with due consideration for planning, education, training and appropriate deployment of health professionals.

He supported the draft resolution. A close partnership between source and recipient countries should benefit both.

Dr OTTO (Palau) expressed his appreciation for the assistance of WHO and other partners in developing its health workforce. Innovative health mechanisms were needed, including collaboration with nongovernmental organizations and the use of trained volunteers. He supported the draft resolution, as amended by Australia, but proposed two further amendments in paragraph 1(5); to insert the phrase "and nongovernmental organizations" after "the public and private sectors"; and to add, at the end, the words "including consideration of effective mechanisms for utilization of trained volunteers".

Dr CHETTY (South Africa) commended the Secretariat's progress in implementing both resolutions WHA57.19 and WHA58.17 on international migration of health personnel. World Health Day 2006 had been devoted to human resources for health development, a high-priority in the Eleventh General Programme of Work, 2006–2015. The Global Health Workforce Alliance was tackling the challenges in human resources.

International migration was a priority. Her country had signed a bilateral agreement with the United Kingdom of Great Britain and Northern Ireland for time-limited placements of health workers in both countries. Similar agreements were being negotiated with other countries. Working conditions in hospitals were improving. Additional allowances had been introduced in order to recruit and retain staff with shortage skills in rural areas. She supported the draft resolution, as amended by Australia.

Mr SHIRALIYEV (Azerbaijan) observed that the success of public health endeavours depended primarily on health workers. His Government had successfully coped with avian influenza through collaboration between WHO experts and national health workers. Azerbaijan's health system was reinforcing its human resources. Faced with the choice between purchasing an expensive item of medical equipment and raising the salaries of the staff, salaries should be raised; it was people, not medical equipment, that cured patients.

His Government was improving pay and conditions for health professionals so as to stem migration. The health system had suffered considerably following the collapse of the Union of Soviet Socialist Republics. Physicians and nurses had turned to more lucrative jobs, and many had emigrated. However, the outflow had fallen to a third of what it had been. Health workers were returning to the professions and were requalifying. He was confident that the three health-related Millennium Development Goals could be achieved.

Ms RIETSEMA (Medicus Mundi Internationalis - International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN, welcomed the improved information base on health-worker migration, but noted the lack of information on movements of health workers from the public to the private sector and to nongovernmental organizations. Well-funded programmes implemented through nongovernmental organizations often paid salaries higher than local public sector wages, and that undermined the public sector services. That phenomenon needed investigation, and she called on the Secretariat to elaborate a code of practice for disease-control programmes which would not harm health systems. The Global Health Workforce Alliance should step up collaboration between rich and poor countries, in order to redress health inequalities caused by the migration.

As noted in *The world health report 2006*, the result of migration was that lower-income countries were actually subsidizing the health systems of higher-income countries. Donors could commit to long-term financial compensation, with the aim of strengthening health systems in

low-income countries and reducing the "push" factors that encouraged migration. The questioning of the rationale behind compensation mechanisms by the report (paragraph 19) was unjustified: high-income countries had the capacity to train as many health workers as they needed. If enough countries considered financial compensation to be an option, the means of providing it could be worked out.

Although the report stressed the importance of training new health workers, working conditions, benefits, salaries, management and opportunities in source countries must also be dealt with if the newly trained workers were not also to migrate. Financial compensation should not be restricted to investment in training, but should help to create and maintain a better working environment in developing countries and to strengthen the health system as a whole. She called for long-term financial commitments in order to resolve the crisis in human resources for health. The Secretariat and Member States should coordinate the many different initiatives.

Dr KINGMA (International Council of Nurses), speaking at the invitation of the CHAIRMAN on behalf of her own organization and of six health professions – dentistry, medicine, midwifery, nursing, pharmacy and physiotherapy – said that the shortage of staff and the weakened infrastructure of many health systems threatened the delivery of high-quality care and national health targets. Increasingly, health professionals were working in a global labour market, with public and private employers competing for their skills; the factors encouraging health workers to emigrate would remain. Migration was often necessary for professional development and career advancement, but data on the scale and duration of migration were incomplete. She welcomed the work on reliable data collection and analysis in order to support human resources planning.

The infrastructure and training capacity of countries must be strengthened if they were to achieve self-sufficiency in human resources for health. Industrialized countries must reduce the high attrition rates among students and graduates in the health professions. Incentives, such as pay equity and retention packages, were essential for health professionals, including educators, to remain employed in their own countries.

The health professions were planning a campaign in order to improve working environments in the health sector. WHO and other United Nations agencies should join them. Closer cooperation was needed between WHO and the health professions, which ought to be represented on the governing body of the Global Health Workforce Alliance. What strategies and mechanisms would the Secretariat introduce in order to intensify cooperation with the health professions?

Dr OULTON (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that her organization represented 13 million nurses in 129 countries. Migration of health professionals was a problem only as it related to shortages. Until there was equal pay for work of equal value within national health systems, and health professionals were able to enjoy positive working environments, registered nurses and physicians would continue to migrate. Evidence suggested that the mobility of health workers within countries, from rural to urban areas and from the public to the private sector, was an even greater problem than international migration. The Council had undertaken a major two-year study on the nursing workforce and, together with the Commission of Graduates of Foreign Nursing Schools, had established an International Centre on Nurse Migration to serve as a global resource. She would welcome the inclusion of organizations like her own in the programmes launched in collaboration with international organizations.

The Council endorsed the intention of the draft resolution. The underlying principles of human resources for health must be self-sufficiency as the goal for all nations; ethical recruitment by developed countries; freedom for all countries to decide what mix of health-care personnel they required; and the need for relevant and comprehensive planning and policy in all Member States. It was essential to ensure, through re-employment, redeployment and education, sufficient numbers of qualified professionals to support safe patient care and relevant student education and clinical practice. However, focusing on the less skilled workers might result in a crisis for developing countries similar to that of 30 years earlier. The mistakes of the past should not be repeated. Clinical capacity for training was crucial. The Council knew from its study that nurses were concerned about having too

little time to supervise other cadres of health workers, as well as attending to patient needs. What measures was WHO taking in order to prioritize scaling up of the health professions in order to guarantee sufficient numbers of professionals in order to care for patients and supervise other workers?

Dr SHIVA (Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that *The world health report 2006* would help planners to focus on the training and retraining of health workers. Her organization pledged its support in documenting the impact of migration on health systems in Africa. Two recent reports highlighted the obstacles to retaining staff in African national health systems, and provided examples of positive retention practices.[1] Involving health workers in planning processes and mobilizing the diaspora and unions could also be positive for staff retention. Health ministries should facilitate the return of migrant health workers. Positive retention practices would require greater investment by countries in their own health systems, and by international donors, as recommended in *The world health report 2006*. At least US$ 10 per person per year was needed from them in order to train and retain the one million extra health workers needed for Africa. The question of compensation should also be examined.

Dr EVANS (Assistant Director-General) acknowledged the contribution made by the Member States of the African Region to the adoption of resolution WHA57.19, which had provided the Secretariat with the opportunity to respond to the complex matter of the health workforce. The urgency of ensuring an adequate supply of health workers was reflected in the emergency plan introduced in Malawi. Similar plans would be needed in other countries because migration by health personnel was expected to continue over the long term. Policies were needed for managing migration, in both source and recipient countries. Special funding was needed in order to train health workers, together with more involvement of ministries of education and institutions of higher education. Donor assistance should be redirected to providing direct support for the health workforce, and there should be a full debate about what reasonable rates of pay should be. In order to help provide crucial evidence, WHO was actively supporting the development of an observatory for human resources for health in the African Region. Distance-learning technologies could improve access to training, especially in small countries. A new strategy for HIV-positive health workers entitled "Treat, train and retain", was being developed and would complement national human resource strategies. WHO looked forward to working with its various partners, including regional economic communities and others beyond the health sector, through the new Global Health Workforce Alliance.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) suggested deleting the words "and global funds" in paragraph 1(3) of the draft resolution, which already contained the phrase "encouraging financial support by global health partners".

Mr AITKEN (Adviser to the Director-General) read out the four amendments proposed to the draft resolution. Australia had proposed replacing "establishing" in paragraph 1(1) by "giving consideration to the establishment of". The United Kingdom had proposed deleting the words "and global funds" in paragraph 1(3). In paragraph 1(5) Palau had proposed inserting the words "and nongovernmental organizations" after "public and private sectors" and the words "including consideration of effective mechanisms for utilization of trained volunteers" at the end.

Dr WINT (Jamaica) proposed inserting the words "capacity and" before "quality" in paragraph 2(3).

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[1] Blanchet K, Keith R, Shackleton P. *One million more – healthcare professionals for capacity building in Africa*. London, Save the Children, 2006; *Whose charity? Africa's aid to the NHS*. Briefing. London, Save the Children, 2005.

Mr HOHMAN (United Stated of America) expressed concern at the financial implications of the draft resolution: the total estimated cost for implementation was more than US$ 18 million. That implied a cost of over US$ 9 million in the current biennium and a shortfall of over US$ 6 million. What were the prospects of covering the shortfall?

Dr EVANS (Assistant Director-General) explained that the likely shortfall was expected to be covered by resources mobilized through the Global Health Workforce Alliance. Commitments of US$ 4 to 5 million had already been made since its launch earlier in the week, and the Alliance would have an annual budget of around US$ 7 to 9 million.

Mr QUASHIGAH (Ghana) said that the Australian amendment to paragraph 1(1) would weaken the resolution.

Mr SAWERS (Australia) said that his Government had no difficulty with the notion of establishing mechanisms to mitigate the loss of health personnel, but he was calling for some flexibility to determine what kind of mechanisms were most appropriate in different circumstances. He had not yet had time to consult his Government on the question.

Dr YOOSUF (Maldives) proposed inserting the word "developed" after "receiving" in paragraph 1(1). Small recipient countries like his own might not have the capacity to provide support for others.

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

Prevention of avoidable blindness and visual impairment: Item 11.7 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R4 and Annex 4, and A59/12) (continued from the ninth meeting)

The CHAIRMAN drew attention to the revised draft resolution, which read:

> The Fifty-ninth World Health Assembly,
>
> Having considered the report on prevention of avoidable blindness and visual impairment;[2]
>
> Recognizing that more than 161 million people worldwide are visually impaired, of whom 37 million are blind, and that an estimated 75% of blindness is avoidable **or curable using established and affordable technologies**;
>
> Recalling resolution WHA56.26 on the elimination of avoidable blindness;
>
> Noting with concern that only 32% of targeted countries had drafted a national Vision 2020 plan by August 2005;
>
> Acknowledging the links between poverty and blindness and that blindness places a heavy economic burden on families, communities and countries, particularly developing countries;
>
> Further acknowledging that control of both onchocerciasis and trachoma has come about through the commitment of broad international alliances;
>
> Noting that many Member States have committed themselves to providing support for the Global Initiative for the Elimination of Avoidable Blindness, known as Vision 2020 – the Right to Sight**;**

[1] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA59.23.

[2] Document A59/12.

Welcoming the important actions developed at regional, subregional and international levels by Member States with the view to achieving substantial progress in the elimination of avoidable blindness through greater international cooperation and solidarity,

1. URGES Member States:
   (1) to reinforce efforts to set up national Vision 2020 plans as called for in resolution WHA56.26;
   (2) to provide support for Vision 2020 plans by ~~sustaining necessary~~ **mobilizing domestic** funding ~~at national level~~;
   (3) to include prevention of avoidable blindness and visual impairment in national development plans and goals;
   (4) to advance the integration of prevention of avoidable blindness and visual impairment **in primary health care and** in existing health plans and programmes at regional and national levels;
   (5) to encourage partnerships between the public sector, nongovernmental organizations**,** ~~and~~ the private sector**, civil society and communities** in programmes and activities for prevention of blindness at all levels;
   (6) to develop and strengthen eye-care services and integrate them in the existing health-care system at all levels, including the training and re-training of health workers in visual health;
   (7) to make available within ~~national~~ health systems essential medicines and medical supplies needed for eye care;

2. REQUESTS the Director-General:
   (1) to give priority to prevention of avoidable blindness and visual impairment;
   (2) **(a)** to provide necessary technical support to Member States and**;**
   (b) to provide support to collaboration among countries for the prevention of avoidable blindness and visual impairment **in particular in the area of training of all categories of relevant staff**;
   (3) to monitor progress in the Global Initiative for the Elimination of Avoidable Blindness in collaboration with international partners, and to report to the Executive Board every three years**;**
   (4) to include activities for prevention of blindness and visual impairment in WHO's Eleventh General Programme of Work to help provide necessary technical support to Member States, and to strengthen global, regional and national activities for prevention of blindness;
   (5) to add activities for the prevention of blindness activities to WHO's medium- term strategic plan 2008-2013 and proposed programme budget 2008–2009;
   (6) to strengthen cooperation through regional, subregional and international efforts with the view to achieving the goals set up by this resolution.

Mr AITKEN (Adviser to the Director-General) added that the delegation of the Bolivarian Republic of Venezuela had proposed the insertion of two new subparagraphs in paragraph 1, as follows:

"(7) to promote and provide improved access to health services both with respect to prevention as well as treatment of ocular conditions;
(8) to encourage the integration, cooperation and solidarity between countries in the areas of prevention and care for blindness and visual impairment;"

Paragraph 1 would be renumbered accordingly. In addition, the words "activities for" in subparagraphs 2(4) and 2(5) should be deleted.

Mr HOHMAN (United States of America), referring to subparagraphs 2(4) and 2(5), asked how the prevention of blindness and visual impairment could be included in the Eleventh General Programme of Work, which had already been approved. In the same light, how was it proposed to incorporate it into the medium-term strategic plan for 2008–2013?

Dr LE GALÈS-CAMUS (Assistant Director-General) said that, subject to approval by Member States, the prevention of blindness and visual impairment would be incorporated into activities to reduce the morbidity and mortality associated with chronic and noncommunicable diseases, in which emphasis was placed on country programmes. The strategic objectives and expected outcomes for the period concerned were being worked out, and there should be room for the activities contemplated in the draft resolution.

Dr LASSMANN (Austria) said that the European Union, while sympathetic to the proposed new subparagraphs 2(4) and 2(5), shared the concerns of the delegate of the United States of America. Alternatively, he suggested amending the beginning of the paragraph to read "to take into account prevention of blindness and visual impairment in the implementation of WHO's Eleventh General Programme of Work". Paragraph 2(5) could then read: "to consider prevention of blindness activities in the process of developing WHO's medium-term strategic plan 2008–2013 and proposed programme budget 2008–2009;". The European Union would prefer to delete paragraph 1(4).

Dr AL-RAJHI (Saudi Arabia) emphasized prevention; the burden of avoidable blindness in Member States could easily be halved. Seven of the Millennium Development Goals depended on measures that were linked to the achievement of VISION 2020 objectives. Prevention of blindness should therefore be part of the Eleventh General Programme of Work. It was also clear that most delegates favoured making it a priority in the medium-term strategic plan.

The CHAIRMAN invited the delegates of Austria and Saudi Arabia to seek agreement on a proposed form of words for the paragraphs in question.

Ms HEFFORD (Australia) asked how the proposed paragraph 2(4) could be acted upon.

Mr AITKEN (Adviser to the Director-General) explained that the Eleventh General Programme of Work had not yet been adopted in plenary. He suggested that the Committee approve a form of words for the draft resolution that would permit the Secretariat to combine both documents, thus relating prevention of blindness activities to the General Programme of Work.

The CHAIRMAN suggested that the agenda item remain open for further consultations.

It was so agreed.

(For approval of the draft resolution, see page 170 below.)

Dr Leppo took the Chair.

International trade and health: Item 11.10 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R5 and Annex 4, and A59/15) (continued from the tenth meeting)

The CHAIRMAN drew attention to the revised draft resolution:

The Fifty-ninth World Health Assembly,

Having considered the report on international trade and health;[1]

Recalling resolutions WHA52.19, WHA53.14, WHA56.23, WHA56.27, WHA57.14 and WHA57.19;

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

Mindful of the need for all relevant ministries, including those of health, trade, commerce, finance and foreign affairs, to work together constructively in order to ensure that the interests of trade and health are appropriately balanced and coordinated,

1. URGES Member States:

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

(2) to adopt, where necessary, policies, laws and regulations that deal with issues identified in that dialogue and take advantage of the potential opportunities, and address the potential challenges that trade and trade agreements may have for health;

(3) to apply or establish, where necessary, coordination mechanisms involving ministries of finance, health, and trade, and other relevant institutions, to address public health related aspects of international trade;

(4) to create constructive and interactive relationships across the public and private sectors for the purpose of generating coherence in their trade and health policies;

(5) to continue to develop capacity at national level to track and analyse the potential opportunities and challenges of trade and trade agreements for health-sector performance and health outcomes**, also taking into account the special problems of countries through which health goods and services transit;**

(6) to reflect all the flexibilities permitted under international trade agreements in national laws to address public health concerns;

2. REQUESTS the Director-General:

(1) to provide support to Member States, at their request and in collaboration with the competent international organizations, in their efforts to frame coherent policies to address the relationship between trade and health;

(2) to respond to Member States' requests for support of their efforts to build the capacity to understand the implications of international trade and trade agreements for health and to address relevant issues through policies and legislation that take advantage of the potential opportunities, and address the potential challenges, that trade and trade agreements may have for health;

(3) to continue collaborating with the competent international organizations in order to support policy coherence between trade and health sectors at regional and global levels, including generating and sharing evidence on the relationship between trade and health;

(4) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

[1] Document A59/15.

Mr HOHMAN (United States of America) pointed out that the original text had been adopted by the Executive Board by consensus. He queried the meaning of "the special problems of countries through which health goods and services transit" in paragraph 1(5).The proposed new paragraph 1(6) seemed to be adequately covered by other Health Assembly resolutions, including the proposed resolution on intellectual property rights.

Dr BOR (Turkey) corrected the amendment proposed by her country 1(5) to read: "also taking into account the special problems all countries through which goods and services transit may face". Significant public health problems were caused by international trade agreements, and should not be ignored. The products that were subject to such agreements affected the public health of the country through which they transited. The amendment broadened the scope of the draft resolution in order to include that concern.

Mr HOHMAN (United States of America) said that that explanation did not allay his misgivings.

Mr SHARMA (India) said that the new paragraph 1(6) that he proposed was in full conformity with the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration. Developing countries should reflect in their national laws the flexibilities permitted under various international trade agreements. Nonetheless, he was open to changes in the wording of the proposed amendment.

Mr SAWERS (Australia) said that he shared the concerns of the United States of America about the amendments proposed to a text that had been the outcome of a finely-tuned agreement in the Executive Board. The logic of the amendment by the delegate of Turkey was difficult to understand. The amendment proposed by the delegate of India overlapped with the draft resolution on intellectual property rights and other points that he had raised were already covered, to some extent, in paragraph 1(5). The TRIPS agreement enabled countries to make use of the flexibilities in international trade agreements, without compelling them to do so.

Mr HOHMAN (United States of America) said that, in that light, he would prefer to delete the proposed new paragraph 1(6) altogether.

Mr SHARMA (India) suggested, as an alternative, deleting paragraph 1(6) and adding the phrase "using the flexibilities inherent in them" at the end of paragraph 1(2).

Dr SUWIT WIBULPOLPRASERT (Thailand) said that the draft resolution drew attention to both the positive and the negative implications of international trade for public health. It was a question of increasing the positive effects and reducing the negative ones. He supported the proposal to delete paragraph 1(6). If the Committee decided to approve the draft resolution unamended, it should at least take note of the concerns expressed by the delegates of India and Turkey.

Dr BOR (Turkey) said that, despite Turkey's strong feelings about the subject of its proposed amendment, it was prepared to withdraw it for the sake of consensus.

Mr HOHMAN (United States of America), welcoming the spirit of cooperation showed by the authors of the amendments, said that he could accept the Indian proposal if paragraph 1(2) were amended to read "considering where appropriate using the flexibilities inherent in them".

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

Smallpox eradication: destruction of variola virus stocks: Item 11.5 of the Agenda (Documents A59/10 and A59/10 Add.1) (continued from the seventh meeting)

The CHAIRMAN recalled that the draft resolution contained in document A59/10 had been considered by a working group.

Professor WICHIT SRISUPHAN (Thailand), speaking as chairman of the working group, said that, despite its best efforts, the group had been unable to reach a consensus on a final text. It therefore had proposed that the text finalized by the working group should be submitted to the Executive Board at its session in January 2007 for consideration.

The CHAIRMAN said that he took it that the Committee wished to recommend the following decision for adoption by the Health Assembly:

> **"Decision:** The Fifty-ninth World Health Assembly decided to submit the text of the draft resolution entitled "Smallpox eradication: destruction of variola virus stocks" as proposed by a working group of Committee A to the 119th session of the Executive Board for further consideration."

It was so decided.[2]

Implementation of resolutions: progress reports: Item 11.17 of the Agenda (Document A59/23) (continued)

- **Strengthening nursing and midwifery (resolution WHA54.12)** (continued from the third meeting)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Botswana, Canada, Fiji, Ireland, Jamaica, Jordan, Nauru, New Zealand, Pakistan, Seychelles, Thailand, United Kingdom of Great Britain and Northern Ireland and Zimbabwe, which read as follows:

> The Fifty-ninth World Health Assembly,
>
> Having considered the progress report on strengthening nursing and midwifery;[3]
>
> Recognizing the centrality of human resources for health to the effective operation of country health systems as highlighted in *The world health report 2006*;[4]
>
> Recognizing the crucial contribution of the nursing and midwifery professions to health systems, to the health of the people they serve, and to efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;
>
> Recalling resolution WHA57.19 on the challenge posed by the international migration of health personnel;
>
> Recognizing the impact of "push" and "pull" factors in the countries concerned;

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[1] Transmitted to the Health Assembly in the Committee's sixth report, and adopted as resolution WHA59.26.

[2] Transmitted to the Health Assembly in the Committee's sixth report, and adopted as decision WHA59(12).

[3] Document A59/23.

[4] *The world health report 2006. Working together for health*. Geneva, World Health Organization, 2006.

Concerned at continuing shortage of nurses and midwives in many countries, and its impact on health care, and more widely;

Mindful of previous resolutions to strengthen nursing and midwifery, including resolutions WHA42.27, WHA45.5, WHA49.1 and WHA54.12, and the strategic directions for nursing and midwifery services in place for the years 2002–2008;[1]

Concerned that some Member States do not yet give full recognition to the contribution of nursing and midwifery in their programmes and practices;

1. URGES Member States to confirm their commitment to strengthen nursing and midwifery by:

(1) establishing comprehensive programmes for the development of human resources which support the recruitment and retention in sufficient numbers of a skilled and motivated nursing and midwifery workforce within their health services;

(2) actively involving nurses and midwives in the development of their health systems and in the framing, planning and implementation of health policy at all levels, including ensuring that posts of chief officer for nursing and midwifery exist within governments, and have real influence;

(3) ensuring continued progress toward implementation at country level of WHO's strategic directions for nursing and midwifery;

(4) regularly reviewing legislation and regulatory processes relating to nursing and midwifery in order to ensure that they enable nurses and midwives to make their optimum contribution in the light of changing conditions and requirements;

(5) to provide support for the collection and use of nursing and midwifery core data as part of national health information systems;

2. REQUESTS the Director-General:

(1) to ensure the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nursing and midwifery personnel;

(2) to provide continuing support for the work of the Global Advisory Group on Nursing and Midwifery, and to ensure the contribution of nursing and midwifery in the development and implementation of WHO's policy and programmes;

(3) to provide support to Member States in optimizing the contribution of nursing and midwifery to meeting national health policies and the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(4) to encourage and support Member States in the provision of workplace environments that are safe and support the retention of nurses and midwives;

(5) to report to the Sixty-third World Health Assembly in 2010 on progress made in the implementation of this resolution.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, despite increased training capacity for nurses and midwives in public and private colleges, shortages and inequitable distribution persisted. His country had one nurse per 740 people, as against the national target of one per 500. Nursing and midwifery staff, the backbone of the health system, had played a crucial role in national health development in Thailand for several decades, working in subdistrict, district, provincial and specialist hospitals. Nurses had promoted health, including prevention, and curative and rehabilitative care. They fulfilled a range of roles such as: midwifery; community health; providing primary medical care for the treatment of common illnesses; anaesthetists; and clinical nurse specialists. Recently, universal

[1] *Nursing and midwifery services; strategic directions 2002-2008*. Geneva, World Health Organization, 2002.

coverage in Thailand had stretched human resources in the public health sector, including nursing staff. In addition, the increased demand for private hospitals, as a result of economic growth and much higher salaries in the private sector, was contributing to an internal migration of nurses from the public to the private sector. A growing international migration trend was also being observed.

Expressing strong support for the draft resolution, he proposed certain amendments: in paragraph 1(1), to insert ", while ensuring geographical equitable distribution," after the word "retention"; to insert "balanced skill mixed," after the words "sufficient number of a"; to add a new paragraph 1(6), reading "to support the development and implementation of ethical recruitment of national and international nursing and midwifery staff"; and to insert a new paragraph 2(3), reading "to provide support to Member States, in collaboration with local and global partners, to strengthen the application of ethical recruitment guidelines".

Ms BARNES (Ireland), expressing support for the draft resolution, emphasized that nurses and midwives were central to health services, health promotion, prevention, treatment and rehabilitation. Nursing and midwifery were a vital resource for extending health interventions so as to meet national targets. Health care was labour-intensive, and the effective use of nurses and midwives should be integrated into human resources planning; the supply of competent nurses and midwives was essential.

Full use of the skills of nurses and midwives could cut costs and improve the quality of patient care. She therefore requested the Director-General: to continue to provide support for the Global Advisory Group on Nursing and Midwifery and ensure the contribution of nursing and midwifery to WHO policy; to ensure that nursing and midwifery were a major focus of the work of the new Global Health Workforce Alliance; and to support Member States in providing workplace environments that were safe and encouraged nurses to remain.

Mrs BANDAZI (Malawi), supporting for the draft resolution, said that most of the relevant matters had been discussed under agenda item on international migration of health personnel. In Malawi, most migrating workers were nurses; 60% of nursing posts were vacant, resulting in poor working environments and low morale for those remaining. Training institutions were not producing enough nurses. Thus, Malawi would find it difficult to achieve the Millennium Development Goals.

Malawi had begun an emergency training plan and infrastructure investment with partners in order to create more classrooms, libraries and hostel accommodation so that nursing schools could double their intake. More nurse tutors were being trained. Retention of staff was crucial, and the country would introduce incentives for people working in remote areas with housing shortages. Equipment and training were being provided for public sector nurses. The recruitment of retired nurses and those engaged in non-nursing duties had begun, and a recent study indicated positive results. Some bureaucratic difficulties remained, such as in recruitment and payroll. However, those were being dealt with and nursing was receiving necessary support.

Dr Ramadoss took the Chair.

Mr KAZENENE (Zambia), speaking on behalf of the Member States of the African Region, said that the Region was facing a shortage of health-care personnel, particularly nurses and midwives, as a result of migration, limited supply of new nurses and attrition due to HIV/AIDS. In response to resolution WHA54.12, on strengthening nursing and midwifery, the countries of the Region had adopted strategic directions for strengthening those services. The result should be to enhance national health systems in order to meet priority health goals and the goals contained in the Millennium Declaration. Some countries had revised their regulatory framework and training curricula in order to expand the role of nurses and midwives. The Region had benefited from its strategic directions and implementation of the resolution WHA54.12, which would enhance health-care services. He supported the draft resolution.

Ms WANGMO (Bhutan) supported the draft resolution. She gave full recognition to nursing and midwifery services, without which her country would be unable to achieve the Millennium

Development Goals. Great importance was accorded to proper planning for those services, in particular the training and retention of staff. She urged the Director-General to provide support to Member States in order to strengthen their nursing and midwifery services. The present state of both professions made it imperative for the Secretariat to monitor and report to the Sixty-third World Health Assembly on implementation of the draft resolution.

Dr AHMED (Pakistan) said that, in nearly all countries, nurses and midwives were the largest group of health-care professionals and those who had most contact with patients. They were essential to achieving the Millennium Development Goals and other WHO priority programme objectives. A shortage of health-care staff would have adverse effects on patients and health systems. Pakistan shared the concerns of many other countries regarding the recruitment and retention of nurses and midwives. The crisis required urgent, sustainable, country-led action and international support. Pakistan acknowledged the need to strengthen its own capacity, and was therefore working with WHO and other international organizations in order to host a high-level consultation on nursing and midwifery in 2006 in order to examine local, regional and international issues.

Concerted action was needed in order to stem the crisis, and the Health Assembly must monitor the situation of nursing and midwifery, given countries' dependence on nurses and midwives for essential health-care services.

Ms WISEMAN (Canada) acknowledged the contribution of nurses and midwives to the health of people throughout the world. Their shortage in some countries had, however, become a major obstacle to achieving the Millennium Development Goals. The crisis required urgent, sustainable and country-led action in order to build capacity and self-sufficiency.

Ms VALLIMIES-PATOMÄKI (Finland) said that, given the importance the Health Assembly attached to human resources for health, she would have expected the matter to be higher on its agenda. Expressing support for the draft resolution, she proposed two amendments: the addition to paragraph 2(2) of "to recruit nurses and midwives in all relevant WHO programmes," after "Global Advisory Group on Nursing and Midwifery, and", and, in paragraph 2(5), a request to the Director-General to report to the Health Assembly in 2008, as well as 2010.

Dr MATHESON (New Zealand) said that in some countries conflict, disease and international migration had compromised the workforce of nurses and midwives, who were essential in health care. The situation should be stabilized and reversed, with input on nursing and midwifery at senior government level. Nursing and midwifery should be made attractive career options for both newcomers and existing professionals. Conditions should match the responsibility of the job and include fair pay, professional development and the possibility to exercise judgement as to how care was delivered. He commended the draft resolution and looked forward to working with governments, the Health Assembly, and organizations such as WHO, ILO, the International Council of Nurses and the Global Advisory Group on Nursing and Midwifery on its implementation. Every country should sustain, maintain and improve the essential professions in question.

Mr RUÍZ MATUS (Mexico) expressed support for the draft resolution.

(For approval of the draft resolution, see page 167 below.)

Intellectual property rights: Item 11.11 of the Agenda (continued)

- **Commission on Intellectual Property Rights, Innovation and Public Health: report** (Documents A59/16, A59/16 Add.1 and A59/16 Add.2) (continued from the fifth meeting, section 2)

- **[Global framework on] essential health research and development** (Documents EB117/2006/REC/1, resolution EB117.R13 and Annex 4, and A59/17) (continued from the fifth meeting, section 2)

The CHAIRMAN drew the Committee's attention to a new draft resolution, the outcome of an open-ended working group, which read:

The Fifty-ninth World Health Assembly,

Recalling resolution WHA56.27, which requested the Director-General to establish terms of reference for an appropriate time-limited body to collect data and proposals from the different actors involved and produce an analysis of intellectual property rights, innovation and public health;

Further recalling resolutions WHA52.19, WHA53.14, WHA54.10, and WHA57.14;

Having considered the report of the Commission on Intellectual Property Rights, Innovation and Public Health;[1]

Conscious of the growing burden of diseases and conditions disproportionately affecting developing countries, particularly those affecting women and children, including an upsurge in noncommunicable diseases;

Considering the need to continue to develop safe and affordable new products[2] for such communicable diseases as AIDS, malaria and tuberculosis, and for other diseases or illnesses disproportionately affecting developing countries;

Conscious of the opportunities opened up by advances in biomedical science, and the need to harness them more effectively to develop new products, particularly in order to meet public health needs in developing countries;

Aware of the considerable progress that has been made in recent years by governments, industry, charitable foundations, and nongovernmental organizations in funding initiatives to develop new products to fight diseases affecting developing countries, and to increase access to existing ones;

Recognizing, however, that much more needs to be done in relation to the scale of avoidable suffering and mortality;

Concerned about the need for appropriate, effective and safe health tools for patients living in resource-poor settings;

Considering the urgency of developing new products to address emerging health threats such as multidrug-resistant tuberculosis, and other infectious diseases of particular relevance to developing countries;

Aware of the need for additional funding for research and development for new vaccines, diagnostics and pharmaceuticals, including microbicides, for illnesses, including AIDS, that disproportionately affect developing countries;

Recognizing the importance of, and need for, public/private partnerships devoted to the development of new essential drugs and research tools, and aware of the need for governments

[1] Public health, innovation and intellectual property rights. Report of the Commission on Intellectual Property Rights, Innovation and Public Health. April 2006.

[2] The word "products" hereafter should be understood to include vaccines, diagnostics and medicines.

to set a needs-based priority agenda for health, and to provide political support and sustainable sources of funding for such initiatives;

Recognizing the importance of public and private investment in the development of new medical technologies;

Considering that a number of developing countries have been strengthening their research and development capacity in new health technologies, and that their role will be increasingly critical, and recognizing the need for continued support for research in and by developing countries;

Noting that intellectual property rights are an important incentive for the development of new health-care products;

Noting, however, that this incentive alone does not meet the need for the development of new products to fight diseases where the potential paying market is small or uncertain;

Noting that the Doha Ministerial Declaration on the TRIPS Agreement and Public Health confirms that the Agreement does not and should not prevent Members from taking measures to protect public health;

Further noting that the Declaration, while reiterating commitment to the Agreement on Trade Related Aspects of Intellectual Property Rights (TRIPS) affirms that the Agreement can and should be interpreted and implemented in a manner supportive of the rights of WTO Members to protect public health and, in particular, to promote access to medicines for all;

Taking into account Article 7 of the TRIPS agreement that states that "the protection and enforcement of intellectual property rights should contribute to the promotion of technological innovation and to the transfer and dissemination of technology, to the mutual advantage of producers and users of technological knowledge and in a manner conducive to social and economic welfare, and to a balance of rights and obligations";

Stressing that the Universal Declaration of Human Rights provides that "everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits" and that "everyone has the right to the protection of the moral and material interests resulting from any scientific, literary or artistic production of which he is the author";

Concerned about the impact of high prices of medicines on access to treatment;

Aware of the need to promote new thinking on the mechanisms that support innovation;

Recognizing the importance of strengthening capacity of local public institutions and businesses in developing countries to contribute to, and participate in, research and development efforts;

Noting that the report of the Commission requests that WHO should prepare a global plan of action to secure enhanced and sustainable funding for developing and making accessible products to address diseases that disproportionately affect developing countries,

1. WELCOMES the report of the Commission on Intellectual Property Rights, Innovation and Public Health and expresses its appreciation to the Chair, Vice-Chair and Members of the Commission for their work;

2. URGES Member States:[1]

(1) to make global health and medicines a priority sector, to take determined action to emphasize priorities in research and development addressed to the needs of patients, especially those in resource-poor settings, and to harness collaborative research and development initiatives involving disease-endemic countries;

(2) to consider the recommendations of the report and to contribute actively to the development of a global strategy and plan of action, and to take an active part, working

[1] Where applicable, also regional economic integration organizations.

with the secretariat and international partners, in providing support for essential medical research and development;

(3) to work to ensure that progress in basic science and biomedicine is translated into improved, safe and affordable health products – drugs, vaccines and diagnostics – to respond to all patients' and clients' needs, especially those living in poverty, taking into account the critical role of gender**,** and to ensure that capacity is strengthened to support rapid delivery of essential medicines to people;

(4) to encourage trade agreements to take into account the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;

(5) to ensure that the report of the WHO Commission on Intellectual Property Rights, Innovation and Public Health is included on the agendas of WHO's regional committees in 2006;

3. DECIDES:

(1) to establish, in accordance with Rule 42 of the Rules of Procedure of the World Health Assembly, an intergovernmental working group open to all interested Member States to draw up a global strategy and plan of action in order to provide a medium-term framework based on the recommendations of the Commission. Such a strategy and plan of action aimed at, inter alia, securing an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

(2) that regional economic integration organizations constituted by sovereign States, Members of WHO, to which their Member States have transferred competence over matters governed by this resolution, including the competence to enter into international legally binding regulations, may participate, in accordance with Rule 55 of the Rules of Procedure of the World Health Assembly, in the work of the intergovernmental working group referred to under paragraph (1);

(3) that the above-mentioned working group shall report to the Sixtieth World Health Assembly through the Executive Board on the progress made, giving particular attention to needs-driven research and other potential areas for early implementation action.

(4) that the working group shall submit the final global strategy and plan of action to the Sixty-first World Health Assembly through the Executive Board;

4. REQUESTS the Director-General:

(1) to convene immediately the intergovernmental working group and to allocate the necessary resources to it;

(2) to invite, as observers at the sessions of the intergovernmental working group, representatives of non-Member States, of liberation movements referred to in resolution WHA27.37, of organizations of the United Nations system, of intergovernmental organizations with which WHO has established effective relations, and of nongovernmental organizations in official relations with WHO, who shall attend the sessions of the working group in accordance with the relevant Rules of Procedure and resolutions of the Health Assembly;

(3) to invite experts and a limited number of concerned public and private entities to attend the sessions of the intergovernmental working group and to provide advice and expertise, as necessary, upon request of the Chair, taking into account the need to avoid conflicts of interest;

(4) to continue to issue public health-based research and development reports, identifying from a public health perspective**,** gaps and needs related to pharmaceuticals, and to report on them periodically;

(5) to continue to monitor, from a public health perspective, in consultation as appropriate with other international organizations, the impact of intellectual property rights and other issues addressed in the Commission's report**,** on the development of, and access to, health care products, and report thereon to the Health Assembly.

Mr SILBERSCHMIDT (Switzerland), speaking in his capacity as chairman of the drafting group, said that the two original draft resolutions had been combined into one. One small editorial change needed to be made to the English version of the text: in paragraph 3(1), the phrase "Such a strategy and plan of action aimed at" should be altered to read "Such a strategy and plan of action aims at".

The CHAIRMAN invited the Committee to consider the draft resolution, as amended.

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

Implementation of resolutions: progress reports: Item 11.17 of the Agenda (Document A59/23) (resumed)

- **Strengthening nursing and midwifery (resolution WHA54.12)** (resumed)

Ms ZHANG Lingli (China) expressed appreciation that nursing and midwifery had been included in the agenda of the Health Assembly. China had a nursing plan for 2005–2010 and regulations were being prepared. A manual for management of midwifery skills was being drafted in order to improve nursing and midwifery services. The shortage of nurses and midwives was a global problem also faced by China. She supported the draft resolution. The Director-General should continue devoting attention to nursing and midwifery, in particular by assisting developing countries through preferential policies and technical assistance.

Ms CHASOKELA (Zimbabwe) supported the draft resolution.

Dr AL-THANI (Qatar) said that Qatar was experiencing a shortage of qualified nurses and midwives, with only 14% coverage nationally. He applauded the Secretariat's support for nursing and midwifery, and urged Member States to redouble their efforts to strengthen both professions. He supported the draft resolution.

Ms SOUSA (Portugal) supported the draft resolution as amended by Finland. Nurses and midwives made up 80% of health-care professionals and it was important to establish a strategy in order to strengthen the professions and thereby improve motivation by making staff feel more valued.

Mrs TRUELSEN (Denmark), expressing broad support for the draft resolution, nevertheless considered that the detailed recommendation contained in paragraph 1(2) on how Member States should organize health-care authorities fell outside the natural mandate of WHO. She therefore suggested rewording the subparagraph, after "all levels, including ensuring", to read: "that nursing and midwifery is represented at all appropriate government levels".

Ms IWASAWA (Japan) supported for the draft resolution, as strengthening nursing and midwifery was crucial to maintaining health systems. She announced that the International Council of Nurses and the Japanese Nursing Association would jointly host the ICN International Conference in Yokohama from 27 May to 1 June 2007.

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[1] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA59.24.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) expressed strong support for measures to strengthen nursing and midwifery. Nurses and midwives had a crucial role in health-care systems, not only providing health care to people in their own countries but also assisting in achieving the Millennium Development Goals. He supported the draft resolution, as amended by Finland.

Ms BEHRENS (United States of America) said that nurses and midwives around the world represented the largest professional group of health-care providers, and were thus essential to high-quality patient care and the overall health of populations. The shortage already seen in many countries was becoming a worldwide phenomenon, profoundly affecting the provision of care, even at the most basic levels. According to one report, there was a shortfall of 6000 nurses in sub-Saharan Africa, for scaling up priority interventions.

The nursing workforce was ageing. Governments, higher education institutions and the health-care industry must invest in the education infrastructure for training nurses, and remuneration must reflect the high skill levels of nurses and midwives. She supported adoption of the draft resolution as submitted; that would demonstrate that the Health Assembly recognized the shortage of nurses and midwives as a very serious barrier to good health care. The requirement for a report to be submitted to the Health Assembly in 2010 would ensure that the matter was given constant attention.

Mrs COOPER-SHARPE (Jamaica) said that in Jamaica nurses and midwives were included in all health-related human resources initiatives, including research, policy formulation and decision-making at all levels. The curricula of nursing schools had been continually updated, training improved and further education requirements regulated, ensuring relevancy and building capacity to meet health challenges. Although her country had faced serious obstacles to strengthening nursing and midwifery, it would continue seeking new ways to overcome them.

Dr MOETI (Botswana) affirmed the crucial role of nursing and midwifery in Botswana's health services. With the growing complexity of health services, the role of nurses had expanded to include additional tasks and responsibilities. He commended the draft resolution as amended by Denmark.

Ms PÉREZ ALVAREZ (Cuba) said that the migration of nurses and midwives was one of the most acute global problems for health care. The number of nurses and midwives had increased to nearly 90 000 in Cuba, which benefited other countries besides Cuba, and they were appropriately distributed throughout the country. Nursing training had been revolutionized, by starting during the last three years of secondary school. Cuba currently had almost 8200 student nurses and midwives, who would gain technical nursing qualifications before going on to obtain a degree in nursing studies. Furthermore, as a result of new, decentralized teaching methods, some 31 000 students throughout the country were undergoing nursing training. A project was under way to encourage nurses and midwives to participate in the "safe maternity" initiative, in which a number of nursing professionals was being trained to specialize.

Dr PILLAY (South Africa) said that South Africa had a well-regulated and organized nursing sector but, like other developing countries, faced challenges in training and retaining qualified nurses and midwives. South Africa was therefore implementing a nursing strategy, formulated in consultation with nurses and midwives, within the context of the recently launched national "human resources for health" plan. He supported the draft resolution, as amended by Denmark.

Mrs ROROI (Papua New Guinea) supported the draft resolution. Nurses and midwives constituted the bulk of the health workforce, and provided the essential health services involved in attaining Millennium Development Goals 3, 4 and 5. Regrettably, countries in the South Pacific currently had the lowest social indicators. She acknowledged the support and assistance received from regional development partners and WHO.

Dr NYIKAL (Kenya) said that Kenya had an acute shortage of health staff, particularly nurses, who were the mainstay of the district health services, which provided care for most of the population. Kenya needed 47 000 nurses but had only 16 000, thereby thwarting achievement of the Millennium Development Goals. It had revised the Nurses Act in conformity with paragraph 1(4) of the draft resolution, in order to improve training and working conditions and re-position the profession in the health sector. Although the problem of migration had already been examined, he emphasized that receiving countries had a duty to contribute to training in source countries. He expressed support for the draft resolution, as amended.

Dr FAUVEAU (UNFPA) welcomed WHO's decision to focus on the health workforce for World Health Day and in *The world health report 2006*. He supported the draft resolutions on strengthening nursing and midwifery and on the international migration of health personnel. UNFPA focused on health workers responsible for delivering reproductive health services, particularly maternal health services and obstetric care. With regard to the Millennium Development Goal 5 indicator "proportion of births attended by skilled health personnel", he acknowledged that the term "skilled attendant" included not only midwives but also all others with midwifery skills. All the problems and constraints raised in *The world health report 2006* applied to midwives and others with midwifery skills. As a predominantly female workforce focusing on women, that category of health workers was often subjected to gender-related discrimination, in terms of attitudes and rights protection. UNFPA joined WHO and others in calling for an alliance of partners, governments, international organizations, civil society, professional associations, research and training institutions and donors in order not only to mobilize financial and technical resources but also to increase awareness and political commitment in favour of that specific cadre of health workers.

Dr OULTON (International Council of Nurses), speaking at the invitation of the CHAIRMAN, supported the draft resolution. In order to move forward, WHO needed to examine several matters. Nurse leaders of 101 countries had met recently in Geneva, and had issued a communiqué. In regard to its own resources, the Secretariat must take into account that in the past three years the percentage of nursing and midwifery personnel in the professional grades of the Secretariat had fallen from 2.6% to 1.8%. Regrettably, funding for nursing and midwifery within headquarters was so low that it had been necessary to use nurses' fees to the Council to pay the Secretariat for translation of its key nursing and midwifery data collection tool: clearly, something was wrong. WHO must strengthen nursing and midwifery, given the evidence that nurses and midwives provided cost-effective care and better outcomes. She asked what steps the Secretariat would take in order to strengthen nursing and midwifery within WHO, and within national ministries and health systems globally.

Dr EVANS (Assistant Director-General) acknowledged Pakistan's offer to host a global consultation on nursing and midwifery later in 2006. He confirmed WHO's commitment to and ongoing support for the work of the Global Advisory Group on Nursing and Midwifery. In response to the previous speaker, he said that the Secretariat would continue to strengthen nursing and midwifery within the Organization at all levels, and within the health system in general, focusing on the health workforce.

Mr AITKEN (Adviser to the Director-General) read out the proposed amendments to the draft resolution. In paragraph 1(1), Thailand had proposed inserting the words "while ensuring equitable geographical distribution" between commas after "retention", and inserting "a balanced skill mix, and" after "sufficient numbers of". In paragraph 1(2), Denmark had proposed deleting the words "posts of chief officer for", and inserting "is represented at all appropriate governmental levels and has real influence" after "nursing and midwifery". Thailand had also proposed a new paragraph 1(6) that would read: "to support the development and implementation of ethical recruitment of national and international nursing and midwifery staff".

In paragraph 2(2), Finland had proposed inserting before "and to ensure" the words "and to recruit nurses and midwives in all relevant WHO programmes". Thailand had proposed a new

paragraph 2(3) reading: "to provide support to Member States, in collaboration with local and global partners, to strengthen the application of ethical recruitment guidelines". It was proposed that paragraph 2(5) should be amended to read: "to report to the Sixty-first and Sixty-third World Health Assemblies in 2008 and 2010 on progress made …".

Mr HOHMAN (United States of America) sought clarification of Thailand's amendment to paragraph 1(1) concerning the insertion of "equitable geographical distribution".

Professor WICHIT SRISUPHAN (Thailand) said that the phrase was meant to ensure that the nursing and midwifery workforce was not concentrated in cities but evenly distributed throughout the country, including remote areas.

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

Prevention of avoidable blindness and visual impairment: Item 11.7 of the Agenda (Documents EB117/2006/REC/1, resolution EB117.R4, and A59/12) (resumed)

Dr AL-RAJHI (Saudi Arabia) said that agreement had been reached on an amendment to paragraph 2(4), which would read: "to ensure that prevention of blindness and visual impairment are included in the implementation and monitoring of WHO's Eleventh General Programme of Work and provide necessary technical support to Member States and strengthen global, regional and national activities for prevention of blindness". An amendment had also been made to paragraph 2(5), which would read: "to add prevention of blindness and visual impairment to WHO's medium-term strategic plan 2008–2013 and proposed programme budget 2008–2009, which are currently under preparation".

The draft resolution, as amended, was approved.[2]

Implementation of resolutions: progress reports: Item 11.17 of the Agenda (Document A59/23) (resumed)

- **Family and health in the context of the tenth anniversary of the International Year of the Family (resolution WHA57.11)**

Mr MSELEKU (South Africa) said that South Africa had implemented many policies in order to protect vulnerable families, including a range of social programmes, such as the free provision of basic sanitation, water and health care, in which all government departments had been involved. Those services, provided in a coordinated and targeted way, formed part of South Africa's comprehensive strategy to assist the most vulnerable in the enjoyment of the highest attainable standard of health. That was a fundamental right of every human being, as stated in the Constitution of WHO.

Dr PUANGPEN CHANPRASERT (Thailand) said that Thailand had been implementing projects in order to improve maternal and child health through well-established infrastructures, covering all families. Recognizing that the family was the basic social unit, the Ministry of Public Health, Ministry of Social Development and Human Security and other related sectors were working together in order to promote the "Happy Family" – one of the 17 targets of the national "Healthy Thailand" agenda, which promoted closer family relationships. In addition, her Government had proclaimed every Sunday a "Happy Family Day", encouraging all family members to spend time together, in order to bring about happy communities and a happy, healthy nation.

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[1] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA59.27.

[2] Transmitted to the Health Assembly in the Committee's sixth report and adopted as resolution WHA59.25.

Mr HILMERSON (Sweden), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, recalled that rapid demographic and socioeconomic change had influenced patterns of family life and altered family composition and structure. Traditional notions of parental and domestic functions did not reflect current realities and aspirations. That various forms of the family existed should be taken into account in all family policies, including health. In essence, all families were composed of persons with individual rights, whether they were adults, adolescents or children.

Mrs PHUMAPHI (Assistant Director-General) acknowledged the progress Member States were making in the protection of the family, which was the basic community unit. She urged them to continue that work, and assured them of the Secretariat's support as and when requested.

- **Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)**

Ms KONGSVIK (Norway) said that the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden were following with special interest the follow-up by the Secretariat and Member States to the strategy on reproductive health and the recommendations of *The world health report 2005*. The strategy seemed to be used actively at the national level for promoting awareness in the general population and improving access to good-quality services. She looked forward to the assessment of its impact. The Executive Board at its 117th session had discussed unsafe abortions, and she urged Member States to implement the strategy's recommendations on that subject, so as to give that widely neglected area due focus. The Nordic countries emphasized the empowerment of women, education and sexual health counselling for young boys and girls, and the need for human resources in order to increase the access to, and quality of, reproductive health services.

Ms AMIN (Ethiopia), speaking on behalf of the Member States of the African Region, welcomed the Secretariat's efforts to integrate sexual and reproductive health into national policies; to improve the quality of sexual and reproductive services through standard setting for clinical practice; and to enhance collaboration among partners in service delivery. The main problems associated with sexual and reproductive health in Africa included gender inequality, early marriage, female genital mutilation, unwanted pregnancy, unsafe abortion and sexually transmitted infections, including HIV. The situation was exacerbated by inadequate access to information and services (including contraception), weak health systems, limited availability of emergency obstetric care, high population growth rates and the fact that young people constituted the majority of the population. Those factors meant that the goal of achieving universal access to reproductive health by 2015 as set out at the International Conference on Population and Development (Cairo, 1994) would be difficult.

African countries were putting sexual and reproductive health at the top of their development agendas. In Ethiopia, maternal and adolescent health services were prioritized, as was the plan for accelerated and sustained development to end poverty. Reproductive health services were provided through an extension programme. WHO should bring together partners in dealing with sexual and reproductive health, focus on national priorities and common approaches, and mobilize resources in order to strengthen health systems.

Dr PUANGPEN CHANPRASERT (Thailand) said that in Thailand the overall fertility rate had fallen from 5 in 1970–1975 to 1.9 in 2000–2005, which was below the replacement rate. The national family programme had been reoriented towards promotion of well-being. Access to sexual and reproductive health services, such as cervical cancer screening and mammography, was guaranteed by the recent universal coverage scheme under which price was not a basic factor. Under a programme for universal access to antiretroviral medicines, men and women benefited equally and to date more than 80 000 persons living with HIV/AIDS had received medication. In addition, a programme for the prevention of mother-to-child transmission of HIV ensured that all infected pregnant women were given equal access to a standard treatment regimen and breast-milk substitutes free of charge. The

project to reduce unsafe abortion had progressed well since 1998. Amendments in order to expand the scope of the regulations on the protection of women's health, to include physical and mental health relating to pregnancy, were being introduced.

Ms MUIRURI (United States of America) said that her country, the world's largest bilateral donor of reproductive health and family planning assistance, fully supported the principle of voluntary choice in family planning but was opposed to the promotion of abortion as a family planning method. Women who had recourse to abortion should always be given humane treatment and counselling. Reproductive rights in the context of children or adolescents were linked to the rights, duties and responsibilities of parents, who had primary responsibility for the education and well-being of their children.

Mrs PHUMAPHI (Assistant Director-General) said that sexual and reproductive health was arguably the most important area in global health, and essential for the achievement of at least three of the health-related Millennium Development Goals. Member States were therefore urged to increase budget allocations and investment, and to expand effective interventions. Policy briefs for circulation to Member States had been finalized. Member States should make use of the new information in the guidelines on obstetrics, to be published shortly. Actions to deal with unsafe abortion were spelt out in the strategy, and the Secretariat would continue to support Member States wishing to implement the relevant guidelines in that regard.

(For resumption of discussion of implementation of resolutions, see section 4, below.)

3. SIXTH REPORT OF COMMITTEE A (Document A59/55 (draft))

Dr CISSÉ (Guinea), Rapporteur, read out the draft sixth report of Committee A.

The report was adopted.[1]

4. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (resumed)

Implementation of resolutions: progress reports: Item 11.17 of the Agenda (Document A59/23) (resumed from section 2)

- **Sustainable health financing, universal coverage and social health insurance (resolution WHA58.33)**

Dr VIROJ TANGCHAROENSATHIEN (Thailand) welcomed WHO's efforts to encourage Member States to obtain and use additional resources efficiently, and to provide social protection for the poor. Thailand had achieved universal coverage early in 2002, using a contract model and urged WHO to emphasize the value of provider-payment methods, given their potential impact in terms of health system efficiency. The national health account, introduced in Thailand in 1994, had been useful for monitoring health-care policy. That account, based on an OECD manual,[2] would be further

[1] See page 258.

[2] Organisation for Economic Co-operation and Development. *A system of health accounts*. Paris, OECD Publishing, 2000.

diversified in order to show the amounts spent on different disease categories, population groups, and expenditure by gender, with a view to achieving better allocation of resources.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, said that health systems in Africa were seriously affected by the heavy disease burden, inadequate funding, a shortage of health-care workers, weak infrastructure, and high poverty levels. Generally speaking, African countries were introducing a mixture of health-financing strategies, and the sharing of their experiences would be coordinated by the Regional Office for Africa. Despite major obstacles to the introduction of social health insurance in Africa, such as a small formal sector, many governments had decided to introduce social health insurance as an additional strategy in order to fund health services, improve health care and ensure equity. WHO, in collaboration with ILO and other agencies, was urged to provide technical support for the development of social health insurance in Africa, particularly as the customary out-of-pocket financing promoted poverty and inequity in health care.

Dr UWEJA (Nigeria) said that in Nigeria the national health insurance scheme had been launched in 2005 with the formal sector, covering about three million people. Efforts were being made to expand into the organized private sector, and pilot programmes were being conducted in order to extend coverage to the rural health and informal sectors. Nigeria would require substantial assistance from WHO in that regard.

Dr EVANS (Assistant Director-General), in response to the delegate of Thailand, said that a paper on provider-payment mechanisms was being prepared by the Secretariat.

- **The role of contractual arrangements in improving health systems' performance (resolution WHA56.25)**

Ms ANDRIANJAKA (Madagascar), speaking on behalf of the Member States of the African Region, said that, since the adoption of resolution WHA56.25, some African countries, such as Burkina Faso, Chad, Madagascar, Mali, Senegal and Togo, had designed contractual policies, clearly defining parties' roles. Technical support would be essential in order to develop expertise in that area, as would support from WHO to promote regular exchanges of experience among countries. Research, training, and good practice should also be promoted for contracting in the developing countries, with the support of the Regional Office for Africa. The workshops held in Benin and Senegal, with the support of WHO and the World Bank Institute, had been particularly beneficial for reinforcing technical capability, the transfer of knowledge, and exchange of experience in the design of national contracting policies. African countries were increasingly interested in contracting and should evaluate the strategies adopted and their effectiveness within health systems.

Mrs TJIPURA (Namibia) commended the progress report, particularly the section on the role of contractual arrangements in improving health systems' performance.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that since 1990, under a social health insurance scheme, outpatient and inpatient services from public and private providers had been purchased on a competitive basis using a capitation contract model. An evaluation had indicated that performance was good, with greater accountability on the part of providers. In 2002, Thailand had adopted a capitation contract model under the universal coverage scheme for the 48 million people not covered by an employee scheme or social health insurance. A major problem had been the lack of competing providers in rural areas; other obstacles included contract design and enforcement, the purchasing of services and action to be taken in the event of non-compliance with the contract. Institutional capacity in the governance of contractual arrangements needed to be strengthened.

Dr HASSAN (Chad) confirmed that Chad, with the support of WHO, had designed and adopted a national contracting policy. A recent evaluation had shown that results were satisfactory; for

example, a framework convention had been signed with the nongovernmental organizations working in the field. Contracting could greatly assist African countries, and he called on WHO to support his country in improving and implementing its policy.

Dr EVANS (Assistant Director-General) said that he looked forward to continued work on implementing resolution WHA56.25 with regional and country offices.

The Committee noted the progress reports that it had considered.

(For continuation of discussion of implementation of resolutions: progress reports, see summary record of the fifth meeting of Committee B, section 2.)

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 13:10.