

COMMITTEE A

FIRST MEETING

Tuesday, 15 May 2007, at 10:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

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

The CHAIRMAN welcomed participants and introduced Dr Antezana Aranibar and Mr Shiraliyev, the two members of the Executive Board who would report on the Board's discussion of each of the agenda items before the Committee.¹ Any views they expressed would be those of the Board, not of their national governments.

He drew the Committee's attention to the proposals by the Committee on Nominations.²

Decision: Committee A elected Dr A. Balbisi (Jordan) and Professor Eng Huot (Cambodia) as Vice-Chairmen and Dr A. Fúnez (Honduras) as Rapporteur.³

(For continuation of the discussion, see summary record of the Committee's second meeting, section 1.)

2. ORGANIZATION OF WORK

The CHAIRMAN observed that the agenda was lengthy, and called upon delegates to restrict their statements to three minutes. Replying to a question from Dr EL SAYED (Egypt), he confirmed that delegates speaking on behalf of a group of countries would be allowed more time.

Mr HOFMANN (Germany), speaking on behalf of the Member States of the European Union, noted that the European Community and the Member States of the European Union had a shared competence in a number of the matters on the Committee's agenda. He therefore requested that, in accordance with Rule 48 of the Rules of Procedure of the World Health Assembly, the European Commission should participate as an observer, without vote, in the meetings of subcommittees or subdivisions of Committee A dealing with agenda items 12.1 to 12.21 inclusive.

It was so agreed.

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

² See page 309.

³ Decision WHA60(4).

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda

Avian and pandemic influenza: Item 12.1 of the Agenda

- **Developments, response and follow-up** (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R7, and A60/7)
- **Application of the International Health Regulations (2005)** (Document A60/8)
- **Best practice for sharing influenza viruses and sequence data** (Document A60/INF.DOC./1)

The CHAIRMAN, referring to the draft resolution recommended in resolution EB120.R7, noted that two draft resolutions on the same item had been submitted. The first, proposed by the delegation of the United States of America, read:

The Sixtieth World Health Assembly,

Having considered the report on avian and pandemic influenza: application of the International Health Regulations (2005);¹

Recalling resolutions WHA58.3 on revision of the International Health Regulations, WHA58.5 on strengthening pandemic-influenza preparedness and response, and WHA59.2 on application of the International Health Regulations (2005);

Recalling in particular the requests to the Director-General in resolution WHA59.2 to collaborate with Member States in developing capacities for a public-health response specific to the risk posed by avian influenza and pandemic influenza, in reasonable stockpiling of necessary drugs and through the facilitation, in collaboration with international partners, of development and commercial production of vaccines against avian influenza and pandemic influenza; and immediately to 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 epidemics and pandemics;

Recognizing the crucial role that immediate and unhindered access to influenza viruses plays in enhancing human health security and reaffirming the vital need, as urged in resolution WHA59.2, for Member States to disseminate to WHO collaborating centres information and relevant biological materials related to highly pathogenic avian influenza and other novel influenza virus strains in a timely and consistent manner;

Recognizing further that the failure of Member States to provide all information requested by WHO threatens global health security by hindering risk assessment and reducing the chances for success of preventive action near the start of a pandemic;

Acknowledging the growing concern among Member States at the evolving and unprecedented outbreak of avian influenza due to the H5N1 strain of influenza virus, this represents a potentially serious threat to both human health and global security of all countries;

Noting WHO's global pandemic influenza action plan to increase vaccine supply and its goal of reducing the gap between the potential vaccine demand and supply expected during an influenza pandemic by increasing over the medium- and long-term the supply of pandemic vaccine;²

Mindful that support to Member States in response to avian influenza or pandemic influenza events will be enhanced through timely access to safe and effective pandemic influenza vaccines by affected developing countries that could lack capacity to produce influenza vaccine,

¹ Document A60/8.

² Document WHO/IVB/06.13–WHO/ODS/EPR/GIP/2006.1.

1. URGES Member States:
 - (1) to meet the short-term need for access to vaccine developed before and during a pandemic by supporting and strengthening mechanisms, including the stockpiling of candidate H5N1 vaccines, for increasing access to vaccine for developing countries without influenza-vaccine production capacity, through various means, including, but not limited to, financial and technical support, and in-kind donations;
 - (2) to strengthen the capacity of their national regulatory authorities in order to carry out efficiently and effectively the necessary measures for the rapid approval of safe and effective candidate influenza vaccines for use before and during a pandemic;
 - (3) to continue unrestricted sharing of influenza viruses with WHO collaborating centres and H5 reference laboratories in a timely and consistent manner for the purpose of risk assessment and the development of pandemic and pre-pandemic candidate vaccines;
 - (4) to formulate policies on influenza vaccines as an integral part of their national influenza-pandemic preparedness plans;
 - (5) to work to build the necessary capacity in-country for effective surveillance, vaccine production, and deployment strategies.

2. REQUESTS the Director-General:
 - (1) to mobilize financial and technical support from Member States, vaccine manufacturers, development banks, charitable organizations and private donors in order to help to establish a stockpile of a safe and effective H5N1 influenza vaccine;
 - (2) to design mechanisms to promote increased access to influenza vaccine, in particular for developing countries without vaccine-production capacity;
 - (3) to promote the broadest possible access to practical products, including pandemic-influenza vaccines, resulting from research on influenza viruses, including the H5N1 strain;
 - (4) to appoint an ad hoc WHO working group to advise Member States and the Director-General on:
 - (a) the most appropriate size of a stockpile of candidate H5N1 vaccines;
 - (b) operational procedures, based on expert guidance and evidence, for using such an H5N1 vaccine stockpile most effectively;
 - (c) mechanisms to promote access to safe and effective pandemic-influenza vaccine;
 - (5) to explore options to establish a stockpile of candidate H5N1 vaccines as an interim measure, pending completion of the report of the working group referred to in subparagraph (4), in order to enable increased access to safe and effective H5N1 vaccine and to ensure maximum flexibility in its maintenance, monitoring and deployment;
 - (6) to complete the WHO guidelines on regulatory preparedness for human pandemic-influenza vaccines;
 - (7) to provide technical support to Member States, upon request, to increase capacity for vaccine development and production, and strengthen their regulatory pathways for licensing and approving seasonal and pandemic-influenza vaccines that are safe and effective;
 - (8) to facilitate broader and more equitable regional distribution of production capacity for influenza vaccine and increased production capacity for pandemic vaccines by leading implementation of the global pandemic influenza action plan to increase vaccine supply, emphasizing those activities that help to increase access to pandemic vaccines in developing countries and other countries that lack domestic manufacturing capacity;
 - (9) to identify and recommend possible options for promoting the accessibility of pandemic-influenza vaccine to all, and provide support, as appropriate, for their implementation, for example by mobilizing adequate funding for research on, and development of, a pandemic-influenza vaccine;

(10) to continue to work with Member States on studies of disease burden in order to determine whether seasonal influenza vaccine should be introduced into their national immunization schedules;

(11) to continue to explore with Member States the potential for the conversion of existing biological facilities, such as those for the production of veterinary vaccines, so as to meet the standards for the development and production of human vaccines, thereby increasing the availability of pandemic vaccine;

(12) to report to the Sixty-first World Health Assembly, through the Executive Board, on the results of the working group and implementation of this resolution.

The second draft resolution, proposed by the delegations of Algeria, Brunei Darussalam, Cuba, Democratic People's Republic of Korea, Indonesia, Iran (Islamic Republic of), Iraq, Lao People's Democratic Republic, Malaysia, Maldives, Myanmar, Peru, Qatar, Saudi Arabia, Solomon Islands, Sudan and Timor-Leste, read:

The Sixtieth World Health Assembly,

Having considered the Jakarta Declaration on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits and the recommendations by the High-Level Meeting on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits (Jakarta, 26–28 March 2007);

Aware that industrialized countries have greater means at their disposal to offer protection to their populations than developing countries which lack medical supplies, including diagnostics, vaccines and medicines in sufficient quantities and at an affordable price, and that this reduced availability hampers access to those in need, particularly in affected countries that have contributed significantly by providing the viruses for vaccine production;

Underlining that global risk assessment and response to the threat of pandemic influenza, including avian influenza, require concerted efforts among Member States, international partners, including organizations in the United Nations system, donor agencies, manufacturing industries and civil society organizations;

Acknowledging with appreciation the role and contribution of affected countries in their voluntary sharing of materials, which are fundamental to the research on and analysis and use of influenza viruses and parts thereof, including genes, gene sequences and derivatives; and that developing countries should be supported to build the capacity for research and development and to produce vaccines so as better to ensure adequacy of supplies, especially in the event of a pandemic;

Stressing the need for transparent, fair and equitable international mechanisms for the distribution of affordable diagnostics and treatments, including vaccines, to those in need, especially in developing countries, in a timely manner;

Recalling that the Convention on Biological Diversity reaffirms that "States have sovereign rights over their own biological resources", recognizes that "the authority to determine access to genetic resources rests with the national governments and is subject to national legislation" and states that "access where granted shall be on mutually agreed terms, subject to prior informed consent of the Contracting Party providing such resources ..."

Recalling further that the Convention of Biological Diversity recognizes "sharing in a fair and equitable way the results of the research and development and the benefits arising from the commercial and other utilization of genetic resources with the Contracting Party providing such resources" on "mutually agreed terms";

Recalling also that the Convention of Biological Diversity establishes that "Each Contracting Party shall endeavour to develop and carry out scientific research based on genetic resources provided by other Contracting Parties with the full participation of, and where possibly in, such Contracting Parties",

1. URGES Member States:
 - (1) to continue to support, strengthen and improve the WHO Global Influenza Surveillance Network in order to ensure the transparent, fair and equitable sharing of benefits, arising from the generation of information, diagnostics, medicines, vaccines and other technologies, through frameworks and mechanisms that strongly emphasize the principles of prior informed consent and the need for developing countries to benefit also from the timely sharing and dissemination of information, data and biological specimens, benefits that include in particular the development and production of influenza vaccines that are accessible to, and affordable by, all countries, with a view to accelerating local, regional and global preparedness and response to the threat of pandemic avian influenza;
 - (2) to build on WHO's global pandemic influenza action plan to increase vaccine supply in order to ensure adequate supplies of vaccines, medicines, diagnostics and other relevant medical supplies in a timely manner and at affordable prices in developing countries, in particular the affected countries;
 - (3) to prioritize the needs of developing countries, in particular developing countries affected by influenza, ensuring that they have access to vaccines, diagnostics, medicines and other medical supplies in sufficient quantities and at a price affordable for those in need;
 - (4) to prioritize distribution of vaccines to affected countries, while also supporting the global stockpiling of vaccines;
 - (5) to take the necessary measures to ensure compliance with principles in paragraph 2(1) below, to ensure timely and equitable sharing of influenza viruses and sequence data.

2. REQUESTS the Director-General:
 - (1) to launch an inclusive, participatory intergovernmental process in order to review existing practices and mechanisms for sharing influenza viruses, to establish new frameworks and mechanisms, including principles and guidelines for sharing influenza viruses and parts thereof (encompassing genes, gene sequences, derivatives and parts thereof), based on prior informed consent of the country contributing the viruses and parts thereof, and fair and equitable sharing of benefits resulting from the use of the viruses and any parts thereof with the country contributing the viruses, and to review existing terms of reference of WHO collaborating centres and H5 reference laboratories on the basis of the following principles:
 - (a) any international sharing of biological materials with WHO collaborating centres/H5 reference laboratories shall be conducted in accordance with national and international laws and regulations, through agreements on mutually agreed terms, based on the principles of prior informed consent, and fair and equitable sharing of benefits;
 - (b) transfer of any virus and parts thereof (including genes, sequences, derivatives and parts thereof) by a receiving WHO collaborating centre or a H5 Reference Laboratory to another WHO collaborating centre or H5 Reference Laboratory shall be effected on the same terms as the initial agreement entered with the country contributing the virus and parts thereof; the country contributing the virus and parts thereof shall be informed by way of a written notification prior to any such transfer;
 - (c) any vaccines, diagnostics, antiviral agents and other medical supplies arising from the use of the virus and parts thereof (including its genes, sequences, derivatives and parts thereof) must be made available at an affordable price and in a timely manner to developing countries, particularly to those under the most serious threat of, or already experiencing, a pandemic;

- (d) priority should be given to conducting the necessary research on the viruses and parts thereof and to storing the viruses in the affected countries, and WHO should make arrangements for countries to have that capacity;
 - (e) any uses of the influenza viruses and parts thereof, including genes, sequences, derivatives and parts thereof, provided to WHO collaborating centers and H5 reference laboratories shall be within their WHO mandates, and in any event limited to scientific research in the interests of public health and to noncommercial purposes;
 - (f) no viruses/specimens or parts thereof, including genes, sequences derivatives and parts thereof, shall be distributed, nor shall access to the viruses and parts thereof be given, to any party outside the network of WHO collaborating centre/H5 reference laboratories without the written prior informed consent of the country contributing the virus and parts thereof;
 - (g) WHO collaborating centres/H5 reference laboratories shall obtain written prior informed consent from co-authors before publishing findings obtained from the analysis of the relevant viruses/specimens and parts thereof or placing any of the sequence results in public databases;
 - (h) appropriate terms and conditions shall govern access to influenza-related information (including sequences) in any public databases in order to ensure that such information is not appropriated in a manner that prevents others access to, and use of, the information and products, technologies and tools developed through the use of the information, or that denies the appropriate parties fair and equitable sharing of benefits arising from the commercial or other use of information placed in the databases;
 - (i) WHO collaborating centres, H5 reference laboratories, their employees and any other entity involved in the execution of WHO's mandate for the centres or the Laboratories, shall neither claim nor obtain any form of proprietary rights over the virus provided or any parts thereof, including genes, sequences, recombinant virus, derivatives and parts thereof; except with the explicit written prior informed consent of the country contributing the virus and parts thereof;
 - (j) the country contributing the virus and parts thereof and whose prior informed consent is required for the above-mentioned and other activities shall be entitled to establish conditions accompanying any decision on consent, which may include arrangements for sharing, of benefits, which may include access to sufficient quantities of vaccine and other medical supplies at affordable prices for itself and other developing countries, transfer of technology and know-how to strengthen manufacturing capacity and other capacity-building activities, or that may be specified in national or international regulations;
- (2) immediately to intensify, in a manner appropriate to the situation in each developing country and particularly in those countries affected by the H5N1 influenza viruses or those that have high risk due to geographical proximity, capacity-building activities related but not limited to virus identification, virus characterization, identification of new virus strains, generation and interpretation of data on or related to influenza and avian influenza, and generation of seed virus for vaccine production;
 - (3) to decide, in consultation with developing countries, those capacities that should be strengthened or built within each specific country;
 - (4) to take immediate actions to provide more developing countries, particularly those who have been affected by the H5N1 virus or are at high risk due to geographical proximity, with additional capacity building, in order better to contribute to WHO's global influenza surveillance activities, and to enable them to be designated as H5 reference laboratories;
 - (5) to seek the support of industrialized countries, other financial partners and vaccine manufacturers in mobilizing financial and technical support for stockpiling safe and

effective H5N1 and other potential pandemic-influenza vaccines that may be used in developing countries, particularly those that have been affected by influenza or have high risk due to geographical proximity, and for providing the necessary means to developing countries that choose to establish a stockpile of vaccines or other medical supplies;

(6) to seek additional support from developed countries, funding partners and vaccine manufacturers to facilitate the transfer to developing countries of the technology and know-how necessary to establish influenza-vaccine production and to enable production capacity to be functional as soon as possible;

(7) through an intergovernmental process to discuss and formulate mechanisms and guidelines for the fair and equitable distribution of effective pandemic-influenza vaccines in the event of a pandemic in order to ensure timely availability of such vaccines in developing countries;

(8) to report on the implementation of this resolution and submit the outcome of the intergovernmental process to the Sixty-first World Health Assembly in May 2008, through the Executive Board.

Mr SHIRALIYEV (representative of the Executive Board) said that the Board, at its 120th session,¹ had welcomed the progress made in pandemic preparedness and dealing with the continuing outbreaks of avian influenza, and had stressed the sharing of important public health information and support for the WHO Global Influenza Surveillance Network. Several Board members had expressed concerns about access to limited vaccine supplies and geographical inequalities in laboratory capacities, and had requested the Secretariat to consider and promote other public health measures in the event of shortages of antiviral medicines and vaccines. Several members had briefly reported on the progress made in their countries in implementing the International Health Regulations (2005). Member States that had not yet established national focal points had been urged to do so as soon as possible. The Board recommended that the Health Assembly adopt the draft resolution contained in resolution EB120.R7.

Dr HEYMANN (Assistant Director-General) said that influenza vaccines, unlike those against poliomyelitis, measles and yellow fever, were made from an unstable virus and their formulation required periodic updating. For 50 years, a WHO-coordinated network had shared seasonal influenza viruses and, each year, had issued recommendations on composition of vaccines against seasonal influenza. The demand for those vaccines had existed only in industrialized countries and in a few developing countries, whereas H5N1 and pandemic-influenza vaccines would be needed by all countries. From recent consultations with Member States the Secretariat understood that developing countries were seeking assurances that: virus sharing in the WHO network was transparent; their scientists could participate as equal partners in the WHO H5 reference laboratories and in research other than that conducted routinely by the virus-sharing network; and they would have broader access to H5N1 and pandemic-influenza vaccines. Activities to address those issues included discussions with manufacturers of influenza vaccines, and the Secretariat would continue to facilitate consultations with Member States on virus sharing.

Dr KANDUN (Indonesia) said that the second draft resolution, which he introduced on behalf of its 17 cosponsors, was based on the Jakarta Declaration on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits (28 March 2007). The current system for sharing viruses was unfair. Developing countries voluntarily provided viruses to WHO collaborating centres and reference laboratories, institutions that were supposed to manage the virus samples in trust for research. However, samples of the viruses or parts thereof had been received by companies free of charge and used for commercial purposes without the country that had provided the virus being first informed or

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the third meeting, section 2.

its consent sought. Most importantly, there was no mechanism to ensure that developing countries would have affordable and timely access to the vaccines produced. The draft resolution aimed to establish a framework and mechanism for the transparent, fair and equitable sharing of benefits from the generation of information, diagnostics, medicines, vaccines and other technologies. The framework must prioritize the needs of developing countries, particularly affected countries, and ensure access to vaccines, diagnostics, medicines and other medical supplies at affordable prices. The Director-General was requested to initiate an intergovernmental process in order to review existing mechanisms for sharing influenza viruses and to establish new frameworks based on principles that conformed to national and international laws on biological resources, including the Convention on Biological Diversity (1992) and the International Treaty on Plant Genetic Resources for Food and Agriculture (2001).

Indonesia had also proposed amendments to the draft resolution recommended in resolution EB120.R7, and a review of the report on best practice for sharing influenza viruses and sequence data (document A60/INF.DOC./1).

Mr LANGE (United States of America), introducing the first draft resolution, said that international preparation for, and response to, pandemic influenza required the high-level and sustained attention of all Member States and the Secretariat. The United States was committed to working with all stakeholders in order to prevent an influenza pandemic or mitigate its effects should one occur, and to supporting developing countries' preparedness. Member States had a responsibility to share virus samples and sequence data promptly, and report human and animal cases of H5N1 influenza and of seasonal or other novel influenzas immediately and in a transparent manner. The Secretariat, in collaboration with FAO and OIE, should redouble efforts to support Member States in those activities. Adherence to the best practices recommended in document A60/INF.DOC./1 would facilitate sharing.

Current vaccine-production capacity was insufficient to meet global needs, especially in developing countries, in the event of a pandemic. Implementation of WHO's action plan to increase vaccine supply should be accelerated. However, such efforts should not compromise the integrity of the WHO Global Influenza Surveillance Network, which was vital for surveillance, risk assessment, and countermeasures. He supported the current framework for sample sharing and opposed any new encumbrances or material-transfer agreements to govern the sharing of influenza virus samples.

In order to contain or mitigate a pandemic, the finalization of WHO's protocol for rapid response and containment should therefore be given the highest priority. The United States was already implementing the International Health Regulations (2005) ahead of their entry into force in June 2007, and urged all Member States to do likewise. He supported the draft resolution recommended in resolution EB120.R7 and urged its adoption without substantive change.

The United States had been involved informally in the influenza-related draft resolutions, and he proposed that a working group should be established in order to consider the issue.

Dr MONGKOL NA SONGKHILA (Thailand), supporting the concerns raised by the delegate of Indonesia, suggested that the Health Assembly should review the mechanisms governing virus-sample sharing. It was unfair that a developing country that had provided samples was subsequently offered vaccines at an unaffordable price. The current situation resulted from the limited global capacity for influenza vaccine production. The shortfall between potential demand and supply in the event of a pandemic would leave millions of people, especially in developing countries, without access to effective vaccines. Developed countries were stockpiling H5N1 vaccine through advance market commitment, leaving developing countries on the waiting list. WHO should mobilize resources for a collective vaccine stockpile for developing countries.

Individual national measures might prove dangerous and ineffective. The world needed a common defence mechanism. With the collaboration of the governments of Japan and the United States of America and the Asian Development Bank, WHO should support developing countries in setting up national vaccine production. Mechanisms (for example, differential pricing) were needed in order to enable poorer countries to purchase vaccine and to ensure equitable distribution of the

vaccines generated from the seed virus provided by affected countries. The relations between relevant WHO collaborating centres, H5 reference laboratories and the vaccine-production industry should therefore be reviewed. The industry was an important partner in making the vaccine available to all but it should be socially accountable and not derive excessive benefit from the work of the Global Influenza Surveillance Network.

He supported the United States' proposal to establish a drafting group. Its remit should be to draft a single resolution that took into account the existing texts, including that recommended in resolution EB120.R7, the recommendations of the Jakarta High-Level Meeting on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits, and the concerns expressed by Member States.

The meeting rose at 11:30.

SECOND MEETING

Tuesday, 15 May 2007, at 14:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. OPENING OF THE COMMITTEE (Item 10 of the Agenda) (continued)

Election of Vice-Chairmen and Rapporteur (Document A60/52) (continued from the first meeting, section 1)

The CHAIRMAN announced that Dr Fúnez (Honduras), whom the Committee had elected to serve as its Rapporteur, was unable to attend the Health Assembly. Since it was therefore necessary to elect a different Rapporteur, he proposed Mrs Bu Figueroa (Honduras) for the post.

Decision: Committee A elected Mrs G. Bu Figueroa (Honduras) as Rapporteur.¹

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Avian and pandemic influenza: Item 12.1 of the Agenda (continued from the first meeting, section 3)

- **Developments, response and follow-up** (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R7 and A60/7) (continued from the first meeting, section 3)
- **Application of the International Health Regulations (2005)** (Document A60/8) (continued from the first meeting, section 3)
- **Best practice for sharing influenza viruses and sequence data** (Document A60/INF.DOC./1) (continued from the first meeting, section 3)

Professor HORVATH (Australia) strongly supported the WHO Global Influenza Surveillance System. It allowed free sharing of international specimens and sequences, was essential for early warning of effective human-to-human transmission and the commencement of a pandemic, and was important for the development of effective diagnostic tests and pharmaceutical countermeasures.

He understood the position of developing countries that considered that, although they contributed to the international virus-sharing system, they did not receive a fair share of the vaccines and medicines developed as a result. There were no ready solutions, given that global manufacturing capacity for the pandemic influenza vaccine was only in the order of 500 million doses per annum, whereas demand was likely to be billions of doses; equally, no country could afford to rely on pharmaceutical measures alone but would need to institute measures such as infection control and isolation of cases.

¹ Decision WHA60(4).

Given the ease and speed with which communicable diseases could spread over international borders, a pandemic must be contained at an early stage, wherever it originated. Therefore, the international community, led by WHO, had been working in a concerted manner in order to respond to pre-pandemic and pandemic avian influenza. Similarly, Australia had been working with regional countries in order to build laboratory, surveillance and response capacity. WHO had established a global stockpile of antiviral medicines and Australia would consider requests from other countries for access to its stockpile. Australia strongly supported WHO's global pandemic influenza action plan to increase vaccine supply and looked forward to the early finalization of proposals.

Given the range of draft resolutions put forward and the importance of a cooperative approach, he supported the proposal to convene a drafting group.

Dr ALLAH KOUADIO (Côte d'Ivoire), speaking on behalf of the 46 Member States of the African Region, recalled that five years had passed since the detection of the first human case of H5N1 virus infection. By the end of 2006, 59 countries had notified foci of avian influenza, and the number of human cases of avian influenza had reached 291 in April 2007 (with 178 deaths). In Africa foci of avian influenza had been reported in Burkina Faso, Cameroon, Côte d'Ivoire, Egypt, Ghana, Niger and Nigeria, with 36 human cases. The recent cases of humans infected after contact with sick patients presaged human-to-human transmission. The threat of a pandemic was real, even if adaptation of the virus and its virulence in humans had not yet been clearly demonstrated.

Steps taken on the African continent to combat avian influenza included drafting of contingency plans, incorporating early warning; harmonization of action plans at the United Nations Regional Meeting on Avian Influenza in Africa (Libreville, 20–22 March 2006); establishment of interministerial committees; development of tools for notification of suspected cases; training of relevant personnel and sharing of information between countries; strengthening of surveillance, which had allowed for timely culling of infected birds and payment of compensation to breeders; establishment of a subregional mechanism for coordinating prevention and response measures and of a subregional emergency fund following the Ministerial Meeting on a Regional Strategy for the Prevention and Control of Avian Influenza in West Africa (Abuja, 20–23 June 2006); and mobilization and coordination of donor support. At the same time, he questioned the capability of Africa's surveillance systems and laboratories to detect an emerging pandemic and to diagnose cases of pandemic influenza correctly. Did African countries have the resources to implement their plans of action or the capacity to conduct vaccine research, and were their communication strategies relevant? Resource mobilization had not matched expectations.

He supported the agreement reached at the High-level Meeting on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits in March 2007 regarding the manufacture of vaccines, their affordability for developing countries and increased international solidarity.

He invited those present to support the draft resolution contained in resolution EB120.R7.

The CHAIRMAN suggested that, in accordance with the request from Member States, a drafting group be formed in order to consolidate the two proposed draft resolutions with the draft resolution contained in resolution EB120.R7.

Mr SAADAT (Islamic Republic of Iran) questioned the advisability of forming a drafting group until a diversity of views from more countries and regions had been heard.

The CHAIRMAN explained that the group would be formed later that afternoon, following further interventions on the matter.

Mr HOFMANN (Germany) spoke on behalf of the European Union and its 27 Member States. The candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia; the European Free Trade Association country Iceland, member of the European Economic Area; as well as Ukraine and the Republic of Moldova aligned themselves

with his statement. He appreciated the progress already made in the field of influenza pandemic preparedness.

The European Union had contributed to the global conferences on avian and pandemic influenza. Comprehensive surveillance of human and animal influenza and timely sharing of information and specimens in full transparency were essential to pandemic preparedness and a precondition for WHO to carry out its mandate under the International Health Regulations (2005). Information collection and sharing in some affected countries needed improvement, and all partners should cooperate without restriction.

He appreciated WHO's collaboration with the Office of the United Nations System Senior Coordinator for Avian and Human Influenza and other international partners in limiting the global transmission of the highly pathogenic H5N1 virus in poultry, especially in developing countries, and thus preventing the emergence of pandemic influenza. WHO should continue to organize meetings aimed at increasing the access of developing countries to pandemic vaccines. Effective implementation of WHO's global pandemic influenza action plan to increase vaccine supply depended on the combined efforts of governments, international organizations, affected countries and industry. Coordination needed to be strengthened between international organizations in pandemic preparedness planning, particularly at country level, under the leadership of the Office of the United Nations System Senior Coordinator. Capable health systems were a prerequisite for preparedness, and additional support in terms of human, financial and material resources was therefore essential. Sound and evidence-based communication to the public was important.

He supported the draft resolution contained in resolution EB120.R7 and the proposal to form a drafting group.

Professor FAIZ (Bangladesh) said that in his country avian influenza had been detected in poultry in farms. The virus had been successfully contained through the culling of 100 000 chickens. A national avian influenza and human pandemic influenza preparedness plan had been adopted. Some training of health professionals had already been undertaken, and logistics and antivirals had been prepared for future human cases.

The sharing of viruses and the development of vaccines should be reciprocal, with the consent of the "donor" country being obtained by mutual agreement, in accordance with the Convention on Biological Diversity (1992). The vaccines produced should be made available to developing countries; to that end, the technical facilities for production in donor countries should contain costs within an affordable range.

Dr AL-SALEH (Kuwait) requested that the relevant draft resolutions should emphasize assistance to developing countries in producing vaccines and encourage WHO regional offices to bring together the vaccine-producing countries in each region in order to stockpile vaccines, with the financial and technical support of developed countries.

Dr GANGULY (India) said that India had been sharing strains of seasonal influenza virus through the WHO Global Influenza Surveillance Network for many years. Information sharing was crucial for influenza surveillance. India currently had about 50 strains of H5N1 virus which it had sequenced completely. He was concerned, however, that India might be denied access to any products developed as a result of the sharing of those virus strains because of their prohibitive cost. That had happened with the seasonal influenza vaccine, of which India could afford to purchase only 130 000 doses a year. He was also concerned about the intellectual property issues surrounding H5N1 vaccine research and development. Manufacturing companies in India and several other countries were interested in developing H5N1 vaccines in order to ensure affordable access in countries affected by avian influenza, but they might be prevented from doing so because of patent or licensing requirements. Nonetheless, in an emergency, countries that needed vaccines should be able to make them, irrespective of patent.

He proposed that an expert committee should be set up in order to examine in depth all the issues related to virus sharing, information sharing and vaccine research and production, and to

recommend solutions that would guarantee access to the resulting products for developing countries. Also, WHO should develop rules or mechanisms for ensuring compliance with any guidelines on the sharing of influenza viruses and the resulting benefits.

Dr METAI (Kiribati) welcomed WHO's work on the strengthening of vaccine production. Potential shortages of vaccine seriously concerned vulnerable small countries such as Kiribati. WHO should make full use of the technical expertise and experience of all countries, including those non-Member States of WHO that had the capability to produce vaccine and had demonstrated their competence in similar pandemics. He supported the sharing of H5N1 virus stock, but for health purposes only.

He also supported the implementation of the International Health Regulations (2005) with effect from June 2007, but, like other small Member States, Kiribati might not be able to make all the required adjustments in time, owing to resource constraints. His country would be grateful for any assistance that WHO could provide in mobilizing resources.

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) requested information on the results of the pandemic vaccine research mentioned in document A60/7 and on the Organization's position on those studies. She supported the draft resolution on responsible practices for sharing avian influenza viruses and resulting benefits, particularly access to vaccines, medicines, diagnostics and other medical supplies in developing countries. She emphasized equity in the supply, distribution and cost of vaccines and regulating the manufacture and distribution of vaccines, as pandemic influenza was an international public health issue that took precedence over any private commercial interests.

Venezuela was implementing the International Health Regulations (2005) in response to the risk posed by avian influenza. Instruments for assessing the core capacities of ports and airports had been designed and tested, and national IHR focal points had been designated. An avian influenza preparedness plan had been developed with interministerial partnerships. The plan had five components: promotion of best practices in poultry production; epidemiological surveillance of both animals and humans; prevention and containment; health system response; and information and communication. Surveillance of acute respiratory infections had been strengthened. Diagnosis was currently carried out by the national influenza centre, but would be decentralized to sentinel surveillance posts.

Mr DANKOKO (Senegal) said that Senegal had established a committee for the prevention and control of avian influenza and a national plan to combat the disease. The objectives were to strengthen health security and to protect the agricultural economy through surveillance, prevention and response to the potential introduction and spread of avian influenza. Specific objectives and strategies were set out for the health sector.

In February 2006 the President of Senegal had hosted a meeting of West African countries in order to share experiences, coordinate efforts and mobilize technical and financial partners. To date, the H5N1 virus had not been detected in Senegal, but the country was nevertheless strengthening its surveillance and its collaboration with other countries. He supported the draft resolution contained in resolution EB120.R7.

Dr AYDINLI (Turkey) underlined the need to increase the supply of, and access to, pandemic influenza vaccines. WHO should keep the international community informed of the results of research on influenza viruses, including H5N1. His country's experience in 2006 showed the importance of rapid clinical and epidemiological investigation of human infections and sharing the findings with WHO and the international community. Transparency by all countries was vital for global and coordinated alert, response, standards and vaccine research. Information exchange would contribute much to the fight against the H5N1 virus and to vaccine development. However, WHO should establish mechanisms so that countries that provided information would have access to newly developed vaccines and techniques. He supported the draft resolution contained in resolution EB120.R7 and the establishment of a drafting group.

Professor HOUSSIN (France) said that the exchange of information, for instance on circulating virus strains, was crucial to an effective international response to the risk of an avian influenza pandemic. It was a collective obligation and responsibility of all Member States under the revised International Health Regulations (2005). When the new Regulations entered into force as scheduled in June 2007, all countries should take on those obligations and thus fully benefit from enhanced international health security. In order to ensure rapid and effective implementation of the Regulations, WHO should make available multilingual guidelines, such as guides to hygiene and sanitation in ships and planes, as soon as possible. France awaited the release of the strategic plan for implementing the Regulations mentioned in document A60/8.

France supported pre-pandemic stockpiling of H5N1 vaccine, especially in South-east Asia and Africa, in order to enable affected countries to tackle a pandemic, and the provision of assistance in vaccine manufacturing capacity. France would continue to collaborate with the Secretariat, other countries and the pharmaceutical industry in order to increase the availability of vaccines, especially in affected developing countries. He supported the draft resolution contained in resolution EB120.R7 but was willing to discuss the other two draft resolutions.

Mr SAADAT (Islamic Republic of Iran) recalled that his country had cosponsored the draft resolution on responsible practices for sharing avian influenza viruses and resulting benefits. Research on, and use and availability of, genetic resources, including viruses, were crucial for improving public health and countries that shared genetic resources contributed to the global research agenda. Nevertheless, States had a sovereign right over their genetic resources, including viruses, and such resources should only be shared on agreed terms and with the prior consent of the government concerned. The country of origin should share equitably the benefits derived from use of genetic resources, including commercial benefits, information exchange, technology transfer and capacity building. Developing countries, in particular countries of origin of genetic resources, should be assisted in developing the capacities for research and development and producing the vaccines required to respond to a pandemic. A transparent system for access to affordable diagnostics and treatments, including vaccines, and continued availability of genetic resources were essential. He urged support for the draft resolution proposed by Indonesia and its cosponsors.

He had taken note of the submission of a reservation to the application of the International Health Regulations (2005) by one Member State pointing out that implementation of, and compliance with, the Regulations would be conditional on the principles of federalism. Full compliance with the Regulations should apply to all Member States. Iran had objected to that reservation in a note to the Director-General dated 20 April 2007. He was confident that the Director-General had circulated the text of his Government's objection in accordance with the provisions of Article 62 of the Regulations.

Mrs NICOLAI (Netherlands) said that, without thorough preparation at both national and international levels, an influenza pandemic could be devastating. The central role of WHO in the preparation process was welcome. However, the draft resolution contained in resolution EB120.R7 insufficiently reflected two essential elements. The human population was prone to other infectious diseases, due to existing human pathogens that changed characteristics over time, such as multidrug-resistant bacteria, and animal pathogens that adapted to the human species, such as severe acute respiratory syndrome. Influenza pandemic preparedness should therefore include the enforcement of generic infectious-disease preparedness. Greater emphasis needed to be put on non-pharmaceutical interventions that aimed at limiting the spread of the virus, such as coughing hygiene, limitations on social gatherings and school closures, and more research was needed on the benefits and drawbacks of such interventions.

She supported WHO's efforts to make vaccines available throughout the world through the transfer of technology. The implementation of the International Health Regulations (2005) was essential for influenza pandemic preparedness and the control of infectious diseases in general. She urged the Secretariat to develop practical tools to assist Member States in implementing the Regulations, such as information on minimum standards for sanitary inspections, capacity

requirements at a country's points of entry and international contact tracing, in order to avoid major differences in facilities, arrangements or expectations among Member States.

Dr EL SAYED (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized that capacity building would be needed in order to ensure application of the International Health Regulations (2005) in the Region. Technical support must be provided in order to strengthen epidemiological surveillance and response systems, and strengthen national public health laboratories and influenza centres; to ensure prompt and reliable diagnosis of a public health emergency of international concern; to build capacity at designated points of entry; and to assure the necessary supplies, equipment, logistics and communication tools.

The expected human influenza pandemic required collaboration between all countries and international organizations. The countries of the Region had demonstrated clear political commitment and increased national levels of preparedness. However, they still lacked adequate epidemiological and laboratory capacities.

Isolates of influenza viruses should always be shared, for the purposes of vaccine production; otherwise global security would be threatened. Sharing was even more important in the case of newly emerging strains of the H5N1 virus than with seasonal influenza viruses, for which there were well-established procedures. However, the Secretariat and laboratories receiving isolates should guarantee that vaccines would be made available unconditionally to countries in need and at affordable cost. Support, including technology transfer, should be provided in order to boost national capacities for vaccine production.

Dr NGUYEN HOANG LONG (Viet Nam) said that his country, as one of those worst affected by avian influenza, had taken active measures, with support from WHO and the international community, and had succeeded in controlling and containing the disease. Communication and cooperation between countries was critical in dealing with public health emergencies.

He emphasized transparent sharing of information, virus samples and other specimens. However, countries had to receive proper and timely information on the use of the samples they provided, and the benefits of research had to be shared by all. In particular Viet Nam and other low-income countries should have equitable access to vaccines. WHO should continue providing assistance to support increased vaccine-production capacity of low-income countries. He supported the establishment of a drafting group.

Professor MWAKYUSA (United Republic of Tanzania) said that his country shared the global concern that avian influenza had moved from Asia to Europe and Africa. Although no case had so far been recorded in his country, the movement of poultry and poultry products, people or their belongings from infected countries, and migrating wild birds carried the risk of disease. His Government had taken note of the various measures for control of avian influenza proposed at several meetings and conferences. It had developed a national avian influenza emergency preparedness plan and established a disease surveillance and response system. Diseases with epidemic potential or unusual events were reported immediately.

Six high-risk areas for the possible introduction of avian influenza through wild bird migration had been identified. Infrastructure for building rapid response systems and laboratory and surveillance capabilities were all weak. Attention was being focused on building laboratory capacity and infrastructure for virological and epidemiological surveillance, including sentinel laboratory-based surveillance.

The disease was of global concern, necessitating partnerships and shared information and resources, both financial and technical. He supported the draft resolution contained in resolution EB120.R7.

Mr LOBATO (Timor-Leste) said that no case of avian influenza in either poultry or humans had been reported in his country. Beginning in 2004, the ministries of health and agriculture, with technical support from WHO and FAO, had created a national plan and task force for emergency

preparedness and response. The Ministry of Health had already provided WHO collaborating centres with biological materials for research, sending human and animal samples to laboratories in neighbouring and other countries.

The draft resolution on responsible practices for sharing avian influenza viruses and resulting benefits would enable the existing framework and mechanisms to be revised for appropriate virus-sharing practices, and strengthen pandemic preparedness. Global partnerships should be established in order to enhance information sharing, capacity building and technology sharing and to ensure support to any country in the event of an avian influenza pandemic.

Mr JACKLICK (Marshall Islands) fully supported implementation of the International Health Regulations (2005) at both regional and global levels. Once finalized, his country's pandemic influenza plan could be shared with other countries. No case of avian influenza had yet been reported in the country, but it faced significant problems with noncommunicable diseases such as type 2 diabetes mellitus and obesity.

Mr HERBERT (Saint Kitts and Nevis), expressing support for the draft resolution introduced by Indonesia, highlighted key areas for action, including his country's capacity to detect, analyse and respond to an emerging threat; the universal availability and subsequent procurement of vaccines, antiviral medicines and personal protective equipment; and, in the event of a pandemic, keeping his country's economy afloat in the face of an expected rapid decline in travel and tourism. He welcomed the availability of an outbreak response team for the Caribbean under the auspices of PAHO.

Through its focal point for the International Health Regulations (2005), Saint Kitts and Nevis would promptly integrate PAHO's technical expertise into its national response strategy, in conformity with the agreed protocol, and would work with PAHO in order to strengthen surveillance and port health systems.

Vaccine production should continue expanding as scarce supply would place nations without manufacturing capacity at greater risk of exclusion. All countries should share the benefits of a globalized response to the threat of an avian influenza pandemic.

Professor IANCU (Romania) said that implementation of the International Health Regulations (2005) would be crucial in preventing, controlling and responding to the spread of diseases, including pandemic influenza. That risk obliged all countries to establish high-quality surveillance of influenza viruses. Romania had useful experience of influenza surveillance in humans, and therefore participated in the European Influenza Surveillance Scheme. Controlling the spread of avian strains of the disease in poultry in October to December 2005 and April to June 2006 had demonstrated her country's capacity to limit the spread of avian strains to humans. The support of experts from WHO and Member States of the European Union had been much appreciated. Romania was fully prepared for implementation of the Regulations and hoped for fruitful intercountry collaboration in the sharing of samples and genetic sequence data of seasonal influenza viruses in order to support the WHO Global Influenza Surveillance Network.

Dr CARBALLO QUESADA (Costa Rica) said that Costa Rica had drawn up a national avian influenza preparedness plan, which was available on the Ministry of Health's web site. A national influenza centre had been established and formed part of the WHO Global Influenza Surveillance Network, and four surveillance centres were located around the country. She supported the call in document A60/7 for more rapid routine sharing of H5N1 viruses and improved access to pandemic vaccines.

Costa Rica had established a contact centre and focal point for the International Health Regulations (2005), and would respond to WHO's request to verify information on health risks; the public health system had been reviewed; and a plan had been drawn up to improve the country's response capacity. Costa Rica supported the draft resolution contained in resolution EB120.R7.

Dr KAMWI (Namibia) said that the African Region had a responsibility to take preparedness measures and protect public health. In collaboration with development partners such as WHO, Namibia was finalizing a comprehensive plan for the control of avian and pandemic influenza. Efforts were also being made to strengthen surveillance. He supported the draft resolution.

Dr MELNIKOVA (Russian Federation), supporting WHO's activities to consolidate efforts to fight pandemic influenza, underlined the significance of the current practice of sharing clinical samples and viruses through the Global Influenza Surveillance Network, which was effective in evaluating the risk of a pandemic and in planning to reduce the threat. All States could contribute to the Network by sharing viruses and genetic sequence data, but she disapproved of imposing new conditions for their exchanging. Cooperation was needed to ensure that all States, including those without the necessary vaccine-production capacity, had access to diagnostic tools and effective vaccines, and WHO should develop mechanisms for that purpose. She urged all Member States to improve their national public health systems and to extend international cooperation in order to combat influenza.

The Russian Federation had experienced outbreaks of avian influenza over the past three years and was willing to share its experience in preventing the spread of the disease. It was extending international cooperation and a WHO Collaborating Centre had been established in Novosibirsk for researching diagnostics and studying influenza viruses for countries in eastern Europe and central Asia. That initiative had received support from the G8 countries (St Petersburg, July 2006), at which fighting infectious diseases had been a key topic. The Government had already earmarked resources to equip the Centre.

The country's bilateral agreements with Azerbaijan, Belarus, Kazakhstan, Ukraine and Uzbekistan included material and technical support for virology laboratories. Her Government was prepared, if necessary, to increase its production of seasonal vaccines for use by other countries in the Commonwealth of Independent States.

She supported the recommendations on best practices for sharing influenza viruses and sequence data in accordance with current national legislation. She welcomed the application of the International Health Regulations (2005), an important instrument for exchanging epidemiological information, responding promptly to a threat and cooperating to prevent a pandemic.

Dr KAZIHISE (Burundi) said that, although unaffected so far by avian influenza, Burundi was conscious of the threat and had developed a preparedness plan, including a surveillance system for rapid response. The cost of pandemic-influenza vaccines should be reduced to a level that was affordable to countries unable to manufacture them.

Mr CÓRDOVA VILLALOBOS (Mexico) said that his country too had developed a national preparedness and response plan. He offered to share its experience. The seasonal influenza vaccine was administered to children under three years of age, adults aged over 50 and other people at high risk, and a strategic stockpile of personal protection equipment and medicines had been created. Financial support from WHO, amounting to about US\$ 2 million, would enable Mexico to manufacture an influenza vaccine.

Mexico would be applying the International Health Regulations (2005) from 15 June 2007. A national liaison centre would coordinate the work of the two national bodies responsible for protection against health risks and for epidemiological surveillance. A national trial in October 2006 had tested pandemic preparedness and response. He supported the proposal to set up a drafting group.

Dr BIN ABDUL RAHMAN (Malaysia) said that Malaysia was working towards compliance with the provisions of the International Health Regulations (2005), and had established national IHR focal points and surveillance and response mechanisms. Its influenza pandemic preparedness plan was being continuously updated. Simulation exercises were being regularly conducted at local and national levels. Malaysia had experienced some avian influenza outbreaks among poultry, but no human case had yet been detected. He supported the draft resolution contained in resolution EB120.R7. He

stressed transparent, fair and equitable international mechanisms in order to ensure that affordable vaccines should be available to those in need.

Dr HUWAIL (Iraq) said that priority should be given to research on the efficacy of antiviral medicines and pandemic influenza vaccines. WHO should promote domestic manufacturing capacity for influenza vaccine in developing countries, and sponsor the development of national veterinary and public health surveillance systems. The Organization must also provide support for intergovernmental cooperation.

Dr HAO Yang (China) said that China would continue to support global surveillance of avian and human influenza viruses and the sharing by Member States of related information and virus strains. WHO should encourage enterprises to provide financial and technical support to developing countries in order to help to strengthen their human resources and response capacity. He welcomed the efforts of WHO's regional offices in establishing stockpiles of medicines and vaccines and in developing a detailed operational protocol.

Sir Peter BARTER (Papua New Guinea) commended the reports. His country was vulnerable to the spread of avian influenza from neighbouring countries, but lacked the capacity to undertake surveillance and respond effectively to an influenza pandemic. He thanked WHO and other partners for technical and financial support, but his country was still far from being able to implement fully the requirements of the International Health Regulations (2005). Developing countries such as Papua New Guinea needed support for influenza surveillance, pandemic preparedness and response, strengthening capacity for national influenza centres, and full implementation of the International Health Regulations (2005). The draft resolution on mechanisms to promote access to influenza pandemic vaccine for developing countries lacking sufficient influenza vaccine production emphasized instead the identification of, and access to, potential vaccine viruses, vaccine production and stockpiling. He requested that the elements of the draft resolution dealing with support for routine influenza surveillance and pandemic preparedness be incorporated into the text of the draft resolution recommended in resolution EB120.R7. He also proposed inserting the words "and regional" after "global", and the words "and response" after "preparedness" in that draft resolution.

He found it difficult to support the draft resolution on responsible practices for sharing avian influenza viruses and resulting benefits. The language was too confusing in the context of a global health issue that required the attention and cooperation of all nations.

Dr NISHIYAMA (Japan) expressed appreciation of Indonesia's practice of sharing samples of influenza viruses through the WHO collaborating centre network. He emphasized the global benefits of provision of samples from affected countries and the immediate sharing of viruses by all countries, including the affected ones. The National Institute of Infectious Diseases of Japan, being a designated WHO Collaborating Centre, would share the samples and other information on the virus obtained from Indonesia, without specific material-transfer agreements in accordance with WHO's existing policy.

A multilateral mechanism, initiated by WHO, would be important for the impartial and transparent distribution of affordable vaccines to those in need. Partnerships with the vaccine industry should be strengthened.

Dr VIOLAKI-PARASKEVA (Greece) said that the effectiveness of vaccination in controlling infectious diseases, particularly in a pandemic, was well known, but there was a need to improve health services and access to them, especially in primary health care. The ethical issues likely to arise during national and international responses to an influenza pandemic should be explored, as well as the role of the mass media in a pandemic.

Mr MASUKU (Food and Agriculture Organization of the United Nations) said that FAO continued to prioritize efforts to control and prevent avian and pandemic influenza. The intercontinental spread in early 2006 subtype of the highly pathogenic avian influenza virus had

resulted in infections with the H5N1 in many countries for the first time. However, the countries worst affected during the first three years of epizootic waves, including China, Thailand and Viet Nam, had managed to control the situation. The global situation had improved, and most newly infected or reinfected countries had improved their ability to detect, report and respond to outbreaks and to revert to a disease-free status.

The virus continued to circulate in some regions. The current shift to recurrent flare-up or persistence of the disease had an impact on the strategy to control highly pathogenic H5N1 virus infection in poultry. The continued application of culling measures in countries where the disease had not been stamped out had become increasingly unsustainable, and enzootic countries were increasingly relying on vaccination. FAO and OIE supported vaccination in such circumstances, provided that it met internationally accepted standards and followed implementation guidelines. Despite the usefulness of vaccination, there was a risk of continued virus evolution in areas of H5N1 persistence. Control strategies should be considered in combination with the various agro-ecological, socioeconomic, institutional and policy aspects. A global approach was essential, as was the sharing of influenza viruses and sequence data across geographical and political boundaries.

FAO had established support teams in the worst affected countries, and multidisciplinary avian influenza teams at regional level in Africa and Asia. Generous donor support had enabled a crisis management centre to be set up at FAO headquarters. In the field, it was stepping up joint efforts with OIE and the Inter-African Bureau for Animal Resources. With OIE, FAO operated a global framework for the control of transboundary animal diseases in order to support and enhance veterinary services, epidemiological surveillance, laboratory networks and disease early-warning and response mechanisms. Collaboration with WHO was also being stepped up, especially with regard to zoonotic diseases, including the shift of emerging pathogens from animals to humans, and foodborne illnesses. FAO, OIE and WHO had launched a Global Early Warning and Response System to improve international vigilance and enhance the ability to respond to international animal disease outbreaks that posed a threat to public health. Given that the emergence of highly pathogenic avian influenza resulted from human activity, the solution should be a matter of human choice and priority setting.

Dr NABARRO (United Nations System Senior Coordinator for Avian and Human Influenza) warned of a potential major humanitarian crisis. Recent outbreaks of infectious diseases and previous pandemics had had a significant impact on social, economic and governance systems, a fact recognized in the International Health Regulations (2005). In their preparedness strategies, countries were therefore looking increasingly to the impact of a pandemic beyond the health sector. Various United Nations humanitarian agencies were working with ILO, FAO, WHO, UNICEF, the International Civil Aviation Organization, WFP and the United Nations World Tourism Organization to support national strategies, including sustaining essential services and governance in the event of a pandemic. They were also linking up with the International Federation of Red Cross and Red Crescent Societies, and were promoting a strong intergovernmental effort in order to mitigate the impact of the next influenza pandemic. Action through the United Nations system was coordinated by his office and he would continue to engage with national authorities, in conjunction with WHO and other specialized agencies, in order to prepare for the non-health aspects of an influenza pandemic.

Dr RYS (European Commission) said that pandemic influenza was high on the Commission's agenda. Progress towards preparedness was good, but it would require a further two to three years to reach a satisfactory level. The Commission was working closely with the European Centre for Disease Prevention and Control, which had recently reported on the state of preparedness in Member States. Only through international partnership could health threats on the scale of pandemic influenza be properly tackled. Together with the Centre and the Regional Office for Europe, the Commission had organized joint workshops in order to exchange best practices between the Regional Office and Member States.

The Commission supported global efforts to control avian influenza and prevent pandemic influenza, and the provision of technical and financial assistance from the international community to

developing countries affected by avian influenza. He welcomed the International Health Regulations (2005) and looked forward to their entry into force.

Dr DUPLESSIS (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, observed that the magnitude of a human influenza pandemic would require the involvement of governments, in partnership with Red Cross and Red Crescent national societies, civil society and the private sector. Enhanced capacity at the local level and additional resources were urgently needed, but much promised assistance had yet to be delivered.

The International Federation worked towards the prevention and containment of avian influenza outbreaks and pandemic preparedness through its network of members, many of which had substantial experience in emergencies. Trained volunteers delivered preventive treatment everywhere because of their close involvement with local communities. Avian influenza interventions were in progress in more than 20 countries in Africa, Asia and Europe. National societies could play a key role in a phase 4 or 5 alert or a pandemic.

The International Federation had already formed a working partnership with several humanitarian organizations. It also worked closely with the United Nations System Influenza Coordination Office, whose excellent work he commended. The willingness of WHO to promote partnerships through its contacts with ministries of health was particularly welcome. The work with governments would be taken further at the 30th International Red Cross and Red Crescent Conference (Geneva, 20–22 November 2007). Avian influenza must remain a top priority, and not be allowed to fade merely because media warnings had yet to come true. Current work on avian and human influenza also provided invaluable experience in preparing for other global threats.

Dr HEYMANN (Assistant Director-General) acknowledged the needs of many Member States to strengthen capacity in their health sectors to deal with a pandemic, and the offers from other Member States to provide support. Guidance issued by WHO in 2005 on the timely sharing of influenza viruses had remained on the WHO web site until after the meeting of the Influenza Pandemic Task Force in September 2006. As part of the process of early implementation of the International Health Regulations (2005) in relation to avian influenza, during the first meeting of the Task Force on Pandemic Influenza, seven best practices had been devised to reflect the fact that under the revised Regulations virus sharing would be carried out in a different environment and the best practices replaced the guidance from 2005.

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

Smallpox eradication: destruction of variola virus stocks: Item 12.2 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.8, A60/9 and A60/40)

Ms BU FIGUEROA (Honduras), invited by the CHAIRMAN to introduce the item as Rapporteur, said that the Board, at its 120th session, had considered previous Health Assembly resolutions on the destruction of variola virus stocks, and the report of the eighth meeting of the WHO Advisory Committee on Variola Virus Research on the progress made in research and in the development of antiviral agents, improved vaccines, safer diagnostic assays and genomic sequencing.¹ The Board had agreed on the destruction of live variola virus stocks, but not on when to review the research programme so that a firm date could be set for their destruction.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, commented that the destruction of variola virus stocks had been postponed since 1999 for the sake of public health research. The research agenda had been broad, and many of the studies were of

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the second meeting, section 3.

limited public health importance. At its seventh meeting in November 2005, the WHO Advisory Committee on Variola Virus Research had reviewed the progress made in live variola virus research, and had concluded that live virus was no longer needed for work on sequencing, diagnostics and vaccines. WHO should comprehensively assess achievements and set a time limit for the ongoing research and a date for destroying the existing stocks. Developing countries should be empowered to ensure early detection and response of any disease event, as part of global health security. He emphasized WHO's responsibility to ensure that its resolutions were implemented.

Mr MSELEKU (South Africa), speaking on behalf of the Member States of the African Region, recalled that the World Health Assembly had adopted in resolution WHA33.3 a declaration on the global eradication of smallpox. Subsequent Health Assemblies had decided on the temporary retention of variola virus stocks and their eventual destruction. The draft resolution should allow the current Health Assembly to reach consensus. He noted the commitment to a major review of past, present and planned research; annual assessments of the need for further retention of the existing stocks of variola virus; inspections of the two authorized repositories in order to ensure that the laboratories met the requirements for biosafety and biosecurity; and annual submission of detailed reports to the Health Assembly. He also noted the request to the Director-General to review the membership of the WHO Advisory Committee and the participation of advisers and observers in the Committee's meetings so as to ensure balanced geographical representation and the independence of its members.

In view of the significant progress made in meeting the commitments set out in the draft resolution, the African group could agree that 2010 should be the year for completing the review. That would allow consensus to be reached at the Sixty-fourth World Health Assembly on the timing of destruction of existing variola virus stocks. The review should be wide-ranging. Assurances should be obtained that no stocks would be retained without the Organization's knowledge.

Dr WANNA HANSHAOWORAKUL (Thailand) said that variola virus stocks should be destroyed as soon as possible. She was aware that live virus would be needed to ensure efficacy testing in vitro and that no antiviral agents for smallpox had yet been licensed. However, ongoing research should be assessed in terms of its chances of success, and closely monitored according to the planned time frame. Research results should be disseminated publicly in order to permit discussion on the need for further studies.

Reports on the process and outcomes of the safety and security inspections of authorized repositories should be made publicly available. According to the Advisory Committee's report on its eighth meeting, all research projects had been authorized up to the end of 2007, after which they would be re-evaluated. Since it might take a further year for them to be concluded and their findings documented, the major review should be planned to start by 2008.

In paragraph 4(1) of the draft resolution submitted in resolution EB120.R8, the date of the major review should be 2009, and the deadline for the Health Assembly to reach consensus should be the sixty-third session. A new sentence should be inserted at the end of paragraph 4(5), to read: "the inspection mission report should be available on the web for public information".

Mr SCHOLTEN (Germany) spoke on behalf of the European Union and its 27 Member States. The candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia; the European Free Trade Association country Iceland, member of the European Economic Area; as well as Ukraine and the Republic of Moldova aligned themselves with his statement. He acknowledged the remarkable progress in research on new diagnostic tools and treatment of orthopoxvirus infections. He welcomed efforts to increase the probability of the destruction of virus stocks at a precise date in the future, and supported the draft resolution submitted in resolution EB120.R8. Pending the development of alternative research methods, the retention of virus stocks remained necessary, but all approved research should continue to be outcome-oriented, time-limited and transparent. For the time being, further temporary retention of existing stocks at the two repositories should be authorized in order to permit further international research, and a new date

for destruction should be set only when research accomplishments and outcomes allowed a consensus to be reached on the timing and process of such destruction. There should be a major review of research in 2010, so that the Sixty-fourth World Health Assembly could reach such a consensus.

Ms IMAI (Japan) reaffirmed the principle that smallpox eradication called for the destruction of live variola virus stocks in the laboratory. However, given the continuing threat of bioterrorism, current research must contribute to public health goals. Thus, she appreciated the Advisory Committee's continuing review of progress on outcome-oriented, time-limited research.

Recent technological developments enhanced the value of current research. However, generation gaps might mean that some scientists were unfamiliar with the WHO smallpox eradication programme. Research institutes or laboratories should be made aware of WHO policy on the regulation of recombinant DNA experiments related to variola virus fragments.

Consensus on the timing of the destruction of virus stocks might be difficult to reach, especially since a lack of information made it difficult to confirm a research period, but ought to be achieved.

Mr A.P. SINGH (India) welcomed the finding that virus strains in the two authorized repositories were being maintained with appropriate safeguards. However, the continued retention of the variola virus without a definite date for its total destruction was a matter of concern.

India was keenly interested in developing the operational framework for the WHO smallpox vaccine reserve in such a way that it would be able to obtain timely, adequate supplies of the vaccine if necessary. The framework must be developed on the basis of balanced geographical representation and adequate representation of those Member States considered to be most vulnerable to an unforeseen natural occurrence or accidental or deliberate release of any smallpox viruses. The other suggestions contained in the draft resolution deserved support.

Dr OLIVEROS (Philippines) said that the ultimate goal was the destruction of all remaining stocks of variola virus, but the final decision must be taken carefully. The decision on the date for the destruction of virus stocks and the conclusion of ongoing research should be taken in 2010, and not postponed further. Smallpox had been eradicated totally in 1980, so there had already been ample time for research and experiments to be conducted. With the emergence of DNA characterization and genetic materials for vaccine development there was no longer any need for stocks to be retained. There was, moreover, a great threat to biosafety in the event of release into the environment. As biotechnology advanced, there would be more disease agents and new pathogenic organisms could be created.

She strongly supported proposals for more balanced representation in the Advisory Committee and for progress reports on the phasing of the ultimate destruction of smallpox virus.

Mr SAADAT (Islamic Republic of Iran) said that, in the years since the Health Assembly had decided on the destruction of remaining virus stocks, temporary retention of stocks for research purposes had become the rule, because a handful of countries had dragged the issue out. Instead of exerting its authority to ensure adherence to a destruction date, the Health Assembly had allowed the Advisory Committee to authorize an expanded, diversified and seemingly endless research agenda, which was being used to justify the retention of stocks for years to come. However, independent experts had confirmed that all essential research requiring live stocks was complete and that there was a supply of vaccines and diagnostic tools. The Health Assembly should instruct the Advisory Committee to draft a stocktaking report; fix a new destruction date; prohibit all genetic engineering of virus stocks; determine whether the Advisory Committee had fulfilled its mandate; and develop an outcome-oriented, time-bound and regulated research agenda for the period remaining before destruction. The Advisory Committee's composition and working methods had to be reformed. Live virus stocks should be considered a global public good under global jurisdiction. The two existing repositories should be deemed global facilities, with all Member States sharing responsibilities and with global ownership of the research achievements.

The primacy of public health should be upheld in all circumstances: WHO should not be dragged into issues that were beyond its competence or mandate, or be held hostage to interests that were not health related. The availability of viral stocks in biological weapon form was frightening. Because virus stocks could be misused or accidentally released, the reluctance to destroy them made the world less secure. Eradication was an absolute term and covered not just smallpox itself, but also its causal agents. He expressed support for the statement made on behalf of the Member States of the African Region.

Dr STEIGER (United States of America) strongly supported the continuation of essential research using the live smallpox virus stocks held at the two official repositories. At the same time, his Government remained committed to the full implementation of resolution WHA55.15. Eminent international scientists had yet to exhaust the research potential of the live virus and ongoing research was focusing on the development of better diagnostic tools, new antiviral agents and improved vaccines. Recent research also suggested that existing vaccines might be losing their potency. He welcomed the convening of a special panel of African and other scientists in August 2006 in order to review the current status of research. The panel had underscored the continuing need for research of benefit to all, especially those with compromised immune systems.

The Secretariat and the Member States had participated in the various open-ended working groups on the issue over the past year, and he especially appreciated the contributions by African Member States. He supported the draft resolution, which provided for a major review in 2010. The operational framework for the WHO vaccine reserve needed to be completed, and he urged the Secretariat to do so, with input from Member States. With regard to the amendment proposed by the delegate of Thailand to paragraph 4(5) of the resolution submitted in resolution EB120.R8, the report of the inspection team that had visited the repositories in the United States and the Russian Federation contained information that must not fall into the wrong hands. He therefore suggested that the amendment should read as follows: "The inspection mission report should be available on the web for public information, after appropriate redaction".

Mr PIRIMKULOV (Uzbekistan) supported the position of the Russian Federation that artificial deadlines should not be set for the destruction of virus stocks. A decision was premature until research was complete.

Dr HUWAIL (Iraq) said that establishing a clear objective in order to set a deadline for the research process was essential, so that the destruction of virus stocks could be carried out as soon as possible.

The meeting rose at 17:30.

THIRD MEETING

Wednesday, 16 May 2007, at 09.30

Chairman: Dr R.R. JEAN LOUIS (Madagascar)
later: Dr A. BALBISI (Jordan)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Smallpox eradication: destruction of variola virus stocks: Item 12.2 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R8, A60/9 and A60/40) (continued)

Dr AL-SALEH (Kuwait) said that the smallpox threat in Kuwait during the Gulf War had seriously concerned his country and its neighbours. In view of the risk inherent in live viruses, the possibility of bioterrorism and the improved treatment of smallpox, the variola virus stocks should be destroyed by 2010. He fully supported the proposal to that effect.

Mr MACPHEE (Canada) fully agreed that the remaining stocks of the live variola virus should be destroyed. A date for destruction should be established only when the stocks were no longer required for public health research. The major review referred to in paragraph 4(1) of the draft resolution contained in resolution EB120.R8 must be definitive, comprehensive and scientific. Member States must have enough time to consider it carefully before the Health Assembly. He therefore endorsed the view expressed by the delegates of Germany and the United States of America that the major review should take place in 2010. The Sixty-fourth World Health Assembly would reach a consensus on the timing of the destruction.

He agreed with the delegate of Thailand that some form of inspection report should be made available to Member States.

Dr HAO Yang (China) observed that progress had been made in some countries in the diagnosis of smallpox infection, in research and development and in the evaluation of new antiviral agents. WHO should define the programmes and objectives for future research. More stringent measures would ensure biosafety in laboratories. The Secretariat should report to Member States on research progress.

Dr TANGI (Tonga) endorsed the views expressed by the delegate of Canada. The lengthy discussions concerning the variola virus had hitherto focused on the stocks at the two official repositories. However, only when WHO was convinced that there were no unknown stocks of the virus should a time frame be developed for destroying stocks at the authorized repositories.

He requested clarification of the legal significance of the term “ownership” in paragraph 4(11) of the draft resolution. He agreed with the delegate of Thailand that information about the inspections referred to in paragraph 4(5) should be readily available to Member States.

Dr FEDOROV (Russian Federation) said that, given the continued threat of smallpox, the Russian Federation intended to pursue research on variola virus, in accordance with resolutions WHA52.10 and WHA55.15. Despite progress in studying research on the virus, new vaccines, antiviral agents and diagnostics, there were still no licensed, effective and safe means of prevention or treatment.

The possible use of variola virus for terrorist purposes could be catastrophic, especially given that most of the world's population lacked immunity to it. In addition to the stocks held at the two official repositories, there might be stocks not accounted for that could fall into the wrong hands. The destruction of the official stocks could give a signal to bioterrorist groups to scale up their work. Genetic engineering of the virus could render all the tools hitherto developed to deal with smallpox ineffective and even harmful. Retaining the official stocks in the Russian Federation and the United States, and maintaining a laboratory infrastructure with the highest levels of biosafety and highly trained staff, were key factors in preventing the use of the virus for terrorist purposes.

Had enough thought had been given to the possible re-emergence of the smallpox virus from a natural source? The outbreak of monkeypox in 1996–1997 had shown an emerging infection with real potential to spread among the human population. Destruction of the official stocks of the smallpox virus would inevitably lower vigilance with regard to smallpox, and result in the gradual decline and eventual disappearance of the specialist skills – a highly irresponsible loss. Following the global eradication of smallpox, scientific research into the virus, new vaccines and antiviral agents had been curtailed or stopped, and doctors had almost lost diagnostic and treatment skills. If the agent were no longer present, it would be impossible to maintain expensive laboratory capacity and continue to train and develop highly qualified staff. Where would the rapid-reaction health personnel come from in the event of a bioterrorist attack, or a natural recurrence or emergence of disease from an evolved orthopox virus? How would samples be collected and transported, where would suspect samples be taken, who would diagnose them, and who would take the necessary steps to localize any outbreak? These were unanswered questions.

The scientific centres in the Russian Federation and the United States worked under the auspices of the WHO Secretariat and in accordance with the instructions of the Health Assembly. The WHO Advisory Committee on Variola Virus Research reviewed the results of the work undertaken every year and made necessary adjustments. It was imperative that research should be continued on more effective and safer vaccines, better diagnostics, antiviral agents, the virus genome and pathogenesis of the infection. The question of lifting the moratorium on the destruction of the existing authorized stocks of the variola virus should be addressed only when safe and effective vaccines were accessible to the international community, proven antiviral agents with different methods of action had been developed, and diagnostics specific to type and strain were available. That could take 10 years or more.

Dr PARIRENYATWA (Zimbabwe) said that there was consensus on the need to destroy all the known remaining stocks of variola virus: at issue was the timing. The major research review should be submitted in 2010. A date should then be set for the final destruction of the stocks.

Dr OGWELL (Kenya) emphasized that resolution WHA55.15 had authorized the further retention of existing stocks of variola virus on a temporary basis only. Because of the threat of bioterrorism, retention did not make the world a safer place, and could encourage others to acquire similar viruses. The focus should be on the public health consequences of the virus being released. The review should be conducted in 2010, and the Sixty-fourth World Health Assembly should set a date for destruction.

Professor HORVATH (Australia) said that Australia supported retention of limited, monitored and controlled stocks of variola virus, for essential research only. The virus stocks would be important for any rapid response and research in the event of natural re-emergence or intentional release of smallpox or a smallpox-like virus. There might also be a future research need for variola virus stock.

All proposals for research using variola virus stocks should be reviewed by the Advisory Committee on Variola Virus Research, in order to ascertain whether the research was essential and whether all biosafety and biosecurity requirements were met. The major review referred to in paragraph 4(1) of the draft resolution should take place in 2010.

Dr ST. JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolution. The major review should be carried out in 2010. She had confidence in the Advisory Committee on Variola Virus Research, and noted that all the stocks were safe and accounted for. Progress in research, declining needs for variola virus, and safety and security were all matters to be kept under review before a firm date was set for destroying the stocks.

Mr AITKEN (Representative of the Director-General) said that, although there had been a mention of 2009 as the date for a major review, countries appeared to favour specifying the Sixty-fourth World Health Assembly in paragraphs 3 and 4(1) of the draft resolution, and the date 2010 in paragraph 4(1). An amendment proposed by the delegate of Thailand to paragraph 4(5), subsequently amended by the delegate of the United States, would result in the inclusion at the end of paragraph 4(5) of the words “the inspection mission reports should be available for public information after appropriate redaction”.

Dr WANNA HANSHAOWORAKUL (Thailand) said that she could accept either 2009 or 2010 as the date for the review. As for the proposed amendment to paragraph 4(5), the inspection reports should be based on scientific considerations and should be free of any trace of political influence. They should therefore be available without redaction.

Mr AITKEN (Representative of the Director-General) said that the full reports might contain information, for example relating to access to sites where variola virus stocks were held, that should not be made freely available for reasons of safety and security.

Dr WANNA HANSHAOWORAKUL (Thailand) suggested amending the text to “after appropriate scientific consideration”.

After clarification, the draft resolution, as amended, was approved.¹

Dr Balbisi took the Chair.

Control of leishmaniasis: Item 12.3 of the Agenda (Documents EBSS–EB118/2006/REC/1, resolution EB118.R3, and A60/10)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB118.R3.

Professor FAIZ (Bangladesh) said that Bangladesh’s early success in controlling visceral leishmaniasis, which was endemic with around 40 000 cases per year, had been a collateral benefit of indoor residual spraying with DDT to control malaria. Bangladesh had signed a memorandum of understanding with India and Nepal in 2005 to eliminate visceral leishmaniasis by 2015, elimination being defined as fewer than one case for every 10 000 people. In Bangladesh control measures included indoor residual spraying with deltamethrin, early diagnosis using the recombinant k39 dipstick test, and oral treatment with miltefosine, dispensed at hospitals on an outpatient basis. A phase IV trial was being conducted in 11 sub-district hospitals, involving more than 300 patients, and it was hoped that compliance could be improved by administering a combination treatment: a short course of amphotericin B and a 14-day oral course of miltefosine. Further research was needed on different treatment regimens. Key strategies for elimination would include early diagnosis, prompt treatment, entomological and epidemiological surveillance, indoor residual insecticide spraying, and information, education and communication activities. Elimination of visceral leishmaniasis should boost efforts to alleviate poverty. Consideration was being given to setting up a regional registry for

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA60.R1.

cases of visceral leishmaniasis in pregnancy. Bangladesh was requesting financial support for its leishmaniasis control activities, and he hoped that WHO would negotiate with industry for a reduction in the price of miltefosine.

Dr MESSELE (Ethiopia), speaking on behalf of the 46 Member States of the African Region, said that visceral and cutaneous leishmaniasis caused considerable morbidity and mortality in Africa; several countries had experienced epidemics. The disease burden was not well defined, owing to the lack of surveillance systems, nor was the disease well recognized by the general public or most health workers. Coinfection with visceral leishmaniasis and HIV was compounding the problem. Treatment was expensive, and had side effects. The African group welcomed the efforts being made by WHO to control the disease. WHO should also facilitate research into safer, effective and cheaper medicines, operational research, and cross-border collaboration on leishmaniasis control. He supported the draft resolution.

Mr CHAOUKI (Morocco), speaking on behalf of the 22 Member States of the Eastern Mediterranean Region, said that leishmaniasis was endemic in many countries in the Region, and periodic epidemics were common. Buildings and infrastructure destroyed by conflict or natural disaster provided breeding sites for the sandfly vector, leading to the rapid spread of the disease. Refugee movements also contributed to the spread. Two cutaneous and two visceral forms of leishmaniasis were found in the Region. Outbreaks of zoonotic cutaneous leishmaniasis caused by *Leishmania major* occurred in desert regions after rainy years or following water-development projects, owing to population increases in rodents forming the wild reservoir. Many countries in the Region were affected, experiencing some 50 000 cases per year. Zoonotic cutaneous leishmaniasis could be controlled by ecological modifications to reduce the rodent reservoir. Paragraph 2(2)(a) of the draft resolution should therefore be amended by inserting "and reservoir" after "vector". There had been significant outbreaks of anthroponotic cutaneous leishmaniasis in recent years, for example in Afghanistan in 2003, mainly as a result of the displacement of non-immune populations to endemic areas. Vector control through residual insecticide spraying, although effective, was neither practical nor affordable. However, insecticide-treated bednets could make a useful contribution. Infantile visceral leishmaniasis occurred sporadically in the Region. Outbreaks of anthroponotic visceral leishmaniasis occurred mainly in Sudan, but had declined in recent years as a result of a reduction in population movements and better diagnostic and therapeutic coverage.

The substantial price reduction negotiated recently by WHO for meglumine antimonate for the public sector in developing countries should provide a major breakthrough in scaling up treatment. Thanks were due to all parties concerned. He supported the draft resolution with the proposed amendments.

Speaking as the delegate of Morocco, he said that the country was endemic for the cutaneous and visceral forms of leishmaniasis. The control programme was based on vector control, case detection and treatment, raising awareness among the population, and strong intersectoral collaboration. It was necessary to strengthen local capacity to control the disease, to develop effective low-cost medication and to encourage the use of insecticide-impregnated bednets.

Dr ZARAMBA (Uganda) welcomed the focus on neglected tropical diseases and their control. Mucocutaneous and visceral leishmaniasis were endemic in the north-east of Uganda. Control activities were hampered by shortcomings in the health system and the high cost of miltefosine and amphotericin B. He supported the draft resolution.

Dr SADRIZADEH (Islamic Republic of Iran) said that leishmaniasis remained one of the most neglected of the tropical diseases, with few tools for control and no criteria to govern control measures. Coinfection with visceral leishmaniasis and HIV was an ominous global trend, resulting in the spread of leishmaniasis beyond previously endemic areas. There was an urgent need for research, under the auspices of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, on cheap effective medicines and rapid and reliable diagnostic tools.

Mapping the distribution of the disease and the populations at risk was another priority. Integrated vector management and control would strengthen a multipronged approach to interrupting the transmission of the disease. His country remained endemic for cutaneous leishmaniasis, and could share experience gained in prevention and control with other endemic countries. He supported the draft resolution.

Ms JOHRI (India) said that India had signed a memorandum of understanding with Bangladesh and Nepal, the other two countries in the South-East Asia Region endemic for visceral leishmaniasis, on harmonizing prevention and control interventions and fixing 2015 as the target date for eliminating the disease in the Region. India was committed to elimination by 2010 and was providing funding to provincial governments for control measures through the primary health care system. She supported the draft resolution, but suggested the inclusion of references to surveillance of post-kala-azar dermal leishmaniasis, which remained a potential source for the transmission of *L. donovani*, and to the policy on treatment for coinfection with HIV and visceral leishmaniasis. Since leishmaniasis affected the most vulnerable population groups and could be eliminated rather than simply controlled, Member States should make that their goal.

Mr HAGE CARMO (Brazil) supported the draft resolution, but proposed adding three more subparagraphs to paragraph 1, to read: “(6) to promote the sustainability of surveillance actions and leishmaniasis control; (7) to support studies concerning the surveillance and control of leishmaniasis; (8) to share experiences in the development of studies and technologies applied to the prevention and control of leishmaniasis”.

Three subparagraphs should also be added to paragraph 4: “(8) to promote actions together with the main laboratories in order to reduce medicine costs to developing countries; (9) to foment and support studies on (a) the evaluation of the efficacy of new medicines, (b) the evaluation of dose and length of treatment for existing medicines, and (c) standardization of reagents for diagnosis of the disease, with emphasis on visceral leishmaniasis; (10) to implement actions in order to improve coordination among leishmaniasis multilateral institutions and international donors.”

Dr HUWAIL (Iraq) said that both visceral and cutaneous leishmaniasis were seasonal in Iraq, with transmission from May to October after the hatching of sandfly eggs, and a peak in new cases between December and February. Population movement was a main variable affecting incidence of the disease. WHO should support research into the effectiveness of insecticides for indoor and outdoor spraying, and help in evaluating the efficacy of fogging in reducing vector density; early case detection; procuring treatment and evaluating its effectiveness; regular and sustainable follow-up after treatment; institutional and individual capacity building in all aspects of leishmaniasis prevention and management; and the readoption of specific measures for prevention and control of the disease among internally displaced and immigrant populations.

Dr PHUSIT PRAKONGSAI (Thailand), referring to the memorandum of understanding signed by Bangladesh, India and Nepal, agreed that leishmaniasis placed a heavy socioeconomic burden on families, communities and health systems in affected countries. Reliable epidemiological data were vital in monitoring the disease and assessing its impact on populations and health systems. WHO should work to improve surveillance of leishmaniasis, the vector and wild reservoirs in endemic countries. Thailand was willing to share its experience from over two decades of combating communicable diseases in rural areas. Strong capacity, good primary and secondary health care infrastructures, and improvements in public knowledge and socioeconomic status were crucial to communicable disease control.

Paragraph 1(3) of the draft resolution should be amended by inserting the words “in providing primary and secondary care” after “centres”, and adding a new subparagraph to paragraph 1, to read: “(6) to improve knowledge about and skills to prevent leishmaniasis among people in the rural areas, including their socioeconomic status”. A new subparagraph should be added to paragraph 4, to read: “to promote and support the development of safe, effective and affordable vaccine, diagnostic tools

and medicines with less toxicity for leishmaniasis control". Paragraph 4(6) should be amended by adding "WHO regional offices and governments of the Member States affected by leishmaniasis".

Dr AL-SALEH (Kuwait) said that leishmaniasis remained a major threat worldwide, even in areas not at present affected, because of its wide variety of reservoirs and because the vector was strong enough to adapt to different environments. The draft resolution should therefore contain, in paragraph 1(5), a reference to collaboration between national and international parties or organizations. In the same subparagraph, the words "and the common threat of the disease" should be inserted after "common foci". The private sector should be involved in both national and international plans.

Dr AYDINLI (Turkey) called for a multidisciplinary approach, embracing all relevant institutions and organizations within a national control programme supported by policy-makers. Turkey had a comprehensive leishmaniasis control programme, and both forms of the disease were on its list of notifiable diseases. Cases had fallen from almost 5500 in 1994 to 1800 in 2006, with no fatalities. Medicines for treating patients were provided and administered free of charge by the Ministry of Health.

Dr NYIKAL (Kenya), welcoming WHO's work on leishmaniasis, said that the visceral form of the disease was a public health problem in Kenya. The main obstacles were the cost and complexity of the treatment, since available medicines were expensive and difficult to administer. He supported the draft resolution, in particular paragraph 2(2)(b).

Dr LEVENTHAL (Israel) drew attention to the need to identify good practices in cross-border leishmaniasis control projects. Such practices should be implemented on the eastern side of the Mediterranean.

Mr ABDOO (United States of America) said that his Government provided significant support for research to combat and control leishmaniasis. A sustainable control strategy included better diagnostics and therapies; improved access to health care; and health-sector reform. Novel approaches might include therapeutic vaccines and prophylactic vaccination in order to control cutaneous and mucocutaneous leishmaniasis. Those treatments had proved effective in parts of South America and Africa. In treating visceral leishmaniasis, immune-based therapies could replace current medicines, which did not work well in HIV-coinfected patients. He congratulated WHO on raising global awareness of the need to control and eliminate leishmaniasis, and endorsed the draft resolution.

Mrs REITENBACH (Germany) asked whether there was any prospect of obtaining a substantial price reduction for liposomal amphotericin B, referred to in paragraph 9 of document A60/10. If so, how would that affect the recommendations in the draft resolution?

Mr MENESES (Mexico) drew attention to the difficulty of comparing data, on account of the variety of procedures and methods used by different countries for diagnosis and epidemiological surveillance. Member States should agree on standards for diagnosis, surveillance and control, treatment and access to medicines in order to make progress towards preventing and controlling visceral leishmaniasis, the form taken by the disease in his country. There was a lack of skilled human resources in the areas of epidemiological surveillance, health promotion, diagnosis and treatment; a shortage of diagnostic and entomological reference centres; and inadequate quality control and timely access to medicines in affected areas. Visceral leishmaniasis prevention required interdisciplinary groups, and health promotion programmes needed support from WHO. The activities of ministries dealing with public health and vector control were poorly coordinated. Countries in the Americas should strengthen their national leishmaniasis control programmes by making them part of their national and subregional agendas. Calling on the Health Assembly to make a commitment to

strengthening leishmaniasis prevention and control programmes, especially in the Americas, he endorsed the draft resolution.

Dr ALVAR (Innovative and Intensified Disease Management), replying to the question raised by the delegate of Germany, said that in March 2007 the company producing liposomal amphotericin B had announced a 90% reduction in the price. WHO would negotiate with other companies on price reductions for other medicines; a successful outcome would have a great impact on evidence-based policy for leishmaniasis control.

The CHAIRMAN suggested that a new version of the draft resolution, incorporating the amendments proposed, should be prepared for distribution.

It was so agreed.

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

Dr Jean Louis resumed the Chair.

Poliomyelitis: mechanism for management of potential risks to eradication: Item 12.4 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R1, and A60/11)

Mr SHIRALIYEV (representative of the Executive Board) said that the Board at its 120th session had focused on the need to intensify eradication efforts in four countries: Afghanistan, India, Nigeria and Pakistan.¹ Board members had also discussed the steps individual Member States could take in order to reduce the risk of reintroduction of polioviruses by travellers from poliomyelitis-infected areas. The Board had agreed on the advisability of full immunization against poliomyelitis for all travellers to and from areas in which poliovirus was circulating and that an appropriate standing recommendation to that effect should be considered under the provisions of the International Health Regulations (2005) upon their entry into force in mid-2007. Work was required in order to establish a mechanism for minimizing and managing the long-term risks of poliovirus reintroduction or re-emergence in the post-eradication era. The Board had adopted resolution EB120.R1, which recommend a resolution to the Health Assembly.

Ms JOHRI (India) said that her Government was fully committed to eradicating poliomyelitis within the country, and preventing its international spread. Poliomyelitis eradication was the largest single programme in India's health sector, and, although government investment had been rising, contributions from development partners were declining. Circulation of poliovirus had been contained within just two endemic states, and the genetic biodiversity of the viruses had been reduced. The outbreak in 2006 had been much less intense than that in 2002. Surveillance of acute flaccid paralysis in India was extremely sensitive. A mass immunization programme, conducted since 2003 with WHO and UNICEF, had achieved high levels of coverage. India was dealing with a growing number of susceptible people and foci of missed children in underserved pockets. Significant gains gave confidence for eradicating poliomyelitis in the near future.

She underlined the request to the Director-General, in paragraph 3(2) of the draft resolution, to assist in mobilizing financial resources. In view of the high level of commitment for poliomyelitis eradication, and limited technical, financial and management capacities of many Member States, she proposed several amendments. In paragraph 1, the phrase "in certain geographical areas," should be inserted after the word "prevalent,". Paragraph 2(1) should be amended to read "to review and if appropriate update national recommendations on immunization against poliomyelitis to reduce the risk

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the second meeting, section 3.

of international spread". In paragraph 2(3) the word "importation" should be replaced by "international spread". Paragraph 3(4) should be replaced by "to continue to examine and to disseminate measures Member States can take to reduce the risk and consequences of international spread of polioviruses, including, if and when needed, the consideration of temporary or standing recommendations under the International Health Regulations (2005);".

Dr VÁSZONEZ (Ecuador) said that circulation of the wild poliovirus had been interrupted in Ecuador for 17 years. Vaccination coverage had been maintained at more than 94% in 90% of regions. For five years, vaccination of children under five had been stepped up in towns with a coverage of less than 80%. Epidemiological surveillance indicators were in line with international standards. Control of circulation of poliovirus in the post-eradication era was based on a policy of confinement of the virus in laboratories. For various social, demographic, economic, political and financial reasons, some countries had still not managed to stop circulation of the wild virus. Countries with effective strategies had brought about a significant reduction in the number of cases. She endorsed the draft resolution.

Dr SUGIURA (Japan) noted the successful action taken against outbreaks of wild poliovirus in Indonesia and Yemen in 2005. His country would provide support for the four countries where poliomyelitis was still endemic, particularly Nigeria. He welcomed the recommendation in the draft resolution contained in resolution EB120.R1 relating to the immunization of travellers from countries where wild poliovirus was circulating. He proposed the following addition to the preamble of that draft resolution: "Noting that the maintenance of routine immunization in polio-free countries contributes not only to reducing the risk of wild poliovirus outbreaks but also to minimizing the spread of vaccine-derived poliovirus outbreaks".

Dr OUAHDI (Algeria) suggested that the draft resolution should be amended in order to reflect the fact that poliomyelitis was also a waterborne disease, with the addition of appropriate references to environmental health and the treatment of drinking water.

Dr VIOLAKI-PARASKEVA (Greece) said that the eradication of poliomyelitis was technically feasible but it would require considerable political commitment from endemic countries. Every country must set up active surveillance programmes with the immediate notification of all cases. In her country, immunization against poliomyelitis was provided free of charge for everyone. She supported the draft resolution, with the following amendment at the end of paragraph 2(3): "... supplementary poliomyelitis immunization activities by additional campaigns in close collaboration with the mass media and the public".

Dr WANNA HANSHAOWORAKUL (Thailand) said that the eradication of poliomyelitis involved four main activities: surveillance of acute flaccid paralysis, routine immunization, national and subnational immunization campaigns, and mopping-up activities following case detection. Those activities demanded enormous resources, which countries could not afford indefinitely. Cases caused by imported polioviruses were likely to occur. Low-income countries would need the technical and financial support of WHO and international donors, and a detailed procedure would be required for monitoring the effectiveness of immunization of travellers entering or leaving endemic areas.

She asked for the following information: of all annual cases of poliomyelitis in the world, what proportion was represented by imported cases? What were the cost implications of immunizing travellers entering or leaving endemic areas? Did the health systems of the four endemic countries have the necessary capacity to implement such a policy? She suggested that a sentence should be added at the end of paragraph 3(4) of the draft resolution, to read: "... areas where poliovirus is circulating. The financial implications, operational issues and lessons drawn from implementing this policy should be shared with the public."

Professor TLOU (Botswana) said that, when poliomyelitis had broken out in neighbouring Namibia in 2006, Botswana had avoided imported cases by means of heightened surveillance and

social mobilization in high-risk districts along the border between the two countries. She appreciated the cooperation of Namibia in the implementation of WHO travel advice and the sharing of information, as well as the technical assistance provided by WHO.

It was essential to minimize the risk of reintroducing wild polioviruses into poliomyelitis-free areas and prevent the re-emergence of the disease in the post-eradication phase. She therefore supported the draft resolution, particularly the provision related to the immunization of travellers under the International Health Regulations (2005).

Dr DEGROOF (Belgium) expressed concern about the suggestion that an annex should be added to the International Health Regulations (2005), dealing with compulsory immunization of travellers, since the Regulations had not even come into force yet. However, a standing recommendation under the Regulations would be acceptable, and he could therefore support the draft resolution.

Dr ASSOGBA (Benin) said that wild poliovirus had last been detected in his country in 2004. The Government had implemented the strategies recommended by WHO, including: supplementary immunization campaigns, which had achieved coverage of over 95%; active surveillance of acute flaccid paralysis, with a rate achieved of 2.4 cases per 100 000 children aged under 15 in 2006; and the maintenance of routine immunization coverage of more than 90%, reaching 93% in 2006. The Government aimed to reduce the risk of cross-border transmission of wild polioviruses by organizing joint immunization campaigns with neighbouring countries, monitoring travellers at its borders, and financing activities in order to prevent the re-emergence of poliomyelitis in the post-eradication phase.

Dr NYIKAL (Kenya) said that his country had reported two cases of imported poliomyelitis in 2006, after 22 years free of the disease. Three supplementary immunization campaigns had been conducted, and 11 subnational campaigns in collaboration with neighbouring countries. Those campaigns imposed a great financial burden and jeopardized routine immunization. Countries needed support if they were to remain poliomyelitis-free; it was a matter of global as well as national concern. He supported the draft resolution, particularly subparagraphs 3(1) and 3(2) on the need to provide technical and financial support.

Dr AYDINLI (Turkey) said that the world would remain at risk from poliomyelitis until the transmission of wild polioviruses had completely stopped. Turkey was concerned about the risk of importing poliovirus from Africa and some countries of the Eastern Mediterranean Region. The proposal to immunize travellers from poliomyelitis-infected areas appeared to have a sound scientific basis. WHO was ensuring that expertise was available to countries that intended to impose stricter immunization requirements. Turkey provided support to WHO and the Organization of the Islamic Conference in their poliomyelitis eradication activities in Afghanistan and other countries. He supported the draft resolution.

Dr KANDUN (Indonesia) said that, since a recent outbreak of poliomyelitis caused by imported poliovirus, his country needed to review its current policy for travellers to areas in which polioviruses were circulating. He supported the proposals to establish temporary or standing recommendations under the International Health Regulations (2005), once they entered into force; to increase the coverage of routine immunization to above 90%; and to conduct supplementary immunization campaigns whenever appropriate.

Both cross-border and long-distance importation of polioviruses remained a threat for Indonesia and other developing countries. The use of poliomyelitis vaccines continued to be required in all countries. Indonesia had suffered a major outbreak of poliomyelitis caused by circulating vaccine-derived polioviruses, which had paralysed 43 children on the island of Madura, where routine immunization services had been suspended following the economic crisis of 1998.

Dr AL-SALEH (Kuwait) noted that some countries had eradicated poliomyelitis, only for it to re-emerge after one or two years. It might be better to target an entire region rather than an individual country. Paragraph 2(2) of the draft resolution should be amended to read: "... countries in which wild poliovirus is circulating or has recently been circulating in accordance with temporary or standing recommendations ...".

Professor FAIZ (Bangladesh) said that his country had suffered cases of poliomyelitis due to imported polioviruses in March 2006, after almost five years of freedom from the disease. The Government had conducted two rounds of immunization in March/April 2006 and a further campaign in October/November 2006. Two rounds of immunization would be carried out every year until its neighbour, India, became poliomyelitis-free. The border between Bangladesh and India was so long that it might not be economically feasible to institute enforcement measures under the International Health Regulations (2005). He supported the proposal to immunize travellers entering or leaving poliomyelitis-endemic areas.

Dr HAO Yang (China) said that his country was conducting immunization programmes and other measures so that it stayed poliomyelitis-free and prevented the potential entry of wild polioviruses. He was concerned that some countries that had eradicated poliomyelitis had suffered new cases as a result of the use of live-attenuated oral poliomyelitis vaccines. WHO should refine its immunization strategy and promote the use of inactivated vaccines. His country was also working to mitigate the potential risks arising from infectious poliovirus materials.

Dr ALA (Philippines) said that immunization was a public health priority in her country, which had been poliomyelitis-free for almost six years, but the risk of importing polioviruses was high. The national "Reaching every infant in every village" strategy, adapted from WHO's "Reaching Every District" strategy, had improved routine immunization coverage. Integrated child-survival monitoring tools were especially valuable in certain districts that were home to about 50% of unimmunized children. An Expanded Programme on Immunization surveillance officer had been assigned to every region in the country. Surveillance of acute flaccid paralysis remained of a high quality, although financing for active surveillance in sentinel sites and hospitals was a concern.

All countries should conduct laboratory surveys and prepare inventories of retained wild poliovirus materials, especially those that had been certified poliomyelitis-free. She agreed that travellers entering or leaving poliomyelitis-endemic countries should be fully immunized.

Ms NGHATANGA (Namibia) said that an outbreak of wild poliovirus infection in her country in May 2006 had affected 19 people. The Government had responded within 72 hours, with technical and material support from partners including WHO and UNICEF and a prompt response from local nongovernmental organizations and the business community. The Government had provided 80% of the funds needed to control the outbreak, a three-round vaccination campaign had been carried out and the last case had been recorded on 26 June 2006.

Since the outbreak, technical cooperation with Angola had increased. Two meetings had been held to discuss cross-border immunization campaigns and to set dates for the national supplementary immunization campaigns planned for June and July 2007. Surveillance remained a challenge, however. The Reaching Every District approach was strengthening routine immunization at district level. She supported the draft resolution.

Professor IANCU (Romania) said that the persistent transmission of wild poliovirus in areas bordering the European Region posed a real threat of importation to the Region, which had been declared poliomyelitis-free. National and regional poliomyelitis eradication programmes must be maintained. Romania was one of the 43 Member States in the European Region conducting national surveillance of acute flaccid paralysis and was one of 21 countries in the Region that had achieved a detection rate of one case per 100 000 children under 15 years of age. In over 80% of such cases, two adequate stool specimens had been tested in accredited laboratories. Further efforts were required in

order to ensure that acute flaccid paralysis surveillance remained sustainable. In 2005, some 97% of the target population received three doses of vaccine. Romania was fully meeting the targets for completeness and timeliness of reporting, compared with a level of less than 80% the previous year.

Dr MELNIKOVA (Russian Federation) said that recommendations on vaccination against poliomyelitis for people travelling from regions where poliovirus was circulating should be included in the International Health Regulations (2005). She supported a process of amending the Regulations for the long-term use of poliomyelitis vaccines and biocontainment of poliovirus materials in order to minimize the risk of the re-emergence of poliomyelitis once eradicated. She also supported the continued provision of technical and financial support to countries where poliovirus was circulating and those at high risk of importation of poliovirus. In July 2006, her country had pledged US\$ 18 million to the Global Polio Eradication Initiative at the G8 summit meeting.

Dr ASLANYAN (Canada) supported the draft resolution and the renewed focus on eradication. The possible re-emergence of poliomyelitis as a global problem was of great concern to Canada. His country had contributed almost Can\$ 200 million to the Initiative and would continue to provide targeted support in the remaining endemic countries.

Dr NJEPUOME (Nigeria), speaking on behalf of the African group, said that, notwithstanding significant success worldwide towards interrupting the transmission of wild poliovirus, four countries including her own had yet to reach that goal. In May 2006, Nigeria had introduced “Immunization Plus Days”, reducing the number of cases of wild poliovirus infection to fewer than 80 in the first quarter of 2007. African governments remained committed to implementing the relevant Health Assembly resolutions, in order to eradicate poliomyelitis from the continent. The endemic countries committed themselves to working with poliomyelitis-free Member States, donors and other partners to this end; bordering States should synchronize their supplementary immunization activities, as they had done from 2000 to 2002. Countries to which the wild poliovirus was imported should receive full international support.

He supported the draft resolution but proposed two amendments. Paragraph 2(2) should be replaced by the following paragraph: “to review, and if appropriate, revise national policy on immunization of travellers from countries in which poliovirus is circulating, to reduce the risks and consequences of poliovirus importation”. Paragraph 3(4) should be replaced by the text: “to initiate the process to examine the potential usefulness of a standing recommendation under the International Health Regulations (2005) to reduce the risk of the international spread of poliovirus”.

Mr GAUDÊNCIO (Brazil) supported the draft resolution, emphasizing the need for a new vaccination policy for international travellers under the International Health Regulations (2005). Resources must be guaranteed, and vaccination and surveillance strategies made viable, to achieve global poliomyelitis eradication. He underlined the request to the Director-General in paragraph 3(5) to formulate a plan for the post-eradication era, including the use of intramuscular vaccines to replace oral vaccines.

Dr KEBELA ILUNGA (Democratic Republic of the Congo) said that his country had been poliomyelitis-free for five years, but that new cases had appeared in four border provinces in 2006, all in non-vaccinated children. Member States in the African Region should synchronize cross-border vaccination campaigns in areas where the poliovirus was still circulating, and strengthen routine immunization in order to increase coverage with three doses of oral poliomyelitis vaccine. He supported the draft resolution.

Dr ST. JOHN (Barbados), speaking on behalf of the member countries of the Caribbean Community, said that they were largely poliomyelitis-free and would continue high levels of immunization, currently at 90% to 95%. Their policy was to inform travellers of the need for

susceptible persons to be immunized when travelling to countries where poliovirus continued to circulate.

The Caribbean Epidemiology Centre assured surveillance for acute flaccid paralysis and provided training for health professionals. In preparation for the Cricket World Cup 2007, the Community countries had responded to the risk of poliomyelitis importation by implementing centralized daily reporting of diseases and syndromes. Some countries had immunized susceptible adults, particularly those working in tourism and the security forces. That framework had improved implementation of the International Health Regulations (2005).

She urged all concerned to continue their support for the efforts of the four remaining endemic countries to eradicate poliomyelitis, and supported the draft resolution.

Mrs BONNIN (France) requested clarification about adding an annex to the International Health Regulations (2005). She shared the concerns expressed by the delegate of Belgium on reopening discussions on those Regulations, which could be a long and risky exercise. In such an event, she would support the use of a more flexible mechanism.

Mr MENESES (Mexico) said that significant progress had been made towards eradicating wild polioviruses, even though poliomyelitis remained endemic in four countries owing to low immunization coverage. Local and national leaders in those countries should seek to improve security and implement immunization campaigns and thus protect global public health. Given the risks associated with a failure to eradicate poliomyelitis, immunization coverage must be maintained (it currently stood at 97% in Mexico). The draft resolution should be adopted.

Mr ABDOO (United States of America) supported the concerns expressed by the delegates of Belgium and France at the suggestion of an additional annex to the International Health Regulations (2005). As the largest single financial contributor to the Global Polio Eradication Initiative, his Government believed that poliomyelitis eradication was feasible. All Member States should remain focused on that goal, and on garnering the human and financial resources necessary to reaching that objective, nationally and globally.

At the current end-stages of eradication, all countries should reduce the risk of importing the virus and ensure they had the ability to detect circulating poliovirus rapidly and respond effectively. Political leadership in Africa, the Middle East and Asia was essential in order to improve the quality of supplementary immunization campaigns, increase routine immunization coverage and enhance surveillance for acute flaccid paralysis.

The reintroduction of poliovirus was a major concern for all Member States. Recommendations from his country's Centers for Disease Control and Prevention and WHO had established some precedent in requiring that travellers to poliomyelitis-endemic areas should be vaccinated. Although there was limited evidence in its support, the recommendation that all travellers from countries where poliomyelitis was circulating should be fully immunized could also prove to be an effective tool in eradicating poliomyelitis. A standing recommendation on poliomyelitis immunization for such people, established under the Regulations after their entry into force in June 2007, would be a possible way to implement that measure. Poliomyelitis would appear on the list of diseases for which immediate notification was required under the Regulations once they came into effect. All States should adhere to that reporting requirement immediately, on a voluntary basis, and should remain vigilant against importation of wild poliovirus.

Given the significance of the potential further international spread of poliovirus in the final stages of poliomyelitis eradication, he fully supported the draft resolution.

Miss DE HOZ (Argentina) said that the entire American continent had been free of poliomyelitis for many years. Her country had begun implementing the International Health Regulations (2005) on a voluntary basis, but it was concerned at the reference to a "potential standing recommendation" in paragraph 3(4) of the draft resolution. Moreover, since those Regulations had not yet entered into force, she had misgivings about reopening discussions on them.

Dr AHMED (Pakistan) commended the spirit of the draft resolution and supported it in general. However, he aligned himself with the position of the delegate of India regarding paragraphs 2(1) and 2(2) on the immunization of travellers.

Mr MABUZA (Swaziland) supported the draft resolution. Poliomyelitis eradication strategies were being implemented in his country and there had been no wild poliovirus cases. The Government was financing the procurement of all oral poliomyelitis vaccine, thus demonstrating its political will to achieve eradication. Sustaining current levels of poliomyelitis vaccine coverage and wild poliovirus surveillance, however, suffered from lack of resources. Falling levels of vaccination coverage could adversely affect his country's implementation of eradication strategies. He therefore appealed to WHO for assistance in accessing vaccines through the GAVI Alliance.

Dr HUWAIL (Iraq) said that, despite the current situation, his country had been free of poliomyelitis since January 2000. Most children were immunized and national immunization days took place annually; those in 2006 resulted in the immunization of more than 4.25 million children under the age of five years. Routine immunization coverage and surveillance of acute flaccid paralysis had improved. Iraq was also taking steps to monitor oral poliomyelitis vaccine coverage at district level, conduct mopping-up activities in high-risk areas, hold meetings with neighbouring governments on preventing cross-border transmission, train staff in the Expanded Programme on Immunization and surveillance activities, and equip the national laboratory with the necessary resources for accreditation as a national poliovirus laboratory.

Dr SEVER (Rotary International), speaking at the invitation of the CHAIRMAN, pledged the continued commitment of Rotary International to ending poliomyelitis worldwide. Rotarians from more than 160 countries had voted in April 2007 to continue supporting eradication until certification was reached. In February 2007, stakeholder consultations had reached broad consensus that the goal of poliomyelitis eradication was feasible and realistic. Poliomyelitis outbreaks following importations of the poliovirus could be controlled.

The success of the global effort currently rested on the ability of the governments of the four remaining poliomyelitis-endemic countries to implement immunization activities that reached every child. The leadership and oversight of the heads of State of the four countries were essential to mobilize government resources, coordinate ministries, monitor progress and hold officials accountable at all levels of government.

As the second biggest donor to the Global Polio Eradication Initiative, Rotary International was well aware of the extraordinary investment by the international donor community over the previous 19 years. However, the donor community must complement the efforts of the poliomyelitis-affected countries by providing urgently needed funds to close the funding gap of US\$ 575 million for 2007–2008. The G8 countries were urged to take rapid action to operationalize their poliomyelitis-funding commitments made in Gleneagles, Scotland, in 2005. Rotary International also called on the Gulf Cooperation Council, the Organization of the Islamic Conference, and countries in Asia, Europe and South America that had never contributed to that historic effort. Without prompt financial help, the opportunity to achieve poliomyelitis eradication could be lost forever, and related gains in routine childhood immunization, global surveillance capacity for communicable diseases, and the momentum needed to achieve other global child survival targets could be imperilled.

The support of WHO and UNICEF remained crucial for proper planning, community mobilization, and implementation of high-quality immunization activities.

Dr AYLWARD (Polio Eradication Initiative) explained that there was no proposal for an annex or an amendment to the International Health Regulations (2005) that would require reopening of negotiations at the current time. The only issue under discussion was the use, if necessary, of provisions in the form of a temporary or standing recommendation for the management of the international spread of poliomyelitis in the future.

On the question of the burden of disease due to imported and indigenous poliomyelitis, he noted that, in 2005, half the poliomyelitis cases worldwide had occurred as a result of outbreaks in poliomyelitis-free countries. Owing to the implementation of guidance given by the Fifty-ninth World Health Assembly in 2006, the proportion of cases in poliomyelitis-free areas had been reduced to less than 6% of all cases. However, the management of cases in poliomyelitis-free countries had still cost the programme and Member States more than US\$ 450 million since 2003.

Implementation of the provisions in the draft resolution regarding immunization of travellers was feasible, with limited cost implications, as evidenced in the comments made by delegates from endemic and reinfected countries, and in the implementation of a similar recommendation for travellers to the hajj in 2006 and 2007.

The current Poliomyelitis Eradication Initiative differed significantly from that considered the previous year. It included new tools for interrupting wild poliovirus transmission and new tactics for limiting its international spread and interrupting transmission in the endemic foci that remained. There were also new commitments from political organizations, heads of State and religious leaders, which would be critical in immunizing all children in the remaining infected areas.

The CHAIRMAN suggested that the Secretariat should prepare a revised text of the draft resolution, taking account of the amendments proposed, for consideration at a later stage.

It was so agreed.

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

The meeting rose at 12:40.

FOURTH MEETING

Wednesday, 16 May 2007, at 14:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

DRAFT MEDIUM-TERM STRATEGIC PLAN, INCLUDING PROPOSED PROGRAMME BUDGET 2008–2009: Item 11 of the Agenda

Draft Medium-term strategic plan 2008–2013: Item 11.1 of the Agenda (Documents A/MTSP/2008–2013/PB/2008–2009 and A/MTSP/2008–2013/PB/2008–2009 Corr.1 and Corr.2)

Proposed programme budget 2008–2009: Item 11.2 of the Agenda (Documents A/MTSP/2008–2013/PB/2008–2009 and A/MTSP/2008–2013/PB/2008–2009 Corr.1 and Corr.2)

Real estate: draft capital master plan: Item 11.3 of the Agenda (Documents A60/5 and A60/INF.DOC./3)

Dr ANTEZANA ARANÍBAR (representative of the Executive Board) said that the draft Medium-term strategic plan 2008–2013 and the Proposed programme budget 2008–2009 had been reviewed by the Programme, Budget and Administration Committee before their consideration by the Executive Board at its 120th session in January 2007. The Board had broadly supported the Medium-term strategic plan, its directions, priorities and core functions, noting its linkages to the Proposed programme budget, the Eleventh General Programme of Work and the United Nations Millennium Development Goals. The Board had also expressed broad support for the integrated budget and the approaches for financing the Medium-term strategic plan, including the three categories of financing.¹

While applauding the results-based approach, Board members had voiced some concerns about the use of historical perspectives for resource allocation in respect of assessed contributions and the application of the validation mechanism. The Board had emphasized budgetary discipline, greater efficiency and transparency, and a fuller justification of the proposed budget increase.

The Board had broadly supported the strategic objectives and Organization-wide results identified in the Proposed programme budget 2008–2009, financed by means of assessed, negotiated core and other, voluntary, contributions. Members had sought clarification on specific items, including sexual and reproductive health, noncommunicable diseases, traditional medicine, blindness, global health security, essential medicines, strengthening of health systems and United Nations reform. Although the proposed budget had increased in absolute terms, some members had expressed concern about the proportional decrease in the allocation for the African Region.

The draft capital master plan, Proposed programme budget and Medium-term strategic plan were linked and had been considered together. The current mechanism for financing capital expenditures within the overall biennial budget was inadequate. The Board had welcomed the integrated 10-year capital master plan and the inventory of the Organization's real estate. Resource requirements for the capital master plan should be integral to the biennial budget. The Board had requested the Director-General to pay due regard to the financing required to ensure the safety, health and well-being of staff, delegates and visitors.

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the seventh meeting of the 120th session.

In order to balance resource demands across the five bienniums, the Board had requested the Director-General to review the phasing of the real estate and accommodation proposals, especially in locations where rental costs were becoming prohibitive. However, deferring capital expenditures could necessitate costly emergency repairs.

Dr NISHIYAMA (Japan) commended the revised budget document and the clear explanation for the budget increase. Japan remained committed to providing financial and technical contributions to WHO. Securing the Organization's budget was crucial. Every effort should be made, however, to spend resources more efficiently and to identify and discontinue programmes that were not cost effective or that duplicated other programmes.

Dr HAO Yang (China) supported the Medium-term strategic plan, which was rich in content and included clear goals. China's chief concern was implementation: the Organization should make full use of its technical strengths in that regard. He appreciated the plan's acknowledgement of the importance of traditional medicine. Under WHO's leadership traditional medicine could be better understood and strengthened.

He also agreed with the proposed 4% increase in the regular budget. WHO needed the finances in order to play its role as the world's largest health organization. The increase should be used in core areas and WHO should continue to increase its efficiency.

Mr MACPHEE (Canada) supported the Medium-term strategic plan, endorsed the six-item agenda, the 13 strategic objectives, and the plan to improve the management of WHO, including financial resources, provision of effective operational support and assurance of robust accountability, notably as set out in paragraph 7 of the Proposed programme budget 2008–2009. The normative function of WHO – for example the establishment through the Codex Alimentarius Commission of norms and standards for food and nutrition – was funded mainly through the assessed share of the budget. These functions should not suffer as the Organization sought to meet the many demands placed upon it. He looked forward to the monitoring of the strategic plan through the annual assessment of programme budget performance, and evaluation of the achievement of the 13 strategic objectives at the end of the six years.

He welcomed the commitment to budget discipline, the setting of priorities, and clarifications regarding the proposed increase in the regular budget. He recognized the difficulty of balancing demands, priorities and available resources. With voluntary contributions three times as much as assessed contributions, he welcomed the Director-General's focus on that fundamental shift. Member States should be made aware of the consequences of the heavy reliance on voluntary contributions, and diversion of resources away from normative functions.

He welcomed the assurances that 13% of voluntary contributions would be used to meet the budgets of strategic objectives 12 and 13. Voluntary funding should meet its share of administration and delivery costs. The regular budget should not be used to supplement overhead costs of voluntary funding without the express agreement of Member States.

Finally, the 2008–2009 budget proposal called for development of a new element: core voluntary funding, which was unearmarked and could be allocated as required. Canada viewed such funding as specifically intended for development at the field level, and he requested clarification on the use of such funds. He had some concerns about the planning of a 100% increase in such funding, as voluntary contributions were by nature unpredictable.

Mrs REITENBACH (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey; the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia; and the Republic of Moldova, Switzerland, and Ukraine aligned themselves with her statement. The European Union favoured a continued focus on WHO's core functions, identified in the Eleventh General Programme of Work; the global health agenda; and WHO's role as a leading standard-setting organization in international health. However, the lack of gender mainstreaming throughout the document was a cause for concern, as the commitments

contained in the draft resolution on gender currently before the Health Assembly were not adequately reflected. Gender equality indicators should be incorporated into the strategic objectives.

At the 120th session of the Executive Board, the European Union had called for more emphasis on global health security in the five main areas of the Eleventh General Programme of Work. The emphasis subsequently placed on prevention and health promotion in the draft Medium-term strategic plan 2008–2013 and the draft Proposed programme budget 2008–2009 had been appreciated. However, even fewer funds had been allocated to sexual and reproductive health. That allocation should be increased, particularly in the light of the feminization of HIV/AIDS. Greater alignment was also needed between WHO's strategic objectives and the Millennium Development Goals related to sexual and reproductive health. WHO had a key role in UNAIDS, yet strategic objective 2 made no mention of WHO's participation in the Committee of Cosponsoring Organizations, and contained no indicators for WHO's role in the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors.

She welcomed the increased resources allocated to noncommunicable diseases, but doubted whether the low budget levels for that area could cope with the growing burden of global noncommunicable diseases. She questioned how resources were being allocated within strategic objectives 3, 6 and 7, and wanted better linkages between strategic objectives 1, 2 and 7.

The concentration of the strategic objectives into 13 key items achieved greater synergy and consistency. The elaboration of particular strategies made the plan clearer and avoided redundancy and fragmentation, but policy priorities included in each objective lacked transparency. Some mandates of WHO were not sufficiently reflected in the expected results, particularly access to medicines. The Organization's monitoring of the effects of trade agreements in the health sector and devising strategies for health research should be highlighted.

The prevention and containment of infectious diseases and achieving several of the health-related Millennium Development Goals made WHO's leadership in multisectoral efforts to contain antimicrobial resistance paramount. The rational use of medicines needed to be encouraged, but antimicrobial resistance should be at the core of the communicable diseases agenda and methods of measuring the global burden of disease caused by antimicrobial resistance should be explored.

The revised Proposed programme budget 2008–2009 revealed some shifts between the strategic objectives. How would the Organization's work be prioritized in the event of further budget constraints? More clarity was needed in areas such as aggregate costs: cost efficiencies were essential, but, for example, how much did the Organization spend on publications each year? More information on the recently established group in charge of publication policy would determine whether all economies and efficiencies were being made. She looked forward to the next report on publication policy; to analysis of the financial implications of special days for diseases, such as World Malaria Day; to clarification on how the plan could take account of new resolutions adopted during the six-year period of the plan; and on how donors of voluntary contributions would align themselves with the strategic objectives.

Greater transparency regarding the specific allocation of financial and human resources envisaged in the draft Medium-term strategic plan 2008–2013 was also required. With more than 70% of resources going to the regions, the administrative and management capacities of the regional offices should be reinforced. The failure in some regions to implement the recommendations of the External Auditor was a matter for concern. She proposed monitoring the plan's implementation through a review clause that would give Member States the opportunity to report, for example, in two years.

The plan was more consistent with reforms to the United Nations system. Nevertheless, the potential for enhanced cooperation between WHO and other United Nations bodies needed to be addressed more clearly throughout the strategic objectives and emphasized in strategic objective 12. Targets appeared to be largely defined by the WHO country cooperation strategy, rather than by the planning process of the United Nations Development Assistance Framework and the United Nations system as a whole. Modes of collaboration, division of labour and information sharing should be defined clearly in order to avoid costly duplication.

Mr GREEN (United Kingdom of Great Britain and Northern Ireland) welcomed the changes made to the draft Medium-term strategic plan 2008–2013 following the 120th session of the Executive Board, particularly the focus of the strategic objectives and the one clear objective on health systems. The fact that that objective involved 12 Organization-wide expected results suggested that a coherent approach on health systems needed more than simply combining the work undertaken across the Organization.

Little had changed in the content of strategic objective 12 or other strategic objectives. For example, there appeared to be no mention of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors. WHO was undoubtedly engaged in the process of United Nations reform, particularly in the eight pilot countries. The draft Medium-term strategic plan 2008–2013 should provide objectives and indicators which enabled reporting on improvements in: its collaboration with other United Nations bodies; WHO processes; and the United Nations Development Assistance Framework.

He welcomed the revisions made to the Proposed programme budget 2008–2009 and the efforts made to take account of the Board's comments. He supported the proposed budget. Nevertheless, certain worrying trends in WHO's budget would require serious consideration and consultation over the next two years. The Proposed programme budget 2008–2009 included an increase of just over 15% to more than US\$ 4000 million, yet the possibility of an increase to around US\$ 5500 million by 2014–2015 had already been discussed; should the budget continue to increase with each biennium? Previously adopted resolutions should be closely examined in order to determine whether any might be phased out, which could produce significant savings.

Although paragraph 69 of the draft Medium-term strategic plan 2008–2013 stated that a significant proportion of WHO's budget should be financed through assessed contributions, that proportion had declined further since January 2007, and it was hard to reconcile those two circumstances: the United Kingdom, like many other Member States, would not be in a position to agree to large increases in assessed contributions.

Rather than a system of automatic overall increases, there should be more effective deployment of existing resources. The Director-General had already indicated her commitment to making difficult choices. Member States must share the burden. WHO's planned efficiency savings of some US\$ 5 million needed clear monitoring. As the benefits of United Nations reform filtered through, savings made in "back office" functions should be devoted to front-line activities.

He distinguished between predictable and unpredictable funding. An increase in predictable, multiyear financial commitments was needed, with fewer earmarked voluntary contributions and more negotiated core voluntary contributions, which he would not be in a position to agree to.

Dr STEIGER (United States of America) welcomed the integration of a medium-term strategy into WHO's results-based management framework and presentation of its strategic direction, core functions and strategic objectives. Understandably, the Organization sought to achieve a better balance between assessed and voluntary contributions. Assessed contributions were not a tool for maintaining balance through progressive increases and he welcomed the fact that the revised Proposed programme budget 2008–2009 did not advocate working to increase assessed contributions to a specified level.

He expressed appreciation to the Director-General that possible efficiencies in implementation, prioritized programmes in the revised programme budget, and potential ways of offsetting proposed increases had all been identified. Information on possible savings and the phasing out of activities should be integrated into future programme budget documents, with indications given under the relevant strategic objective.

Member States also needed to exercise discipline with respect to the number and frequency of resolutions adopted, and he echoed comments on the need to examine the relevance of past resolutions. Overall, the Proposed programme budget 2008–2009, including the 4% increase in assessed contributions, was acceptable, reflecting the importance his country placed on WHO's activities.

While certain donors might be willing to accept the proposals concerning negotiated core contributions, others, including the bodies of his Government that made voluntary contributions, had

specific requirements that might not be compatible with their participation in the process. Core negotiated resources should include those made available in response to specific appeals from the Director-General in line with strategic priorities. The mid-term review and programme budget performance assessment were valuable for monitoring the budget over the next biennium and beyond.

He supported strategic objective 4 on the understanding that the language used in the draft Medium-term strategic plan 2008–2013 and Proposed programme budget 2008–2009 was not intended to suggest the existence or creation of a new human right to sexual and reproductive health. The strategic plan allocated resources to implementing WHO's strategy on accelerating progress towards the attainment of internationally agreed development goals and targets related to reproductive health, but he recalled that at the Fifty-seventh World Health Assembly his delegation had not endorsed the strategy.¹ Nothing in the documents under consideration encouraged or compelled Member States to expand the availability of legal abortion. Furthermore, as indicated in resolution WHA55.19, "primary health care services" did not include abortion except when consistent with national and, where applicable, local law, and with full respect for the various religious and ethical values and cultural backgrounds.

It was not clear whether indicator 12.3.3 under strategic objective 12, on the proportion of trade agreements appropriately reflecting public health interests, applied to multilateral or bilateral agreements or both, or what guidance document was being referred to. He questioned the Secretariat's competence to advise Member States accurately on the potential implications of trade agreements. Any information on trade agreements provided by WHO must be unbiased and evidence-based, and should be cleared with WTO and WIPO.

Mr VAN DER HOEVEN (Netherlands) expressed concern at the growing imbalance between assessed and voluntary contributions to WHO's budget. As a Member State organization with global responsibility for normative work and technical assistance, it was imperative, for its credibility and integrity, that a significant portion of its budget should be made up of assessed contributions, in contrast to funds provided by a small number of donors.

In 2006, the Director-General had reapplied Financial Regulation XV by reporting on the financial and administrative implications of draft resolutions, with minimal effect. Member States should assess the costs of draft resolutions when adopting them.

The Proposed programme budget 2008–2009 included an overall increase of 15.2% but only a 4% increase in assessed contributions. If the imbalance was not to worsen, budget increases should be financed by assessed contribution increases of at least the same percentage, and he urged the Director-General to work towards balancing the various sources of funding, including by increasing the amount of predictable voluntary contributions.

With relevance to strategic objective 9, he supported maintaining WHO's contribution to the Codex Alimentarius Commission and related activities for the biennium 2008–2009 at no less than the 2006–2007 level of US\$ 1.2 million.

Dr URBINA (El Salvador) echoed the concerns expressed by the delegate for the United States of America with regard to the strategic objective on sexual and reproductive health, and specifically the issue of abortion, which ran contrary to the laws, values and Christian principles of his country.

Prince BIN AHMED BIN ABDELAZIZ (Saudi Arabia) recalled that, in response to the problem of visual impairment, resolution WHA59.25 requested the Director-General, among other things, to give priority to preventing avoidable blindness and visual impairment and to add prevention of avoidable blindness and visual impairment to the draft Medium-term strategic plan 2008–2013 and the Proposed programme budget 2008–2009. His delegation wished to propose amendments to those documents to reflect the resolution.

¹ Document WHA57/2004/REC/3, summary record of the seventh meeting of Committee A.

Dr AL-RAJHI (Saudi Arabia) added that the proposals were intended to strengthen and clarify the strategic plan and budget documents. In document A/MTSP/2008–2013/PB/2008–2009, he proposed the addition of the words “and visual impairment, including blindness” at the end of the title of strategic objective 3 and the insertion in the box with indicators and targets of a fourth bulleted item that would read “To halt and begin to reverse current incidents of disability from visual impairment, including that caused by blindness”. He further proposed the insertion of the phrase “and visual impairment, including blindness” at the end of the second bulleted item in the box on the Secretariat’s focus, at the end of the Organization-wide expected results 3.1, 3.2, 3.3, 3.4 and 3.6. In the Proposed programme budget, the same words should be added at the end of the heading and Organization-wide expected results 3.1, 3.2, 3.3, 3.4 and 3.6.

He shared the concern expressed by the delegate of the United States of America on strategic objective 4.

Dr DAHN (Liberia), speaking on behalf of the 46 Member States of the African Region, expressed concern that some targets ascribed to the 13 strategic objectives, such as a two-thirds reduction in the mortality rate of vaccine-preventable diseases and the elimination of malaria in seven targeted countries by 2013, would require more resources than those provided for in the draft Medium-term strategic plan. She asked how the commitments to health made by the G8 countries and African leaders would be met, and recommended that the issue should be examined by the Executive Board. She also expressed concern that the allocation to combat HIV/AIDS, malaria and tuberculosis in 2010–2011 had been reduced by 4%, whereas the allocations to the other 12 strategic objectives all showed an increase, ranging from 6% for strategic objective 1 to 53% for strategic objective 4. Moreover, for 2012–2013, the allocations to strategic objectives 1 and 2, of great importance to the African Region, represented the lowest increase, of 5%. How would those figures align with the Director-General’s stated vision? Strengthening or establishing social protection and health systems was a priority for the African Region. What was the proposed budget in the Medium-term strategic plan for those programmes?

She welcomed the increase in the total budget for the African Region from US\$ 900 million in the current biennium to US\$ 1200 million in 2008–2009, but was concerned that the proportion allocated to the African Region had fallen from 28.7% to 28.2%. In contrast to the other five regions, the proportion of the proposed allocations to the African Region for 2008–2009 had not increased. She asked what action would be taken to ensure alignment between the financial resources allocated and the Director-General’s vision for the health of Africa’s people.

Ms TOR-DE TARLÉ (France) fully supported the draft Medium-term strategic plan and the proposed programme budget, and commended the presentation of the strategic objectives and results-based management, which reflected a desire for greater transparency and strengthened links between headquarters, regions and country offices. Predicting results would enable WHO to better measure its performance. However, the amount of detail varied greatly between strategic objectives. Some did not reflect the Organization’s mandates. For example, the predicted results of the establishment, by virtue of resolution WHA59.24, of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property were not reflected in strategic objective 11. Did that mean that no financial resources had been allocated to that Group or that the overall financing of that objective would need to be changed? Furthermore, presenting the predicted results of and the overall resources allocated to activities that were divided among several strategic objectives would enhance the transparency of the strategic plan and programme budget. Examples of such activities were reproductive health and combating sexually-transmitted diseases, which were divided between strategic objectives 2 and 4, and implementing the Global Strategy on Diet, Physical Activity and Health, which was divided between objectives 3 and 9.

WHO should cooperate with other United Nations agencies, with vertical and horizontal funding programmes, and international financial institutions. Since cooperation with United Nations agencies affected all 13 strategic objectives, it should have been integrated as an objective in all of them, not solely in objective 12. The Medium-term strategic plan should focus on strengthening such

cooperation; however, only a brief reference had been made in strategic objective 11 to the Global Fund to Fight AIDS, Tuberculosis and Malaria and to the International Drug Purchase Facility (UNITAID) – one of WHO's key partners.

Since expenditure on human resources represented more than 42% of the budget, the Medium-term strategic plan would benefit from the projected medium-term and long-term management of human resources, and greater coordination was needed between the budget and management of the Organization's human resources. In the context of WHO's performance, the Internal Auditor's recommendations should be followed up and integrated into strategic objective 13.

She requested clarification of the role of multilingualism and the link between the Medium-term strategic plan, which contained some projected results on multilingualism, and the action plan on multilingualism which was on the agenda of the 121st session of the Executive Board.

Mr WONG (Singapore) welcomed the reduced number of strategic objectives, and urged further streamlining of the strategic plan. He also welcomed the emphasis that both the strategic plan and the programme budget placed on communicable diseases, and the level of resources allocated to combating avian influenza and other emerging infectious diseases. However, WHO should review regularly the implementation of its broad and ambitious plans. He commended the transparency of the budgetary process.

Mr BRUN (Norway) said that the proposed Medium-term strategic plan clarified objectives through indicators and targets. He supported the proposed increased budget and improved balance between assessed and voluntary contributions. He concurred with the comments made by the delegate of the Netherlands in that regard. Norway emphasized the Organization's work on sexual and reproductive health. Budget allocations to that area should be increased and shown through a separate budget line in order to enhance transparency. He endorsed the statement of the delegate of Germany on: gender mainstreaming; WHO's role in assisting countries in the use of flexibilities in the Agreement on Trade-Related Aspects of Intellectual Property; coherence between WHO's role and the United Nations system-wide planning tools; and noncommunicable diseases.

Mr VAN MEEUWEN (Belgium) expressed satisfaction with the Proposed programme budget 2008–2009, the strategic plan, and the reduced number of strategic objectives. He commended the clear and quantifiable objectives presented in terms of expected results to be achieved. However, the proposed change would not make comparison with past results easy, as areas of work in the previous budget overlapped several of the strategic objectives for the biennium 2008–2009.

He expressed concern over the growing imbalance between resources for the regular budget and voluntary contributions. WHO had to have sufficient resources to fulfil its mandate. Its role as the leading United Nations agency in the health sector and its normative function depended on its human resources. He was concerned that WHO might be transforming itself into a United Nations fund. The increase in the regular budget should be proportionally the same as that of extrabudgetary contributions. Voluntary contributions were unpredictable and could be negotiated for use as general resources, although that would constitute only a short-term solution.

It was essential to prioritize among the 13 strategic objectives proposed, so that decisions could be taken in case of insufficient resources to meet all the Organization's commitments. He was also concerned over the undue importance given to the technical aspects of combating diseases, when it was recognized that the sustainability of health interventions depended on operational health services responding to people's needs. Health services had to be given enough financial resources to make them accessible to those that needed them most, namely the poor and the marginalized.

He expressed disappointment that no explicit reference had been made to the principles of the Paris Declaration on Aid Effectiveness, particularly those concerning alignment, harmonization and coordination.

Mr MCKERNAN (New Zealand) endorsed the draft Medium-term strategic plan 2008–2013. The clear goals and targets would only be achieved through improved management and capacity building at regional and country levels. He welcomed the specific focus on underlying social, cultural

and economic determinants of health and the related budget increase. He had noted the level of contributions made by the voluntary sector to WHO's overall budget and reiterated the concerns expressed by other Member States about long-term financing. WHO should be the only organization to shape the global health agenda. The proposed increase in the programme budget was significant in both absolute and percentage terms. However, certain comments in audit reports, leading to a number of recommendations where financial controls and management action had fallen short, were a cause for concern. He requested the Director-General to follow up on all such outstanding recommendations so that further budget resources were spent efficiently. He supported results-based planning and budgeting in order to increase transparency and accountability.

Dr BUDIARDJA (Indonesia) welcomed the draft Medium-term strategic plan 2008–2013. Several priorities reflected Indonesia's health development strategic plan. They included: reducing maternal mortality; strengthening health systems and health access; building capacity to implement the International Health Regulations (2005); and tackling chronic noncommunicable diseases. His Government had made poverty reduction a priority, and was committed to addressing health inequality through the provision of health insurance for almost 60 million poor people. Progress towards the Millennium Development Goals must be supported with actions and resources. Reducing the maternal mortality ratio, as laid down in Goal 5, would require substantial resources. Hence a technically sound approach needed to be introduced into the draft Medium-term strategic plan that would enable cost-effective, tailor-made interventions to be devised, particularly for countries with high maternal mortality and limited resources.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the draft Medium-term strategic plan 2008–2013 and welcomed the emphasis on accountability, performance and results-based management. The draft Medium-term strategic plan could be used in aligning WHO's programme budget with national priorities.

He supported the draft Proposed programme budget 2008–2009 with its inclusion of regular and voluntary contributions in a single budget. Implementing the budget proposals would require WHO to work closely with all its partners. Resources should be equitably distributed between countries, requiring transfer of between 70% and 75% of WHO's resources to the regions and countries for implementation. The predictability of the increased voluntary contributions was of great importance. At the same time, the Organization must increase its effectiveness and efficiency. The need for flexibility in cases of natural disasters and complex emergencies should also be taken into account.

The proposed overall increase of 15.2% over the current biennium in the Proposed programme budget 2008–2009 reflected the needs of Member States and confidence in WHO's work. However, in order to preserve its identity and retain the support of its membership, the Organization had to balance assessed and voluntary contributions. During implementation, WHO needed to take account of national particularities, especially when problems were compounded by complex emergencies, a lack of human and financial resources and weak managerial capacity. Making pregnancy safer, child and adolescent health, women's health, food safety, and research policy and promotion all remained underfunded. A lack of financial flexibility impeded the transfer of resources to underfunded areas of work.

Dr BUSUTTIL (Malta), referring to strategic objective 4 of the Medium-term strategic plan 2008–2013, said that the references to sexual and reproductive health services contained in the Medium-term strategic plan should not be interpreted as creating an obligation on any party to consider abortion a legitimate form of sexual or reproductive health service.

Dr TANGI (Tonga) welcomed the Medium-term strategic plan 2008–2013, which provided a clear direction for the Organization over the six years ahead. However, he doubted WHO's capacity to implement such a broad agenda. The 15.2% increase in the Proposed programme budget 2008–2009 matched the priorities set out in the budget, which focused on emerging health problems that were the subject of many Health Assembly resolutions. There was a tendency to adopt resolutions without

understanding their financial implications. The proposed budget should make the Medium-term strategic plan operational, at least for the first two years. He welcomed the proposed increase of 21% in funding for noncommunicable and chronic diseases. He shared the general concern over the integrity of the Organization in the face of a smaller percentage of assessed contributions. However, the late Director-General's mooted idea of increasing Member States' assessed contributions had not drawn strong support.

Dr KHALFAN (Bahrain) supported the comments of the delegates of Saudi Arabia on sexual and reproductive health and visual impairment.

Dr VIOLAKI-PARASKEVA (Greece) welcomed the Medium-term strategic plan 2008–2013 and the improved allocation of resources in the Proposed programme budget 2008–2009, which should underpin areas of work where good progress might be made in achieving the Millennium Development Goals. Overall progress could be clearly evaluated. Goals, objectives and expected results needed clarification. It was essential to maintain links with the Programme budget 2006–2007 and show the progress made over the previous biennium towards the Goals.

WHO should receive a larger proportion of its financial resources from the regular budget than from voluntary contributions, for the sake of good governance, integrity and low transaction costs. All voluntary donations should be used for priorities agreed on by the governing bodies, and the management of existing resources should be improved. The strategic objectives should be prioritized and the clarity of the Proposed programme budget 2008–2009 enhanced. Indication should be given of the Organization's priorities if it failed to obtain the expected resources. The Proposed programme budget 2008–2009 integrated the work carried out under the total available resources, which should enable Member States to improve governance of expenditure in line with Health Assembly priorities.

Dr SUWIT WIBULPOLPRASERT (Thailand), referring to the Director-General's foreword to the Medium-term strategic plan 2008–2013, expressed concern that a bullet point, on the broader aspects of health and its interaction with other sectors through the Commission on Social Determinants of Health, had been omitted from the current version. The current wording reflected an inadequate understanding by the Secretariat of the complex interrelation between social factors and health. The Director-General should reinstate the reference to the Commission in the foreword.

He urged more active interest in the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property and more leadership in support of its work, without which it would fail. The wishes of the previous Director-General should be respected.

He expressed concern that the increase in assessed contributions was only 4%, when Member States were prepared to pay more. The proportion of assessed contributions would decrease further while voluntary contributions were earmarked in order to serve donors' interests. That meant that all Member States were paying to maintain a WHO Secretariat worldwide that was simply serving donors' interests and neglecting those of developing countries. The Director-General should provide an analysis combining non-earmarked contributions with assessed contributions, so that Member States could observe the trend in budgetary funds that were free from donor influence and be reassured that they were not paying the Secretariat to promote the interests of a handful of countries.

His Government was considering making a small, non-earmarked contribution to WHO, in order to help to make the Secretariat less biased and more transparent. Only the previous day, it had emerged in the drafting group on avian influenza that a WHO collaborating centre had sent the virus to a laboratory outside the terms of reference and had prevented a specimen from being shared. Instead of investigating the Centre's conduct, the Secretariat had erased the terms of reference from the web site. It had criticized other centres for not sharing the virus, but taken no action against the Centre in question. The work being done by other collaborating centres was vital to the global effort to prevent an influenza pandemic, but Member States needed to be able to trust them.

Dr SOARES MARQUES DE LIMA (Sao Tome and Principe) said that the Proposed programme budget 2008–2009 caused him concern. Under strategic objective 2, how would universal access to prevention, treatment and care for combating HIV/AIDS, tuberculosis and malaria be

achieved when the proposed budget had been reduced by 10% from the 2006–2007 level? Those diseases remained the principal causes of morbidity and mortality in the developing countries, particularly in Africa. Allowing for support from partners, the allocation for those objectives should be increased. Further, the 44% increase for strategic objective 3 was insufficient, given the burden imposed by chronic noncommunicable conditions, mental disorders and injuries, particularly in low- and middle-income countries, where they caused at least 80% of all deaths.

Mr KHALEEL (Maldives) acknowledged the Medium-term plan's coherent linkages between the different strategic objectives. The Secretariat should try to increase the proportion of non-earmarked voluntary contributions and direct them towards areas with greater funding gaps, in line with the strategic objectives.

Mr MENESES (Mexico) acknowledged the effort required in drafting the Medium-term strategic plan and the Proposed programme budget 2008–2009. The delegate of Thailand had lamented that the biggest contributors wielded the most influence. Mexico was the tenth largest contributor to WHO and his Government sought to ensure that the budgets of international organizations were transparent and efficient and reflected a correspondence between programme priorities and budgetary allocations. The proposed budgetary allocations would doubtless be revised in the light of the delegates' comments. Traditionally, Mexico had supported zero real growth. When the new budgetary base for WHO's activities came to be discussed, Mexico would seek to ensure that budgets were based on zero nominal growth.

Turning to the strategic objectives, he sought more specific reference to combating obesity and diabetes mellitus under efforts to prevent and reduce chronic noncommunicable conditions. The Region of the Americas was facing epidemics of obesity and diabetes mellitus that would have huge social costs in the future. All countries should try to contain those epidemics and to consider the social determinants of health and their role in those conditions. WHO must help to provide the means for regulation and self-regulation of the food industry as a means of preventing those conditions.

He welcomed the continuing campaign against tobacco consumption, and the decision to declare the Health Assembly smoke-free.

Dr AL GHAFIRI (Oman) noted the regional dimension of some health problems. For instance, 75% to 80% of cases of blindness in her country were avoidable and a resolution of the Regional Committee had expressed support for efforts to address the problem.

Ms FRUTOS (Paraguay), referring to the statements made by the delegates of the United States of America and El Salvador concerning strategic objective 4, said that there was no new human right to sexual and reproductive health and that sexual and reproductive health services did not include abortion.

Dr HUWAIL (Iraq) said that the Medium-term strategic plan should concentrate on epidemiological and demographic variables, consider the social and economic determinants of health and crisis management, and emphasize: the changing epidemiological pattern of some diseases; emerging priorities; the need for efficient financial systems; capacity building and encouraging research; and improving health systems.

The Proposed programme budget 2008–2009 should emphasize the Millennium Development Goals and total quality management. Budgetary resources should be distributed to regions on the basis of their human resources needs rather than their population.

Mrs SCHAER BOURBEAU (Switzerland) supported the statement made on behalf of the European Union on item 11.1. How would WHO's activities such as the work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property be funded without being mentioned in the Medium-term strategic plan?

The draft capital master plan gave a complete picture of WHO's real estate needs. Every international organization was required to earmark in its regular budget sufficient resources to finance

infrastructure overheads and capital expenditure. The WHO Real Estate Fund had long been underfinanced owing to the understandable desire to fund programmes rather than real estate, resulting in urgent and higher remedial investment. Good building maintenance was an essential responsibility. Adequate, predictable financing must be guaranteed from the regular budget and not depend on voluntary contributions. The estimated capital expenditure costs at US\$ 22.9 million for 2008–2009 should be approved from the regular budget.

Dr AL-SHATTI (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region and the health ministers of the Arab League, expressed appreciation of the Medium-term strategic plan 2008–2013. He emphasized the prevention and reduction of disability and premature death from chronic noncommunicable diseases. The global burden of visual impairment affected some 314 million people, of whom 153 million had refractive errors, 124 million had low vision and 37 million were blind; 85% of blindness was avoidable by means of established and affordable technologies. He supported Saudi Arabia's request to include visual impairment under the third strategic objective pursuant to resolution WHA59.25.

On strategic objective 4, his country shared the concerns expressed by many Member States, including Saudi Arabia, the United States of America and Malta, about access to abortion at the primary health level and its use as a family planning tool.

Dr WANGCHUK (Bhutan) said that the Medium-term strategic plan gave clear direction to the Organization, could be aligned with country priorities and was based on results. It dealt with accountability, gave indicators and incorporated mechanisms for monitoring and evaluation. He supported the Medium-term strategic plan, the Proposed programme budget 2008–2009 and the proposed amendment by Saudi Arabia on strategic objective 3.

Mrs KNUTSDOTTIR (Iceland) supported the suggestion made by the delegate of Saudi Arabia in respect of strategic objective 3, whose wording should be revised accordingly.

Mr KOCHETKOV (Russian Federation) welcomed the setting of the 13 strategic objectives for at least six years in order to facilitate budgetary analysis. However, strategic objective 10 was too broad; it should only deal with health systems. Although Organization-wide expected result 7.5 was clear overall, none of its three indicators would measure progress on gender issues; such an indicator should be included.

He had concerns about the monitoring and evaluation mechanism used in the plan and budget; while there was provision for corrections to be made after a six-monthly review, it was unclear whether they would be incorporated in the following plan. Furthermore, the disparity between assessed and voluntary contributions was growing. The Russian Federation supported the small increase in the Proposed programme budget 2008–2009 and encouraged WHO to work with donors in order to secure non-earmarked funds. Combating communicable and noncommunicable diseases was a priority, but insufficient resources had been allocated to that end. He emphasized a results-based management approach in the regional distribution of resources; those regions that coped best with their tasks under the Medium-term plan should receive a bigger share of resources. He supported the Medium-term strategic plan and Proposed programme budget 2008–2009.

Mr WATERBERG (Suriname), speaking on behalf of the member countries of the Caribbean Community, commended the Medium-term strategic plan and Proposed programme budget 2008–2009. He agreed with previous speakers about the imbalance in extrabudgetary funds. Although vertical programming on HIV/AIDS, tuberculosis and malaria had proved its worth, health systems should also be strengthened in order to provide quality services and attain the Millennium Development Goals.

The proposed increase of 4% in country contributions appeared appropriate to reduce maternal and child mortality, combat chronic diseases, implement the International Health Regulations (2005), and improve systems. Those programme areas were important to Caribbean countries, where chronic

diseases had increased dramatically; the countries comprised the second most affected region for HIV/AIDS. He looked forward to greater support as a result of the budget increase and to the direct benefits deriving from achievement of the strategic objectives. Given the steady decline in life expectancy in the Caribbean, a review of the criteria for budget allocation should be undertaken and consideration given to redistribution in favour of the Caribbean.

The DIRECTOR-GENERAL thanked delegates for their recommendations and advice. The Medium-term strategic plan and Proposed programme budget 2008–2009 had been initiated by Dr Lee Jong-wook and she paid tribute to him and all her colleagues throughout the Organization who had contributed to its preparation. She had noted the requests for more emphasis on sexual and reproductive health, the African Region, visual impairment, communicable and noncommunicable diseases, health systems, medicines, partnerships and work with other bodies in the United Nations system. She had also noted the need to explore more savings through efficiency and to end some programmes. There was a wish that the Organization should preserve its normative functions and continue to advocate more resources for health through working with other partners. She was glad that some Member States had expressed concerns about the impact of some resolutions on the budget. She was grateful for the overwhelming support the proposed budget had received.

Responding to points raised by the delegate of Thailand, she explained that she took personal responsibility for any changes made in the foreword to the draft Medium-term strategic plan and Proposed programme budget 2008–2009. Tackling the social determinants of health was extremely important and she had mentioned them in her address to the Health Assembly the previous day. However, since the report of the Commission on Social Determinants of Health would not be ready until June 2008 at the earliest, she had intended to present the report's recommendations for discussion at the Health Assembly in 2009. She could not pre-empt the decisions of Member States at a future Health Assembly and therefore it had not been intended to set aside a budget allocation for implementing any recommendations of the Commission until the following biennium.

Regarding the WHO collaborating centres and their work in influenza surveillance, she acknowledged their major contribution and crucial role in WHO's work. She appreciated the resources provided by countries in hosting or supporting those centres, which contributed to the Organization's scientific credibility and integrity. Some instances of conduct in some centres had raised concerns, and WHO took full responsibility for not having monitored their implementation of the relevant guidelines. The terms of reference of collaborating centres were therefore under review.

The CHAIRMAN said that he would request the Secretariat to prepare a resolution on the Medium-term strategic plan and the appropriation resolution for the financial period 2008–2009. Both would be issued the next day.

It was so agreed.

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

The meeting rose at 17:25.

FIFTH MEETING

Thursday, 17 May 2007, at 09:25

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. FIRST REPORT OF COMMITTEE A (Document A60/54)

Mrs BU FIGUEROA (Honduras), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

2. DRAFT MEDIUM-TERM STRATEGIC PLAN, INCLUDING PROPOSED PROGRAMME BUDGET 2008–2009: Item 11 of the Agenda (continued from the fourth meeting)

Eleventh General Programme of Work: monitoring implementation: Item 11.4 of the Agenda (Documents A60/6 and A60/48)

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Medium-term strategic plan 2008–2013 provided clear guidance on action to be taken by Member States and the Secretariat in implementing the global health agenda set out in the Eleventh General Programme of Work. WHO should play a pivotal role in standardizing services and mechanisms in order to safeguard the needs of poor people, so that the concept of “health for all” continued to inspire health care services and access to them. Monitoring and evaluating the General Programme of Work and the strategic plan would be a collective responsibility. The Secretariat should develop monitoring and evaluation tools and guidelines for use by countries, and report periodically to the Health Assembly on results. Deliverables should be classified in the operational plans according to core functions.

Dr DAHN (Liberia), speaking on behalf of the 46 Member States of the African Region, commended the Eleventh General Programme of Work and the Medium-term strategic plan, and emphasized the monitoring of implementation. Health partnerships involving civil society and the corporate sector would improve efficiency, enhance the implementation of health programmes and promote joint action on the social determinants of health. Many African countries would benefit from policy frameworks for establishing such partnerships.

The Health Assembly had acknowledged the importance of shaping the research agenda and stimulating the collection and dissemination of knowledge when monitoring implementation of the General Programme of Work. However, in many Member States capacity to conduct research and use research data was inadequate, and many key policy decisions were not based on evidence. Research strategies should therefore take into consideration the need for both capacity building in Member States and improved access to consolidated research information.

¹ See page 310.

Setting norms and standards, and promoting and monitoring compliance with them, was a crucial part of the global health agenda. The preparation of normative guidance needed to improve. Cost-effective, ethical and equitable policies should be developed for use in a variety of socioeconomic settings. The transparency of procedures for the selection and tenure of external experts should be improved. Local expertise in monitoring and evaluation should be strengthened. Networks with other partners and harmonized approaches originating from regional initiatives would also be useful.

Professor MIKHAILOVA (Russian Federation) said that health issues were increasingly important in determining priorities for global development, making WHO a lead agency in the pursuit of the Millennium Development Goals. She attached great importance to its initiative in strengthening links with ministries of health, governments and their technical institutions, and cooperation with other bodies in the United Nations system, nongovernmental organizations and its own country offices. Planning by WHO must be geared to concrete results. It required the combined efforts of many partners, detailed agreements on timing and monitoring, and transparency and accountability of expenditures.

She welcomed the emphasis in the Medium-term strategic plan on assisting Member States to strengthen health systems, including staffing, financing, information retrieval and scientific research. Those elements, considered by the Executive Board at its 120th session as separate objectives, had been brought together as strategic objective 10, with 12 expected results for that objective alone. The use of the term “health services” to cover so many elements was confusing. Some of the indicators used for health service development were too vague; a base-level indicator should be developed for each country, because no standardized method of evaluation was common to countries at different levels of development.

She endorsed the core functions and the 13 strategic objectives set out in the Medium-term strategic plan 2008–2013.

Ms WARANYA TEOKUL (Thailand) endorsed the indicators for monitoring the global health agenda summarized in Table 1 of document A60/6 and the summary of key actions in Table 2. She expressed concern, however, that too few resources had been allocated to monitoring support of health information systems. The Eleventh General Programme of Work and the Medium-term strategic plan comprised six core functions, 13 strategic objectives and 40 programmes of work, but the allocation of resources was skewed towards only a few strategic objectives. WHO should monitor the implementation of its programmes in terms of those strategic objectives which received the highest allocation of resources.

Mrs PRADHAN (Assistant Director-General) said that monitoring implementation of the Eleventh General Programme of Work and the Medium-term strategic plan would be complementary exercises, focused on monitoring the strategic objectives at a high level. Delegates’ comments, including the request for periodic reporting to the Health Assembly, would be taken into consideration in developing the monitoring process further.

The Committee noted the report.

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Malaria, including proposal for establishment of Malaria Day: Item 12.5 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R16, and A60/12)

Dr NYIKAL (Kenya), speaking at the request of the CHAIRMAN on behalf of the representative of the Executive Board, said that at its 120th session¹ the Board had welcomed WHO's efforts to coordinate global, regional and national malaria prevention and control activities by establishing the Global Malaria Programme, and strengthen the capacities of Member States to plan, implement, monitor and evaluate malaria control measures. WHO had been asked to continue its guidance on malaria control. The Board had supported the use of insecticides, including DDT, for indoor residual spraying, and expanded measures to monitor drug and insecticide resistance. The Board had noted that the cost of artemisinin combination therapies remained a major barrier to access to treatment and that counterfeit antimalarials were a problem in some countries.

The Board had adopted resolution EB120.R16, recommending a resolution to the Health Assembly. Two alternative texts were proposed for paragraph 1(5) of that draft resolution, which related to the application of the provisions of the Agreement on Trade-Related Aspects of Intellectual Property Rights. The draft resolution called for the establishment of an international Malaria Day to increase public awareness and expand opportunities for advocacy.

Dr PARIRENYATWA (Zimbabwe), speaking on behalf of the 46 Member States of the African Region, expressed appreciation for WHO's support to the African Union in developing the Africa Malaria Strategy. Each year malaria continued to kill more than one million people globally. In the African Region, malaria caused acute suffering, long-term disability and killed a child every 30 seconds. It resulted in missed school days, low productivity and massive economic loss. The knowledge and tools were available to combat malaria, but prevention and control efforts in the Region fell far short of what was required. Human and financial resources, the health systems, monitoring and evaluation capacity, and access to affordable diagnostic tools, vaccines, antimalarials and preventive technologies were all inadequate. Further obstacles included procurement and delivery systems, especially for medicines with a short shelf-life such as those used in artemisinin combination therapies. Increased access to paediatric formulations of artemisinin-based combination therapies and further research on new, effective and affordable antimalarial agents were needed.

At the African Summit on Roll Back Malaria (Abuja, 25 April 2000), African leaders had set new targets for malaria control. In 2006, they reaffirmed their commitment to halving the continent's malaria burden by 2010. The Regional Committee for Africa, at its fifty-sixth session, had recommended the intensification of cross-border initiatives, the integration of malaria control activities and public-private partnerships. He supported WHO's statement on the use of DDT for indoor residual spraying, and looked forward to publication of the related guidelines. Affected Member States should increase access to insecticides for indoor residual spraying and for insecticide-treated bednets.

He supported the draft resolution, endorsed the actions called for in paragraph 1, and preferred the first alternative text of paragraph 1(5). In paragraph 4, "Malaria Day" should be amended to "World Malaria Day" and the event should take place on 25 April each year.

Professor MWAKYUSA (United Republic of Tanzania) said that his country aimed to halve mortality and morbidity from malaria by 2012. Recent achievements included the introduction of artemisinin-based combination therapies, establishment of a malaria epidemic database in 19 districts, a voucher scheme for subsidized bednets and the use of rapid diagnostic tests in peripheral health centres. Challenges included the overestimation of malaria cases, owing to the lack of laboratories and qualified personnel at health facilities, and meeting the high cost of artemisinin-based combination

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the second meeting, section 3.

therapies. He thanked partners for support in acquiring artemisinin-based combination therapies, and he appealed to the manufacturers to reduce the number of tablets in an adult dose, a move that would improve compliance; paediatric formulations were also needed. He supported the draft resolution and the suggestion to establish a Malaria Day.

Professor KEVAU (Papua New Guinea) said that Papua New Guinea ranked third among the 10 countries of the Western Pacific Region for confirmed malaria cases. Artemisinin-combination therapy had been introduced in 2000 for severe malaria and treatment failure, but was currently being used as a first-line medicine. The emergence of counterfeit artemisinin was a concern, and a major infiltration into the current distribution system had recently been detected. He thanked WHO notably for securing support from key partners for the introduction of long-lasting impregnated bednets. He welcomed the inclusion of international organizations in the draft resolution.

He preferred the second alternative text of paragraph 1(5) of the draft resolution. Bearing in mind the importance of research, he suggested including in paragraph 3(1) the words “mobilization of resources and increased support for research in the development of new tools and strategies for prevention and control of malaria”.

Mr MARTIN (Switzerland) expressed broad agreement with the draft resolution. He welcomed the reference in paragraph 1(3) to the promotion of artemisinin-combination therapies. That paragraph should also include, in suitable wording, a reference to prohibiting the distribution, not merely the production, of counterfeit medicines, and a further reference to enforcement measures. He favoured the second alternative text of paragraph 1(5).

He agreed with the principle set out in paragraph 3(3) of bringing together the different stakeholders in the fight against malaria, but questioned whether it was necessary to create a special forum for that purpose. As existing mechanisms could serve the same purpose if given a wider mandate, he suggested adding the following sentence: “This forum could take advantage of similar meetings which take place in any case, such as the Global Forum for Health Research”. Whatever the wording chosen, such a forum should include the countries that had to implement prevention and control.

Dr HUWAIL (Iraq) said that, in spite of the current situation in his country, the number of cases of malaria had decreased from about 100 000 in 1995 to only 24 in 2006, the result of effective prevention and control measures. He urged WHO to support his country in eliminating malaria, ensuring prompt diagnosis and treatment, spraying and fogging activities, the distribution of bednets, vector surveillance, health education, and the incorporation of malaria prevention and control activities in primary health care. He supported the proposal for a Malaria Day.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized the need to strengthen technical support for malaria control at country level, especially countries facing a heavy burden of disease or complex emergencies. He welcomed the request in the draft resolution to international organizations to support the capacity to expand interventions, such as case management with combination therapies, long-lasting insecticide-treated bednets and indoor residual spraying. There was still a huge shortfall to reaching 80% coverage by 2010 for those interventions in countries most affected.

The limited human capacity at country level, weak health systems, and a shortage of medicines, trained entomologists and vector control teams were all impeding progress in controlling malaria and other vector-borne diseases in endemic countries. It was therefore crucial to build resources for vector control at all levels. Several countries of the Region had made good progress in integrated vector management, but the range of insecticides at country level was limited. Several countries were embarking on malaria elimination at subregional, national or subnational level. He looked forward to support for malaria elimination from other partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria. WHO should continue to support capacity building by organizing training courses and by developing manuals and guidelines. The Regional Office for the Eastern Mediterranean

had begun to document the successful experience of malaria elimination of countries such as Morocco, which could benefit countries in other regions. A Malaria Day would offer a good opportunity to raise stakeholder awareness, mobilize resources and scale up interventions against the disease. His delegation would be proposing certain amendments to the draft resolution.

Dr ASSOGBA (Benin) observed that, notwithstanding all the efforts and resources invested in malaria prevention and control by Benin and its international partners, malaria had yet to be eradicated. It remained a complex and major public health problem. In 2004, Benin had adopted a new, three-pronged malaria control policy consisting of: the use of artemisinin-combination therapies for uncomplicated malaria; intermittent preventive treatment in pregnancy; and integrated vector control based on long-lasting insecticide-treated bednets, indoor spraying and the use of larvicides. The new policy included door-to-door campaigns offering renewed treating of bednets. He wanted to see a world partnership to fight malaria, and firmly supported the proposal to establish a Malaria Day.

Mr CHAOUKI (Morocco) said that his country had made gigantic strides in the fight against malaria. No new case had been detected in 2006, suggesting that the disease had not progressed. The successes achieved were the result of vector control and the policy of monitoring travellers entering the country. Efforts to eliminate malaria were continuing in 2007. A new strategy for 2008–2012 would emphasize vector control, and target every other factor in the spread of malaria. WHO should assist countries endeavouring to halt the progress of the disease. It should also offer support for preventing the importation of malaria and the re-emergence of the disease in certain regions. WHO should formulate an integrated plan in order to combat all malaria vectors.

Professor FAIZ (Bangladesh) said that malaria was a major public health problem in 13 districts of his country, including three hill districts with relatively inaccessible terrain and populated mainly by ethnic minority groups; 80% of the cases were falciparum malaria. The national malaria control programme had been revised in 2004 in order to emphasize early diagnosis and effective treatment through artemisinin-combination therapies; integrated sector management; a strong information, education and communication component; and operational research. The objective of reducing malaria-specific mortality by 50% by 2010 was within reach. Assistance in sustaining the malaria control programme was essential. The observance of Malaria Day on 25 April would be a milestone for malaria control.

Successes in malaria research included the development of artesunate suppositories for use at community level in *non per os* cases of malaria, and the conclusive proof of the superiority of injection artesunate over quinine in adults with severe malaria. At peripheral level, where access to treatment of falciparum malaria before referral was very poor, the use of rectal artesunate could reduce mortality significantly.

Dr HAO Yang (China) welcomed the efforts of WHO to coordinate the work of international organizations and to create a partnership in the fight against malaria. He supported the establishment of a Malaria Day. However, 25 April would be an unwise choice of date for China and other countries in the region, where malaria occurred between May and the autumn months; moreover, in 1986 China had declared 25 April “child vaccination day”.

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that her country’s strategy for combating malaria was based on early diagnosis and timely treatment. Successes of that strategy included the change-over to combined therapies as the first-line treatment for falciparum malaria; the use of impregnated bednets in endemic areas; and the inclusion of indigenous populations of miners in detection, diagnosis, treatment and prevention of malaria and other communicable diseases. Important recent innovations included artesunate and mefloquine-combination therapy, the establishment of new diagnostic centres, integrated vector control and the promotion of personal protection. Her Government recognized the importance of malaria control, and supported all pertinent initiatives in that respect.

She proposed that, in the third preambular paragraph of the draft resolution, the words “President of the United States of America” should be amended to “United States of America”. In paragraph 1(5), the words “whenever necessary” should be deleted, because that language could pose an obstacle to the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights. She suggested 6 November as a suitable date for Malaria Day, that being the day on which Alphonse Laveran first observed the presence of malaria parasites in a patient’s blood. It was already the national Malaria Day in Guyana.

Mr DANKOKO (Senegal) said that his country had had about 1.5 million cases of malaria in 2006, accounting for about 34% of total morbidity. There had been no significant reduction in morbidity since 2000, despite the efforts of the authorities, which included the provision of insecticide-impregnated bednets at a greatly subsidized price, free intermittent preventive treatment for pregnant women, and artemisinin-based combination therapy for cases of uncomplicated malaria.

However, health service providers tended to classify all fevers automatically as malaria, which might be a partial explanation of the high morbidity rates. A new initiative for the accelerated reduction of morbidity from malaria aimed to improve case definition, rapid diagnostic testing, and the quality of the data collected, and to minimize the risk of errors in diagnosis and case notification. Hospital deaths from malaria had decreased markedly, from 37% of admissions in 2000 to 19% in 2006.

Because of increasing resistance to conventional antimalarial medicines, Senegal had switched to artemisinin derivatives in March 2006, which were currently widely available throughout the country. Equipment for rapid diagnostic testing would be supplied free to all clinicians. Insecticide-impregnated bednets had been distributed throughout the country, with the support of partners. In 2006, 45.6% of children under five years of age and 32.6% of pregnant women had possessed a bednet, compared with 1.7% of those groups in 2000. Bednets would be distributed free to vulnerable groups during immunization campaigns. A pilot project on indoor spraying with insecticides was under way in three districts. The results were expected in a year’s time, and would help in deciding whether to scale up the project.

He supported the draft resolution. World Malaria Day should be celebrated on 25 April.

Mr HERBERT (Saint Kitts and Nevis), speaking on behalf of the member countries of the Caribbean Community, said that two previously non-endemic countries, the Bahamas and Jamaica, had recently experienced outbreaks of malaria, which had been rapidly contained, with no malaria-related deaths. With the support of PAHO and WHO, they had increased their laboratory capacity, mobilized resources for vector control, worked with the regional partners to minimize the impact of the outbreaks on the tourist trade, and procured significant amounts of antimalarial medicines. PAHO had also provided related support during the Cricket World Cup 2007.

All countries should assign adequate resources, both human and financial, to the fight against malaria. The movement of persons was expanding rapidly because of tourism and the creation of the Caribbean Single Market and Economy. He welcomed the proposal for an international Malaria Day, and suggested holding it on 6 November.

Mr SELWIG (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia, and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Serbia, as well as Ukraine and the Republic of Moldova aligned themselves with his statement. He welcomed the increased commitments of the international community to fighting malaria. Endemic countries had been stepping up their malaria control programmes. The European Union supported country-led efforts based on effective case management with artemisinin-based combination therapy, prevention by means of insecticide-impregnated bednets, and other tailored vector control strategies.

He welcomed WHO’s strong support for the Stockholm Convention on Persistent Organic Pollutants, which allowed the temporary use of DDT for malaria vector control while calling for its

eventual replacement by other insecticides. He also supported WHO's recommendations for alternative measures for vector control, in a context of integrated vector management. He requested a more comprehensive overview of progress made by the Secretariat's task forces, the Strategic and Technical Advisory Group and the six working groups referred to in paragraph 13 of the report. He supported the draft resolution.

The problem of malaria involved issues of social and gender equality. Effective antimalarial medicines and impregnated bednets should be regarded as global public goods, access to which should involve a discussion about innovative forms of financing. It was important to develop local production and distribution of antimalarial medicines and impregnated bednets in developing countries. Pharmaceutical research, programme monitoring and continued evidence building through initiatives such as the Medicines for Malaria Venture and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases would require cooperation and exchanges between countries and regions.

He supported the first alternative text for paragraph 1(5) of the draft resolution.

Dr MELNIKOVA (Russian Federation) said that malaria caused enormous human and economic losses. With tuberculosis and HIV/AIDS, it placed a heavy burden on weak health systems. Many countries, particularly in Africa, did not have the national capacity to implement a malaria control strategy and experienced difficulties in establishing cross-border cooperation, or lacked financial resources and trained staff.

Recent years had seen considerable growth in the resources and strategies for funding devoted to malaria prevention and control. The Russian Federation was experienced in malaria control, in both the endemic and the post-eradication phases, with an adequate epidemiological monitoring system. It would contribute to the World Bank's malaria-control activities for the period 2007–2009 by financing laboratories in Africa, organizing management courses for bilateral malaria-control programmes, and providing technical assistance from Russian parasitologists and entomologists.

She supported the draft resolution, including the proposal for an international Malaria Day. WHO should improve the global surveillance system in order to identify regions where specific measures would be required, including the monitoring of migration, the status of risk factors for malaria and phenological forecasting. Scientific research institutes in the Russian Federation and other countries should collaborate with WHO in the development and production of rapid diagnostic test equipment, effective combinations of antimalarial medicines, and insecticides and larvicides with a low environmental impact. WHO should promote further research on the sensitivity of malarial plasmodia to antimalarial medicines and the sensitivity of the vector to synthetic pyrethroids that have been used in malaria-endemic areas for many years.

Dr VIOLAKI-PARASKEVA (Greece) said that there was little general awareness of malaria as a global health problem. Her country was free of malaria, but there was still a risk of re-emergence or importation of the disease by migrants. The Government had therefore introduced a surveillance programme, emphasizing blood transfusion services, and all categories of health workers were trained to identify and treat malaria. She supported the draft resolution, including the proposal to establish a Malaria Day which should draw attention to both the health and economic aspects of the problem.

Mr NDONG NCHUCHUMA ESOMOYO (Equatorial Guinea) said that his country had established a malaria control programme which included vector control (more than 700 000 homes had been sprayed with residual insecticides since 2004) and the distribution of insecticide-impregnated bednets free to all children under the age of five and pregnant women attending prenatal clinics. Artemisinin-based combination therapy had been introduced.

On the island of Bioko, all children under the age of 15 years received free antimalarial treatment at public health centres, and pregnant women received free intermittent preventive therapy from the second trimester of pregnancy. On 25 April 2007, Africa Malaria Day had drawn attention to the recommended prevention and control measures. He expressed his appreciation to partners, including the private sector, and supported the draft resolution.

Dr OPART KARNKAWINPONG (Thailand) said that malaria control in his country took the form of integrated programmes in low-endemic areas and vertical programmes in high-endemic areas. He supported the strategic directions identified in the Global Malaria Programme, and thanked WHO for its support in the development of artemisinin-based combination therapies for use along the border between Thailand and Cambodia. The mefloquine-artesunate combination had been in use along the border since 1995 and in the rest of the country since 2005. Surveillance for antimalarial drug resistance had been conducted in nine border provinces for over 10 years, using both in vivo and in vitro methods: resistance had been detected in only one of the surveillance areas.

Antimalarial medicines were licensed for use only in public health facilities, although private hospitals could use them with the permission of the Ministry of Public Health. Public awareness campaigns were conducted in May every year, just before the peak season for malaria in Thailand. He expressed concern about the use of DDT for indoor residual spraying, mentioned in paragraph 2(1) of the draft resolution. The cost-effectiveness of DDT was still in question because of its environmental impact, and its use was banned in Thailand.

He supported the draft resolution, with the following amendments. In paragraph 2(1), the text should be amended to read: "... spraying with appropriate, safe and environmentally nonpersistent insecticides ...". A new paragraph 2(3) bis should be added, to read: "to continue an ongoing support mechanism, in collaboration with the United Nations Environment Programme, to obtain information on the use of DDT and other evidence in order to evaluate the continued need of DDT use for vector control".

Dr CHITUWO (Zambia) said that malaria was a leading cause of morbidity and mortality in tropical areas. Many proven interventions were out of reach for poor countries, including insecticide-impregnated bednets, indoor residual spraying, artemisinin-based combination therapy and intermittent preventive treatment in pregnancy. Health systems needed to be strengthened in areas with high resistance to conventional antimalarial medicines before those methods could be introduced. Ill-health was the main threat to development, growth and equity in sub-Saharan Africa. Greater investment was needed in research on a malaria vaccine and in human resources at all levels.

Partnerships were essential to the success of malaria control programmes, and should draw on the relative strengths of each partner. He paid tribute to his own country's partners in malaria control, and he looked forward to cooperation with new partners, such as the Malaria Initiative. Zambia's partners observed the "Three Ones" principle: one national plan, developed by one national authority, with one agreed system of monitoring and evaluation. Under Zambia's malaria control programme a total of 300 000 pregnant women had received intermittent preventive therapy; ownership of insecticide-impregnated bednets had increased from 14% to 50%; and coverage with indoor residual spraying had increased by 46%. Mortality from malaria had fallen by 16% and the overall incidence of the disease had decreased by 10% between 2003 and 2005.

World Malaria Day should be celebrated on 25 April, although Member States in the Southern African Development Community celebrated an additional malaria day of their own in November every year.

He warned of the potential impact of climate change on the incidence of malaria. Areas that were not currently capable of supporting the *Anopheles* mosquito might easily become so in the future.

Mr MENESES (Mexico) said that in his country transmission of malaria had been reduced, and the number of malaria cases was at its lowest ever. Some 80% of cases caused by *Plasmodium vivax* occurred in small endemic areas on the border with Central America. Most of the few cases of falciparum malaria had been imported from Central America and had been quickly detected and treated, thanks to nationwide epidemiological surveillance.

Since 1999, Mexico's malaria programme had focused on the elimination of vectors, plasmodia in humans and mosquito-breeding sites. The information system was able to identify risk factors and types of malaria, and to implement targeted use of medicines and other antimalarial measures, excluding spraying with DDT.

He supported the draft resolution. However, the declaration of a World Malaria Day would not solve the problem of the high incidence of malaria in some countries and regions. He proposed the day should be celebrated on 16 November, or alternatively that each country should choose its own appropriate date.

Professor TLOU (Botswana) observed that malaria was a major public health problem in Botswana; the unstable and highly seasonal transmission of malaria meant that acquired immunity to malaria was negligible and all age groups were at risk of severe forms of the disease. Antimalarial medicines policy had changed to artemisinin-based combination therapies. Local production of insecticide-treated bednets and lower prices had increased their availability and uptake.

Botswana's national malaria control programme had been evaluated in 2005, following which a five-year strategic plan had been devised. The national malaria indicator survey would assess progress towards the targets set out in the Abuja Declaration on Roll Back Malaria in Africa (2000). She thanked her country's partners, including WHO, for their support in the Roll Back Malaria initiative, and supported the draft resolution.

Dr YOSHIDA (Japan) said that by the end of 2007 his Government would donate a further 10 million insecticide-treated bednets to African countries, in addition to the eight million already provided.

Japan had once been endemic for malaria. The risk of re-emergence was well recognized, particularly through importation. He supported the basic provisions contained in the draft resolution, but was concerned at the strengthening of WHO's technical support for indoor residual spraying with DDT. The Organization should establish a system for monitoring such interventions that took into account the sustainability of using DDT, which was a persistent organic pollutant regulated by the Stockholm Convention, and the possible emergence of resistant mosquitoes. A system for monitoring residual DDT should also be established jointly with the Secretariat of the Stockholm Convention, in order to minimize the economic damage to other sectors, such as agriculture.

He supported the second option for paragraph 1(5) of the draft resolution.

Dr STEIGER (United States of America) observed that the Malaria Initiative of his President provided evidence of his country's recognition of the importance of global malaria control. The White House Summit on Malaria (Washington DC, 14 December 2006) had united stakeholders who had called on wealthier countries to increase their funding for malaria control. He supported the proposal in the draft resolution to declare 25 April World Malaria Day. Such a measure, however, would not reduce the global burden of the disease. Renewed focus was required on the malaria control interventions outlined in the report, particularly in affected Member States.

He appreciated the clear statements made by the head of the Global Malaria Programme in favour of using DDT for indoor residual spraying. However, other members of the Secretariat appeared to have contradicted that position in recent weeks. The Director-General should issue a statement on the use of DDT in malaria control programmes. The Malaria Initiative was financing the use of DDT and other safe insecticides in carefully controlled household-spraying campaigns, with the full support of the host governments in the target countries.

The Director-General should also reaffirm the importance of quality standards for antimalarial medicines, and the need to conduct robust campaigns against counterfeiting. In their work and public statements, Secretariat staff should support the procurement policy set by the Global Fund to Fight AIDS, Tuberculosis and Malaria for the purchase of antimalarial medicine with Global Fund financing.

He urged donors to match his President's specific multiyear financial commitments to malaria control. Affected countries, particularly in Africa, should increase spending in order to meet the targets set out in the Abuja Declaration on Roll Back Malaria in Africa (2000). They should also eliminate all taxes and tariffs on imported medicines and bednets.

Turning to the draft resolution, he supported the second option for paragraph 1(5) and the wording in parentheses in paragraph 1(6).

Dr NYIKAL (Kenya) observed that in Kenya malaria caused more deaths than HIV/AIDS. Costly malaria control strategies had been effective, but would be unsustainable without continued support from partners. He thanked the various partners for having facilitated numerous interventions, including indoor residual spraying and artemisinin-combination therapies. The focus should be on improving access to technologies and commodities for malaria diagnosis, prevention and treatment. In the draft resolution, Kenya supported the second option for paragraph 1(5), because it accurately reflected the Board's decision. He also supported the choice of 25 April for World Malaria Day.

Dr DE ASSUNÇÃO CARVALHO (Sao Tome and Principe) said that his country had introduced artemisinin-combination therapies, intermittent preventive treatment in pregnancy with sulfadoxine-pyrimethamine, free distribution of insecticide-treated bednets to pregnant women and children under 10, and indoor residual spraying. Those measures had resulted in fewer malaria patients being admitted to hospital, from 9258 per 100 000 in 2004 to 1300 per 100 000 in 2006. Malaria currently accounted for 3% of deaths in his country. Sustaining the plan at its current level would, however, prove difficult.

He thanked partners for their support to combat malaria. In general, awareness about the disease was still low despite increased funding for malaria control. He endorsed holding World Malaria Day on 25 April and the other provisions in the draft resolution.

Mr WATERBERG (Suriname) said that between 2000 and 2006 the number of malaria cases in Suriname had been reduced by 70%. Measures introduced included a rapid diagnostic test and artemether-combination therapy in 2004, and were made possible through strong cooperation between national and interagency stakeholders and with support from partners including PAHO's Amazonian Network for Surveillance of Antimalarial Drug Resistance. Continued collaboration with its partners would assist Suriname to eliminate malaria by 2015. The results had improved the health of the population, particularly pregnant women and children, and encouraged the socioeconomic development of endemic areas.

He supported the draft resolution and would welcome the establishment of World Malaria Day on 6 November in the Region of the Americas.

Dr KANDUN (Indonesia) said that about half the population of Indonesia was living in malaria-endemic areas, covering 70% of the country. There had been a significant decrease in the number of cases in the west of the country, but the disease was still widespread in the east, mainly because of poor access to health services. Growing resistance to some existing treatments had led to the introduction of new types, including artemisinin-combination therapies. Although efforts were being made to ensure comprehensive coverage of interventions through better targeting, limited resources were hindering progress. Current donor support had been directed towards combating malaria in the east of the country.

Given the low level of awareness about malaria in Indonesia, greater visibility should be given to the malaria programme as well as to political support. He therefore supported the proposal for 25 April to be declared World Malaria Day.

Dr LAL (India) said that in India malaria was particularly debilitating in young children and pregnant women. About 90% of the population lived in malaria-endemic areas, but 80% of cases were confined to only 20% of the population. The Government had launched, in 2005, the national rural health mission in order to improve the availability of, and access to, health care, for those living in rural areas, the poor, women and children. It was also implementing a national vector-borne disease control programme. Malaria control activities were being implemented by provincial governments through the primary health care system. They included: disease management; integrated vector management for transmission risk reduction, including indoor residual spraying in selected high-risk areas, distribution of insecticide-treated bednets, and use of larvivorous fish and other anti-larval measures; and other interventions, such as efforts to change behaviour, public-private partnerships, intersectoral convergence and capacity building. After the early 1970s, there had been a countrywide

resurgence of malaria which, as a result of the Government's efforts, had been contained below two million cases.

Drug resistance was being monitored and medicines policy revised periodically. Where resistance to chloroquine had developed, artemisinin, in combination with sulfadoxine-pyrimethamine, was being used. Under the revised medicines policy, primary health centres clustered around areas where chloroquine resistance had been reported would shift to second-line treatment. The efficacy of sulfadoxine-pyrimethamine was being monitored and, in case of resistance, treatment would be changed. Rapid diagnostic tests were also being extended, and the use of treated bednets and indoor residual spraying in high-risk areas promoted.

In India, transmission generally started during the monsoon. An antimalaria month in June every year sought to create an environment for its prevention and control through advocacy, intersectoral meetings, media and interpersonal communication. A World Malaria Day would mobilize the international community and national governments to step up prevention and control. However, Member States should be free to decide the date in accordance with the transmission season. India had therefore chosen 1 June as Malaria Day. He supported the draft resolution.

Mr MABUZA (Swaziland) said that malaria remained a major public health problem for his country, where about one third of the population was at risk. The objective was to reduce the burden of disease to a level where it ceased to threaten economic development. An estimated 90% of recurrent expenditure on malaria control came from the Government, attesting to its commitment, and the remaining 10% from partners.

Swaziland had been steadily reducing malaria-related mortality and morbidity, and funding had been received from the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to scale up vector control and strengthen capacity for epidemic preparedness and response. As a result of that funding, his Government's commitment and collaboration with neighbouring countries, mortality and morbidity due to malaria had been reduced by more than 70% in the past five years, with parasite prevalence falling from 2% in 2000 to 0.02% in 2006. He welcomed continued support from the Global Fund and other partners. The current challenge would be to sustain those achievements in the prevailing economic and social climate. Swaziland would continue to observe 25 April as its national malaria day.

Dr FIKRI (United Arab Emirates) said that, following intense efforts over more than three decades, his country had been declared free of malaria by WHO early in 2007. That experience could serve as a model for other countries in the Eastern Mediterranean Region. In 1977, his country had devised a strategy for combating the disease. Once the spread of the disease had been halted in 1998, a national programme, approved by WHO, had been developed for the post-certification period. He thanked WHO for its assistance. He supported the draft resolution and agreed that Malaria Day should be commemorated on 25 April.

Dr MESSELE (Ethiopia) said that malaria was a major health concern in her country and tackling it was an important component of the health extension programme. Prevention and control were being stepped up, including use of insecticide-treated bednets and early diagnosis and treatment. Of the 20 million insecticide-treated bednets due to be distributed by August 2007, 15.8 million had already been handed out.

Increasing prevalence of drug resistance required close monitoring of national treatment policy. Indoor residual spraying was more extensive and social mobilization helped to accelerate the prevention and control programme. She endorsed the draft resolution.

Dr WANGCHUK (Bhutan) said that the attainment of the Millennium Development Goal relating to malaria was proving difficult for several Member States in the South-East Asia Region due to the persistent high burden of disease. He welcomed the involvement of the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners, and WHO's coordination work through the

Global Malaria Programme. He agreed that Malaria Day should be commemorated annually on 25 April, and supported the draft resolution.

Dr MUSTAFA (Sudan) supported the draft resolution and suggested the addition of a new paragraph 2(3), to read: “to support research and development for new drugs and vaccines”.

Dr JALLOW (Gambia) said that malaria was a major killer of children under five years of age in Gambia, and was responsible for more than 50% of outpatient visits. Malaria control strategies applied in her country included: vector control, with selective larviciding; use of insecticide-treated bednets and their free distribution to children under five, pregnant women and vulnerable groups; effective and prompt case management, with artemisinin-based combination therapies to be introduced later in 2007; and global partnerships (including the private sector). Community structures disseminated information on malaria, and the Government had removed taxes and tariffs on insecticide-treated bednets and other malaria control items. It was also planning to introduce indoor residual spraying, working closely with the WHO country office.

Mr KAZIHISE (Burundi) said that malaria was the leading public health problem in Burundi. More than half the population was at risk and a quarter lived in hyperendemic areas. Malaria accounted for half all consultations at health-care facilities. More than two million cases were recorded annually, of which 40% were in children under five years of age; 48% of deaths in that age group were attributable to malaria. Thanks to control measures, malaria had declined in recent years, following a peak of more than three million cases during a widespread epidemic in 2001. Artemisinin-combination therapies had been used since the end of 2003. Health care, including treatment for uncomplicated malaria, had been free for children under five years of age since May 2006 and was heavily subsidized for other age groups: 78% of patients received treatment that conformed to national guidelines. Laboratory equipment was available in 80% of health-care facilities. Still, coverage with insecticide-treated bednets remained low despite considerable efforts. Coverage of 95% for indoor residual spraying in one region of the country had prevented malaria outbreaks there.

After a decade of political instability, poverty was widespread and health needs were in competition with other basic needs. Burundi was grateful for the support for malaria control provided by many partners.

Dr KAMWI (Namibia) emphasized prompt diagnosis and treatment of malaria, and the adoption of WHO recommendations on the use of artemisinin-combination therapies. Namibia supported the designation of 25 April as World Malaria Day. The uninterrupted use of DDT for indoor residual spraying as a vector control measure in Namibia had led to a remarkable reduction in mosquito density and to the virtual elimination of *Anopheles funestus*. It was therefore of concern that a statement made by a WHO official on such use conflicted with the statement issued previously. The Director-General was requested to issue a formal statement on the matter based on scientific results. He supported the draft resolution.

Mr MOONASAR (South Africa) supported the first option for paragraph 1(5) of the draft resolution and the use of DDT for indoor residual spraying for vector control, which had proved successful when used safely and responsibly. The substantial reduction in malaria cases in the areas covered by indoor DDT residual spraying programmes undertaken in border areas in cooperation with Swaziland and Mozambique had led to the hope that malaria could be eliminated. Such programmes should therefore be expanded in accordance with WHO guidelines. South Africa supported the designation of World Malaria Day and endorsed the need for flexibility in the application of malaria prevention and control measures to take into account different epidemiological and geographical settings.

Dr SADRIZADEH (Islamic Republic of Iran) said that the Member States of the Eastern Mediterranean Region wished to propose some amendments to the draft resolution before the Committee, including two substantive ones. In paragraph 1(3), the request that Member States should cease provision of oral artemisinin monotherapies should be extended to “financing bodies”. In paragraph 3(3) the list of partners should be deleted and replaced with the words “different stakeholders”.

The CHAIRMAN, speaking as the delegate of Madagascar, said that his country had had successes in its fight against malaria. The small island of Sainte-Marie to the north-east was serving as a pilot site, and had reported no case of malaria since October 2006, because insecticide-treated bednets had been distributed to the 18 000 inhabitants, thanks to WHO and other partners. The disease might already have been eliminated on that island. His Government had made a firm commitment to eradicate malaria from the main island by 2012, by following the recommendations issued by the Regional Office for Africa and headquarters.

Dr NAKATANI (Assistant Director-General) welcomed the useful suggestions for strengthening and maintaining effective measures against counterfeit medicines. He had noted the comments concerning research activities, vector control measures (including indoor residual spraying, monitoring and surveillance), malaria days, and the promotion of better coordination among donors. He also appreciated the continued support expressed by donor communities and by potential new donors such as China and the Russian Federation.

He apologized for the confusion regarding the documentation and suggested the production of one consolidated, amended draft resolution.

Dr NEIRA (Department of Protection of the Human Environment) clarified the statement on the use of DDT made by the WHO delegation at the third meeting of the Conference of Parties to the Stockholm Convention on Persistent Organic Pollutants (Dakar, 30 April–4 May 2007). There was no difference in position concerning DDT use between the environmental health team and the malaria group in WHO. The position adopted at the Conference had been balanced: WHO was trying to fight malaria while attempting to reduce reliance on the use of persistent organic pollutants. Malaria control was a priority for WHO, and therefore the use of DDT in certain circumstances, particularly in some African countries for indoor residual spraying, might be indicated. Such use should be in accordance with WHO guidelines and the terms of the Stockholm Convention and always in the context of integrated vector management. Even though, in certain regions like Latin America, the phasing out of DDT was a reality, DDT was still required in some African countries for integrated vector management. The Secretariat would work with Member States in order to ensure that DDT was used in accordance with WHO guidelines and the requirements of the Stockholm Convention.

The CHAIRMAN suggested that a revised version of the draft resolution, incorporating the proposed amendments, should be prepared for consideration by the Committee at a later stage.

It was so agreed.

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

The meeting rose at 12:35.

SIXTH MEETING

Thursday, 17 May 2007, at 14:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Tuberculosis control: progress and long-term planning: Item 12.6 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R3, and A60/13)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB120.R3.

Dr ANTEZANA ARANÍBAR (representative of the Executive Board), introducing the item, said that the Board had examined the draft resolution on tuberculosis control at its 120th session in January 2007. The Stop TB strategy and the Global Plan to Stop TB 2006–2015, which were intended as a framework for achieving the internationally agreed tuberculosis control targets and the tuberculosis-related Millennium Development Goal, had received considerable support. The Board had adopted resolution EB120.R3, which recommended a draft resolution to the Health Assembly.

Dr HUWAIL (Iraq) described tuberculosis as a public health emergency in Iraq, with an estimated prevalence of 200 cases per 100 000 population, following substantial increases in the 1990s and a worsening situation after the war in 2003. All health services had been badly affected but access to tuberculosis care in particular had been seriously restricted, especially among vulnerable population groups. Consequently, the overall case notification rate and the detection rate for sputum smear-positive pulmonary tuberculosis were only 28% and 20% respectively. Based on the figures for 2004, around 37 000 people developed tuberculosis every year and some 8000 died from the disease, but those estimates needed verification. In 2005, a total of 9454 cases had been detected in Iraq, including 6751 cases of pulmonary tuberculosis, of which 3096 were smear-positive, 2887 were smear-negative and 768 were relapses. About 80% of cases occurred in the 15 to 54 year age group, with significant social and development consequences for the country.

Directly observed treatment, short course (DOTS) had been introduced in 1998 and subsequently extended to all governorates. The national objectives were to ensure high-quality DOTS activities; to expand the national DOTS strategy to all districts; to expand access to care for vulnerable population groups; and to improve management capacity. The strategy could be enhanced by improving case detection, standardizing treatment – with supervision and patient support – ensuring effective supplies of medicine, monitoring and evaluation at all primary health care centres, and increasing public awareness of the disease. The strategy would need significant support in order to reach the case-detection rate target of 70%. Active involvement of the private sector and nongovernmental organizations, in addition to community participation in disease detection and control, was of great importance in achieving the Millennium Development Goals.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the report on achieving the internationally agreed tuberculosis-control targets for 2005 provided a platform for long-term planning to achieve the 2015 targets. The figures in the report demonstrated the need for full implementation of the Global Plan to Stop TB 2006–2015 and the Stop TB strategy.

He supported the draft resolution. Tuberculosis in his Region was the leading cause of adult deaths from communicable diseases. Tuberculosis care based on the DOTS approach had achieved 95% coverage and a treatment success rate of 83%. Over five years one million patients had received tuberculosis care. However, the case detection rate was still low (44% in 2005) and only five countries had achieved the global targets for tuberculosis control. There remained an estimated 300 000 undetected cases across the Region.

Countries needed to expand tuberculosis care and widen application of global tuberculosis initiatives, with improved laboratory services and quality of DOTS activities. All health-care providers should be involved and civil society empowered. He emphasized political commitment and sustainable financing for tuberculosis control. His Region had taken steps towards establishing the Eastern Mediterranean Partnership to Stop TB in order to promote international cooperation and provide technical and financial support. He stressed the need to estimate the tuberculosis burden accurately, given the concern that the incidence of the disease was being overestimated in some countries in the Region. He requested the Secretariat to develop specific tools for that purpose.

Dr LAL (India), noting that 1.8 million people developed tuberculosis and 370 000 died from the disease in India every year, said that the emergence of HIV-tuberculosis coinfection and multidrug-resistant strains had increased the severity and magnitude of the tuberculosis epidemic. India's revised national tuberculosis programme, based on the DOTS approach, had resulted in the fastest expansion of DOTS services in the world. Since 1997, the programme had initiated treatment for more than 6.8 million patients, thereby saving at least 1.2 million additional lives. The treatment success rate for new sputum smear-positive cases remained above 85% and the case detection rate was close to 70%. The programme included most of the components of the Stop TB strategy, with the aim of achieving the tuberculosis-related Millennium Development Goal by 2015.

He supported the draft resolution. Tuberculosis control was a long-term activity, and the current global goal was to ensure that the disease was no longer a public health problem by 2050. Tuberculosis control programmes therefore required financial stability. Long-term donor assistance was vital for the sustainability of such programmes. Government funding was not a substitute for international donor assistance but an additional resource.

Basic DOTS activities must be offered in devising treatment programmes for drug-resistant tuberculosis. Well-implemented DOTS programmes prevented multidrug resistance. Extremely drug-resistant tuberculosis could be prevented by the rational use of second-line medicines, in accordance with national and international guidelines.

In India, unlike elsewhere, the prevalence of HIV among tuberculosis patients was only 2% to 5%. With seven million suspected cases of tuberculosis evaluated annually through the primary health-care infrastructure, the policy was not to refer all for HIV testing. Evidence was collected by the national tuberculosis programme in order to evaluate HIV prevalence among tuberculosis patients.

Effective tuberculosis-control programmes required sustainable long-term investment, laboratory capacity for smear microscopy, implementation of external quality assurance and increased capacity for culture and drug susceptibility testing.

Dr OUAHDI (Algeria) said that multidrug-resistant and extremely drug-resistant tuberculosis required additional international research into anti-tuberculosis agents that should be used exclusively for treating tuberculosis. There was a risk that the prevalence of multidrug-resistant tuberculosis might increase if the DOTS approach was not followed correctly, but DOTS programmes could only be applied if there were affordable health facilities and laboratory capacity for populations at risk. Access for tuberculosis patients to community health services would reduce tuberculosis morbidity and mortality with fewer patients cutting short their treatment.

Dr MBOWE (Gambia) reported significant progress in tuberculosis control in his country, with a case notification rate for new sputum smear-positive cases of 66.7% and a treatment success rate of 86% in 2006. The defaulter rate had fallen to 1%, compared with 14% in 2003. Progress was partly due to innovations such as integrating tuberculosis services into the existing primary health-care

system; providing incentives for health-care workers; providing “enabler packages”, including refunds for food and transport, to tuberculosis patients; and building community awareness.

Gambia had developed both short-term and long-term plans for tuberculosis control, on the basis of the goal of ensuring that the disease was no longer a public health problem. He thanked WHO and other partners for financial and technical support. He supported the draft resolution.

Mr ECKENDORF (Germany) spoke on behalf of the European Union and its 27 Member States. The candidate countries Croatia, Turkey and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and the European Free Trade Association country Iceland, member of the European Economic Area, as well as Ukraine and the Republic of Moldova aligned themselves with his statement. He strongly endorsed WHO’s efforts to control tuberculosis through the Stop TB Strategy and the Global Plan to Stop TB 2006–2015. The European Union’s surveillance systems must continue to collaborate with WHO. Although he welcomed the stabilization in the global annual incidence of tuberculosis, he expressed concern at the situation in eastern Europe, the Russian Federation and Central Asia where 14 000 new cases had been registered in 2005 among HIV patients; co-infection posed significant challenges in terms of treatment and care. The development of appropriate medicines for the 900 000 tuberculosis-infected children in those areas also lagged behind. Multidrug resistance was seen in 15% of tuberculosis cases in those areas, a proportion three times higher than in the rest of the world, and access to appropriate treatment was limited. The European Region showed the lowest disease-detection rates and the highest level of resistance to treatment.

Cross-border and regional cooperation among countries with different epidemiological situations and different standards of tuberculosis control should be enhanced through health surveillance for workers from countries with a high incidence of tuberculosis, and through regional discussions. A ministerial forum on tuberculosis, organized by the Regional Office for Europe, would be held in Berlin in October 2007.

Strengthening equitable national health systems was essential; resistance to antituberculosis medicines increased when tuberculosis care was poorly managed. The European Union had helped to stabilize tuberculosis incidence rates through its continuing contributions to the Global Fund to Fight AIDS, Tuberculosis and Malaria and to WHO and through bilateral support to endemic countries. It was important to assure the financing of first-line medicines and the creation of emergency stockpiles where necessary.

Better diagnostics and external quality control of laboratory diagnosis enhanced control of multidrug-resistant and extensively drug-resistant tuberculosis. New medicines were needed, and he welcomed the voluntary, innovative financing initiatives taken by groups of Member States, in particular the International Drug Purchase Facility (UNITAID). All Member States should increase research funding and WHO should lead in promoting global tuberculosis research.

Increased coordination and collaboration with other programmes was needed, especially those on HIV/AIDS.

He supported the draft resolution, but proposed a new additional subparagraph at the end of the preamble that would read: “Welcoming the contribution to the mobilization of resources for development by voluntary innovative financing initiatives taken by groups of Member States and in this regard noting the International Drug Purchase Facility – UNITAID, the International Finance Facility for Immunisation, and the commitment to launch a pilot project within the Advance Market Commitments initiatives”.

Dr HAO Yang (China), commending the Secretariat’s support to Member States in controlling tuberculosis, noted that, although all WHO regions had made progress, the targets for 2005 had not been met and control efforts varied considerably from country to country. The expansion of the DOTS strategy in many countries meant that more attention should go to the quality of DOTS programmes. Member States should strive to achieve the Millennium Development Goal targets by devising medium-term and long-term plans. WHO should establish an effective funding mechanism for tuberculosis control. Since increased multidrug resistance was a major obstacle to tuberculosis control,

the Secretariat should support Member States in developing their laboratory capacity in order to provide for rapid drug-susceptibility testing and greater access to more reliable second-line medicines. Finally, it should strengthen research into new diagnostic methods, vaccines and medicines.

Mr DANKOKO (Senegal), commending the report, said that the incidence of tuberculosis in his country was 110 per 100 000 inhabitants, and in 2006 its national tuberculosis control programme had reported 6882 new sputum smear-positive cases and more than 10 500 cases, of all forms of tuberculosis, making the case-detection rate 55%. The incidence of tuberculosis among HIV-infected people in two urban centres, including Dakar, had been estimated at about 15% in 2004. A multidrug-resistance study, begun in 2005 with WHO support, had revealed a primary resistance rate of 1.9%. A four-year plan for tuberculosis control (2002–2006) had strengthened DOTS programmes and raised the treatment success rate from 53% in 2001 to 70% in 2007; it had also built up the capacity of medical, nursing and laboratory staff and furthered community-based interventions. Commitment to tuberculosis control was demonstrated by a substantially increased budget allocation to antituberculosis medicines. Despite its efforts, however, Senegal was still far from achieving the targets it had set for 2015.

He supported the draft resolution, and urged financial partners to increase their support for national tuberculosis control programmes.

Mr KIFLEYESUS (Eritrea) said that rational use of combination therapy had good treatment outcomes. Multidrug-resistant tuberculosis and adverse reactions needed robust systems of drug regulation, including quality assurance and control for laboratories, an essential requirement. The Secretariat should assist Member States in establishing those systems for tuberculosis laboratories and pharmacovigilance centres, both national and regional, for the purpose of monitoring multidrug-induced adverse reactions. He urged Member States to promote community involvement in DOTS programmes.

He supported the draft resolution.

Dr OPART KARNKAWINPONG (Thailand) noted that, despite considerable progress in scaling up the DOTS strategy, the global targets for 2005 had not been reached. In addition, the problems of tuberculosis/HIV coinfection and extensively drug-resistant tuberculosis needed to be solved. Thailand fully supported the Global Plan to Stop TB 2006–2015 and the Stop TB strategy. The funding gap of US\$ 31 000 million for the 10-year period 2006–2015 was a major impediment to achieving the targets. WHO should work with international donors in order to close that gap. WHO's initiatives to control HIV-related tuberculosis and to overcome multidrug-resistant and extensively drug-resistant tuberculosis by establishing the Global HIV Drug Resistance Surveillance Network had not been successful since few Member States participated in the Network. There had been no consensus on standard guidelines for rapid drug-susceptibility testing, and such testing methods were expensive to initiate and maintain.

He proposed several amendments to the draft resolution. He suggested the addition of new text after the seventh preambular subparagraph, that would read: "Recognizing the importance of situations and trends of multidrug-resistant and extensively drug-resistant tuberculosis in contributing to the achievement of the Global Plan by 2015, and the need for an increased number of Member States participating in the Network and the required additional resources in accomplishing its task;". He proposed inserting in paragraph 1(e), after "from all persons with culture-positive tuberculosis," the words "where resources are available"; the addition of a new subparagraph, after paragraph 2(1), that would read: "to continue to support the Global Drug Resistance Surveillance Network by increasing the number of Member States in the Network in order to establish the trends and situations of multidrug-resistant and extensively drug-resistant tuberculosis to inform the Global Plan to Stop TB"; and insertion at the end of paragraph 2(5) of text reading "including the development of consensus guidelines for rapid drug-susceptibility test methods, mobilization of funding and appropriate techniques for laboratory strengthening".

Professor TLOU (Botswana) commended the priority accorded by WHO to tuberculosis control. Botswana's notification rates for tuberculosis had risen sharply since the 1990s, and its case-detection and treatment-success rates had reached 87% and 67%, respectively, in 2005. The rate of coinfection with HIV among tuberculosis patients was 60% to 80%. The incidence of multidrug-resistant tuberculosis was low but increasing. A survey was under way to detect the existence of extensively drug-resistant tuberculosis. A five-year strategic plan was being elaborated in line with the Global Plan to Stop TB 2006–2015. The DOTS strategy had been introduced in Botswana in 1986 and was being expanded; 14 of the 24 health districts were implementing community tuberculosis care.

She thanked WHO and other partners for technical and financial support. She urged WHO to increase its support for countries affected by extensively drug-resistant tuberculosis and to assist them in building their research capacity in that area. She supported the draft resolution.

Mr VAN OMMEN (Netherlands) proposed amending paragraphs 1(1)(a) and 2(4) of the draft resolution to include the wording "with specific attention to vulnerable groups highly at risk, such as the poor, migrants and ethnic minorities".

Professor KEVAU (Papua New Guinea) said that the rapid expansion of the tuberculosis epidemic in Papua New Guinea was due to weak health services, coexistence with HIV, and the possible emergence of multidrug-resistant tuberculosis. Papua New Guinea ranked third in the Western Pacific Region in terms of incidence, prevalence and mortality, and eighth for the estimated number of cases. The latter were probably underreported as the case-detection rate was only 20%. Both the incidence and the mortality rates were expected to rise sharply as a result of the HIV/AIDS epidemic. Greater support for diagnostic capabilities with high sensitivity and specificity was needed, especially for extrapulmonary tuberculosis. He acknowledged WHO's support. His Government had implemented many of the strategies advocated in tuberculosis plans, including the Global Plan to Stop TB 2006–2015. He supported the draft resolution.

Professor FAIZ (Bangladesh) said that Bangladesh ranked fifth among the countries with high burdens of tuberculosis. Through the rapid expansion of the DOTS strategy, the rates of case detection and successful treatment were 71% and 91% respectively. The tuberculosis control programme collaborated with nongovernmental organizations with funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria. The areas identified for improvement included: case detection and treatment; supervision; monitoring and evaluating through the 28 quality assurance centres; and drug resistance, the prevalence of which was only 2%. Innovative management strategies were being implemented, for example in the workplace. He broadly supported the report but was concerned about the diagnosis and management of extrapulmonary tuberculosis.

Mr MABUZA (Swaziland), speaking on behalf of the 46 Member States of the African Region, expressed support for the draft resolution. The report highlighted the challenges facing African countries, many of which had fallen short of the case-detection and care-rate targets for global tuberculosis control because of many other pressing calls on limited resources. The tuberculosis burden was compounded by the high rates of HIV infection and AIDS. Africa was the only continent with a steadily rising number of tuberculosis cases – 4% annually. The seriousness of the situation had been openly acknowledged by the WHO Regional Committee for Africa at its fifty-fifth session (Maputo, 22–26 August 2005). Subsequently, most countries in the Region had intensified their bid to control tuberculosis. The challenges facing them included weak health systems and a continuing lack of financial and human resources. In order to achieve the targets, African countries would need to improve the quality of tuberculosis treatment and care services, including the DOTS approach, and strengthen the capacity of laboratory services. Poverty was also a factor driving the epidemic; tuberculosis must be a priority in strategies to reduce poverty. Multidrug-resistant and extensively drug-resistant cases, which had so far only been reported in South Africa, presented a new and additional problem. WHO should provide countries with the necessary support and guidance in order to prevent it spreading. He urged the Director-General to mobilize the resources necessary for the

containment and management of the disease, particularly in countries with high HIV prevalence. African countries would also need to scale up their collaboration for tuberculosis and HIV. Tuberculosis should be included in the development agenda of the G8 group of countries in order to attain the Millennium Development Goals by 2015. The Stop TB Partnership should assist countries in achieving the targets set out in the Global Plan to Stop TB 2006–2015.

He proposed that the draft resolution should be amended by inclusion of the following: emphasis on the linkages between HIV/AIDS activities and tuberculosis initiatives; wording in the first preambular paragraph to the effect that Member States should include the private sector in national tuberculosis control programmes; and, in paragraph 2, mention of the need to strengthen urgently the Secretariat's support to Member States affected by multidrug-resistant and extensively drug-resistant tuberculosis.

Mr SAMO (Federated States of Micronesia) said that the report's conclusion that the Western Pacific Region had surpassed the global targets for tuberculosis control should be viewed with circumspection. Small island States tended to be overshadowed by their larger neighbours. His country had made progress in tackling tuberculosis, but geographical considerations and limited resources had made it difficult to reach the entire population. Technical and financial support was needed from WHO and partners in order to successfully control tuberculosis. He supported the draft resolution, but proposed that paragraph 1(1)(c) be amended by replacing "limiting" with "controlling".

Dr BUSUTTIL (Malta) said that his country had adopted the DOTS strategy and achieved a treatment success rate of 100%. The rates of incidence, including all forms of tuberculosis, prevalence and mortality, as well as of new-case detection, for 2005 reflected well on Malta's tuberculosis programme. Regrettably, there had been two cases of multidrug-resistant tuberculosis in 2007. Since 2002 Malta had experienced an increasing influx of illegal immigrants, mainly from countries with a high prevalence of tuberculosis. In 2005, 65% of tuberculosis cases in Malta had been imported. Many immigrants were also suffering from HIV, which could adversely affect tuberculosis incidence in the future. Those aspects should therefore be given high priority. Malta provided free access to health care and tuberculosis treatment for all patients. His Government supported the Global Plan to Stop TB 2006–2015, including the expansion of interventions against multidrug-resistant and HIV-related tuberculosis.

Dr NYIKAL (Kenya) proposed that the draft resolution should be amended to include an additional subparagraph under paragraph 1(1) to read "accelerating HIV/tuberculosis collaborative interventions".

Dr SUGIURA (Japan) asked for clarification of the term "health-information systems" in paragraph 1(1)(b). Paragraph 1(1)(c) contained references to multidrug-resistant tuberculosis and the DOTS strategy, both of which were important enough to warrant individual subparagraphs. One should read: "reaffirming high-quality implementation of the DOTS strategy by tuberculosis programmes as the first and foremost step in full implementation of the Stop TB strategy"; and the second: "limiting the emergence and transmission of multidrug-resistant tuberculosis, including extensively drug-resistant tuberculosis, by ensuring the DOTS strategy and by prompt implementation of infection-control precautions". He supported the Global Plan to Stop TB 2006–2015.

Dr KABELA (Democratic Republic of the Congo) supported the draft resolution. His large country was served by only one single diagnostic laboratory, which made it virtually impossible to detect cases of tuberculosis. New diagnostic laboratories were badly needed. His country had reached the targets for global tuberculosis control, but the situation could deteriorate if cases of multidrug-resistant and extensively drug-resistant tuberculosis failed to be identified early enough.

Professor PEREIRA MIGUEL (Portugal) observed that Portugal had achieved WHO's targets for global tuberculosis control, but the incidence in specific population groups and geographical areas

remained high. Increased capacity for early detection, reduced incidence of HIV-related tuberculosis and control of extensively drug-resistant tuberculosis were needed. Of particular concern were vulnerable population groups, including migrants, who reportedly accounted for a large proportion of tuberculosis cases in several European countries. Portugal was committed to promoting better health for migrants in order to improve the health of all citizens.

Dr BAE Geun-ryang (Republic of Korea) said that his country encouraged international education and training, including laboratory training and tuberculosis-control courses. In 2007 his Government had launched the first phase of a public-private collaboration aimed at reducing the tuberculosis treatment default rate and had increased the success rates for patients receiving treatment in private hospitals and clinics. It planned free treatment for patients with multidrug-resistant and extensively drug-resistant tuberculosis, so that they did not discontinue treatment for financial reasons. In a globalized world, tuberculosis could not be eliminated by nations acting alone: concerted cooperation between all countries was necessary. He therefore urged all Member States to strive to attain the goals of the Global Plan and the Stop TB strategy.

Dr SANOU (Burkina Faso) said that his country's tuberculosis control programme included decentralization of diagnosis and treatment to health and social welfare centres; cooperation with community associations; involvement of the private health sector in detection and treatment of workers' health organizations; detention and correctional centres; and HIV screening and treatment of opportunistic infections for HIV-positive persons. As a result, the detection rate had risen from 18% in 2004 to over 25% in 2006 and the treatment success rate had risen from 67% to 71.5%. In order to build on those results, resources needed to be mobilized from partners and from the state budget, and the DOTS-Plus strategy comprehensively implemented; a six-month treatment regimen and the tuberculosis/HIV plan for the period 2007–2009 must be implemented. Research must be conducted on drug resistance and prevalence. He supported the draft resolution.

Dr KAMWI (Namibia) said that tuberculosis remained a public health concern in Namibia, which in 2006 had reported a case notification rate of 784 per 100 000. It had a case-detection rate of over 70% and a treatment success rate of 75%. An additional concern was that multidrug-resistant cases had been reported in Namibia. A single directorate to oversee tuberculosis, HIV/AIDS and malaria programmes had recently been established, and coordination of the tuberculosis and HIV programmes had also shifted from a health sector to a multisectoral response.

He welcomed the Global Plan to Stop TB, a reference document for Member States. In Namibia, standardized curricula on tuberculosis and HIV for the training of health-care providers had been drawn up, surveillance tools had been updated, and the DOTS strategy expanded. Namibia's tuberculosis programme faced weak coordination at all levels, a shortage of human resources, limited laboratory capacity and geographical inaccessibility. Continued support from WHO and other partners would be required in the areas of infection control, multidrug-resistant and extensively drug-resistant tuberculosis, and health systems strengthening. He supported the draft resolution.

Mr ABDOO (United States of America) said that the overlapping epidemics of tuberculosis and HIV required expanded access to tuberculosis treatment for HIV-infected persons. Member States should integrate clinical programmes for the treatment of the two diseases where coinfection rates were high, as they were in Africa. A strategic response must be found to the growing problem of multidrug-resistant and extensively drug-resistant tuberculosis. Enhanced laboratory capacity would achieve real-time sensitivity testing for first-line and second-line treatments for every person with tuberculosis worldwide. That would inform therapeutic decisions, improve patient outcomes and avoid additional drug resistance. The occurrence of HIV/tuberculosis coinfection and extensively drug-resistant tuberculosis underscored the need for practical infection-control precautions. In addition, investments were needed in research, development and transfer of new rapid diagnostic procedures, including drug-susceptibility tests, safe and effective treatment regimens and vaccines.

He strongly supported the draft resolution but in view of the numerous amendments proposed, a revised version should be produced.

Mr ABDURRACHMAN (Indonesia) said that, pursuant to the Global Plan to Stop TB and the Stop TB strategy, Indonesia was implementing a five-year plan for tuberculosis control. It had met the global targets by achieving 76% case detection and 90% successful treatment of infectious cases. Ensuring sustainable funding was a challenge. Indonesia had responded to multidrug-resistant and extensively drug-resistant tuberculosis. Assessments had been made, the laboratory network was being strengthened at all levels, a drug-resistance susceptibility test would provide results in the coming months and multidrug-resistant tuberculosis pilot sites under the Stop TB Partnership's Green Light Committee would be introduced.

Although he supported the draft resolution, the Secretariat should provide more support in two areas. Once the case-detection target had been reached, guidance was needed on how to reach the remaining cases more effectively, how to make the transition from passive to active case detection and how to target areas with the highest transmission rates in a way that maximized progress towards the Millennium Development Goals. Indonesia urgently required new diagnostic tools at health-care facilities in order to improve detection among those suffering from smear-negative or extrapulmonary tuberculosis; among those with HIV/tuberculosis coinfection; and among children. He sought information from WHO about rapid diagnostic tests. Smear microscopy was no longer adequate as the only diagnostic tool and, in remote areas, it was not always practical.

Those two points should be incorporated into the draft resolution and he requested the Director-General to maintain support for countries struggling to reach the global targets.

Ms NGAUNJE (Malawi) said that tuberculosis threatened sustainable health and development in Africa where the number of cases was rising at an overall rate of 4%. In most African countries, up to half of the active cases remained undetected owing to lack of access to diagnostic facilities, and HIV had compounded the problem. African countries had shown commitment to fighting tuberculosis by increasing regional initiatives to increase access to diagnosis and treatment and declaring tuberculosis an emergency.

Almost half all active tuberculosis cases in Malawi were not detected. Accordingly, the Government had sought to strengthen diagnostic services from the community level upwards. The challenge remained strengthening the health system as a whole and improving core laboratory services. The tuberculosis control budget had been increased by 150%, but the programme had to be balanced against other health priorities.

The emergence of multidrug-resistant and extensively drug-resistant tuberculosis had regional and global implications and could erode past achievements. Multidrug-resistant tuberculosis was already present in South Africa and, given the African countries' high HIV rates and poor laboratory services and surveillance, the Region was sitting on a time bomb. If the Region's countries failed to respond in a timely and appropriate fashion, that additional health challenge would transfer into more loss of life and require huge funding resources.

She urged WHO and other partners to assist the African Region by providing additional funding for specific interventions for universal access to diagnosis, emergency plans for dealing with extensively drug-resistant tuberculosis, and core laboratory services.

Dr ASSOGBA (Benin) said that in his country control of tuberculosis had been integrated into the overall health structures in both the public and private sectors. Since the control programme was introduced in the early 1980s, involving short-term treatment, particularly of smear-positive cases, the treatment success rate had risen to 87% by 2005 and the detection rate for new smear-positive cases to 83%. Challenges remained, including building on those achievements. The problem of HIV/tuberculosis coinfection required not only medical treatment of the two diseases but also food support and treatment of related pathologies. The rural exodus of unemployed young people, drug addiction and crime compounded the difficulties of tackling the disease. Benin hosted an annual

international course on tuberculosis, an opportunity for countries to build the capacities of their health-care providers.

Dr MESSELE (Ethiopia) said that effective collaboration with HIV control programmes was essential in order to control tuberculosis in countries such as hers where coinfection was prevalent. The emergence of drug-resistant tuberculosis and the associated high mortality rate among people living with HIV/AIDS was a wake-up call for accelerated, collaborative activities. She proposed that the draft resolution should be amended by insertion of the words “and HIV-related tuberculosis” after “drug-resistant tuberculosis” in paragraph 1(1)(d) and “and HIV-associated tuberculosis” at the end of paragraph 2(2).

Professor BELLA ASSUMPTA (Cameroon) drew attention to the strong link between tuberculosis and poverty for which HIV infection was a catalyst; poverty reduction should therefore form part of tuberculosis-control strategies. The health sector should improve its prevention programmes through vaccination and develop more reliable tests. Diagnosis was especially difficult in HIV-positive patients. The emergence of multidrug-resistant cases made meeting the challenge of tuberculosis control all the more urgent.

Dr AL-SALEH (Kuwait) said that a breakthrough was required in antituberculous therapy in order to treat the disease effectively, given the rise in multidrug-resistant cases and the difficulty in simultaneously treating both tuberculosis and HIV. Some second-line antituberculosis medicines had limited efficacy although trials of new medicines were under way. The draft resolution should be amended by adding the phrase “especially enhancing research and development of new tuberculosis drugs and the interaction and relevance of nutrition and tuberculosis” at the end of paragraph 2(6).

Dr FAUORI (Jordan) said that Jordan had made significant progress in tuberculosis control, resulting in a low percentage of infections, a detection rate of 85% and a treatment rate of 90%. The DOTS strategy had been implemented successfully although recent drug-resistant cases had been difficult and expensive to treat. Further research on treatment was required. He fully supported the draft resolution.

Dr SALGADO (Chile) supported the draft resolution. Chile had a low and decreasing incidence of tuberculosis and relatively few multidrug-resistant cases or cases of coinfection with HIV. It was working towards an incidence rate of less than 5% in 2020, achieving in good time the targets set by the Millennium Development Goals; cooperation with neighbouring countries would be essential in order to ensure that immigration did not adversely affect the indicators.

Chile’s achievement was based on, among other things, political support; a public health system founded in the 1950s with a strong emphasis on primary health care; a strong health authority; free treatment; training of technical and professional staff with sound knowledge of the tuberculosis programme; control; and follow-up with epidemiological surveillance. Such measures could be helpful for many countries in combating tuberculosis, and Chile was always ready to share its experience.

Mr FORAU (Solomon Islands) said that tuberculosis remained a national health concern in the Solomon Islands with case-detection rates at 80 per 100 000, and 70% cure rates. DOTS was the main strategy used and follow-up was good, although it was difficult to reach patients in remote areas. Rates were probably underestimated, and the true prevalence of the disease was unknown. Thanks to support of donors, medicines were available at all hospitals, and treatment compliance had improved as a result of training of health workers, public education and awareness programmes. With treatment provided free, the national tuberculosis programme was becoming highly successful. He thanked development partners and endorsed the draft resolution.

Dr SEKAJUGO (Uganda) said that the rates for case detection and treatment success in his country stood at 49% and 75% respectively. Deficiencies remained in its laboratory system, with too

few health workers at lower-level health facilities. Measures implemented included: intensified training of health workers in case detection; strengthened support for supervision of peripheral health workers; procurement of laboratory equipment and supplies; and a strengthening of laboratory networks. A new tuberculosis diagnostics partnership had been established. Uganda was committed to the Global Plan to Stop TB 2006–2015 and supported the draft resolution.

Dr DAHL-REGIS (Bahamas), speaking on behalf of 14 member countries of the Caribbean Community, said that they had applied the DOTS strategy and were committed to tuberculosis control, having included the WHO global indicators in their national strategic plans. The region was second only to Africa in HIV prevalence, a factor that affected tuberculosis control in both children and adults. Some countries in the region had not met the detection and treatment rates set by WHO, and multidrug-resistant testing continued to prove a challenge for many of them. She appealed to WHO and PAHO for support for improved supplies of pharmaceuticals and for strengthening laboratory capacity. The Caribbean countries were determined to meet WHO's targets and the Millennium Development Goals. In view of the increase in migration of people from countries with a high burden of tuberculosis, she supported the draft resolution as amended by the delegate of the Netherlands.

Mr MENESES (Mexico) said that, as part of its efforts to control tuberculosis, Mexico's "Stop tuberculosis in Mexico" committee had groups working on: clinical cases; HIV-tuberculosis coinfection; DOTS; public awareness and communication; and monitoring and evaluation. Mindful of the World TB Day 2007 slogan: "From local action to global elimination – Tuberculosis anywhere is TB everywhere", Mexico supported the draft resolution and was ready to work with other Member States and share its experience in an effort to eliminate the disease.

Dr MTONGA (Zambia) said that the presence of HIV/AIDS had exacerbated the tuberculosis burden. There had been a slight reduction in the number of tuberculosis cases in Zambia from 53 000 in 2005 to some 51 000 in 2006. About 70% of people with tuberculosis in Zambia were coinfecting with HIV and about half of HIV patients would go on to develop tuberculosis. Zambia was striving to reach the targets set by WHO through continued strengthening of its DOTS strategy, which had achieved 100% coverage, and through fixed-dose combination therapies, strengthened tuberculosis and HIV collaborative activities, public-private partnerships, increased surveillance for multidrug-resistant tuberculosis and strengthened laboratory and procurement systems. Cure rates had improved from 67% in 2002 to 76% in 2006 and case detection rates had risen to 69%. The treatment success rate was 84%, close to the WHO target. Challenges included limited numbers of health personnel, lack of infrastructure and limited funding. Zambia supported the draft resolution.

Ms DE HOZ (Argentina), citing statistics on tuberculosis cases and deaths in Argentina, said that the country's tuberculosis control programme espoused the principles set out in the report. Her Government had embraced the Millennium Development Goal relating to tuberculosis, and set a national goal of reducing gaps among provinces and departments within Argentina. The tuberculosis programme encouraged community participation, notably in schools, and worked with the national AIDS programme. Argentina would apply to the Stop TB Partnership's Green Light Committee for the procurement of affordable, high-quality, second-line medicines. Argentina's tuberculosis laboratories were raising standards and quality assurance. She supported the draft resolution.

Professor MIKHAILOVA (Russian Federation) noted that the G8 group of industrialized countries, at their summit in St Petersburg in July 2006, had endorsed the Global Plan to Stop TB 2006–2015. Her country was still endemic for tuberculosis and there had been no significant change in the high prevalence. It had not met the internationally agreed targets for case detection or for successful treatment. The number of cases of multidrug-resistant tuberculosis, for which treatment was much more expensive, had increased.

WHO's Stop TB strategy, adopted by the Ministry of Health, contained new methods of detecting, registering and treating tuberculosis patients, and, although training of personnel was

prominent within the strategy, shortcomings had been observed in the complexity of adapting DOTS principles to national practice.

She advocated a systematic approach, based on the strengthening of preventive measures and active detection using all available methods. Treatment should use standard medicines but take into account the nature of each case, and should be evaluated both at individual level and in terms of the entire system of antituberculosis measures. Independent analysis of tuberculosis control should determine its effectiveness and identify potential improvements.

Her country's experience could benefit international efforts to control tuberculosis. She supported the draft resolution and, in order to achieve the tuberculosis-related Millennium Development Goal, the Russian Federation would actively implement the Global Plan to Stop TB 2006–2015.

Mr KAZIHISE (Burundi) said that Burundi had a specific tuberculosis-control programme as part of its public health policy. The disease predominantly affected the population aged 15 to 44 – people in their most active years – who accounted for 75% of cases. With a case detection rate of 42% and treatment success rate of 52% in 2006, Burundi was still far from achieving the targets set by WHO, but Burundi was emerging from a 10-year war and in recent years had suffered a series of severe weather events. Those factors had seriously hindered efforts to control tuberculosis. The health sector would increase its collaboration with other sectors as the foundation for success. He thanked WHO and the other partners that had supported Burundi's tuberculosis-control programme and invited others to join them.

Dr CARBALLO QUESADA (Costa Rica) said that pulmonary disease accounted for 86% of all cases of tuberculosis diagnosed in Costa Rica. Tuberculosis mortality had been declining since 1999 and currently stood at around 2.3 deaths per 100 000 population, although mortality statistics were affected by underreporting and problems with certification of causes of death. Since 2004, DOTS coverage had been 95% and a DOTS-plus programme had been providing second-line medicines to patients with multidrug-resistant tuberculosis. She supported the draft resolution.

Dr OLIVEROS (Philippines) supported the draft resolution and highlighted public–private partnerships, which should be expanded in order to broaden access to DOTS services and to synchronize activities within the national tuberculosis programmes. In the Philippines, the private sector had played a key role in dealing with multidrug-resistant tuberculosis. She endorsed the Global Plan to Stop TB 2006–2015, which called for collaboration with other programmes, notably that for child health, and urged Member States to enhance the management of childhood tuberculosis.

Father VITILLO (Holy See) urged the Health Assembly to promote more effective tuberculosis programming in all countries by adopting the draft resolution. Mindful of community-based tuberculosis programmes sponsored by the Catholic Church and other faith-based organizations, he emphasized collaboration between the Secretariat, Member States and civil society organizations in tackling the tuberculosis pandemic in a holistic manner.

Ms CLARISSA (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, and on behalf of the International Federation of Medical Students' Associations, said that the Federations supported WHO's tuberculosis-control initiatives by raising awareness among medical and pharmaceutical students and among the general public. She supported the efforts of WHO and the Stop TB Partnership to promote research on new diagnostics, medicines and vaccines. Health-care providers and the public should be made aware of the importance of not misusing tuberculosis medicines, especially second-line treatments. It was important to strengthen monitoring mechanisms and estimation of the impact of control activities on the tuberculosis burden. That need was acknowledged in the draft resolution. It was important for the Secretariat and Member States to engage providers in the Stop TB Strategy and to support an environment of multidisciplinary

collaboration. Such collaboration among health-care students would influence their future practice and could be the key to future success in the fight against tuberculosis.

Dr OMI (Regional Director for the Western Pacific) noted that the Western Pacific Region had achieved the global goals for case detection and successful treatment. Several factors had proved crucial to the Region's success. In 1999, the Regional Committee had set the goal of halving tuberculosis prevalence and mortality by 2010. The Region had then developed a strategic plan for 2000–2005 and Member States had then elaborated their own budgets and plans. Strong political commitment by Member States and a powerful partnership between countries and agencies for mobilizing the necessary resources had been instrumental in achieving the 2005 targets.

Dr NAKATANI (Assistant Director-General) congratulated Member States on their successes in stemming tuberculosis. He had taken note of the suggestions with regard to monitoring and surveillance, financial sustainability, the maintenance of a high-quality DOTS programme, enhancement of research and development, the building of laboratory capacity, multidrug-resistant and highly drug-resistant tuberculosis, HIV/tuberculosis coinfection, the need for more financial resources and better coordination, and the importance of addressing the needs of especially vulnerable and high-risk populations.

Responding to the questions raised by the delegate of Indonesia concerning intensified case finding after the 70% case detection target had been achieved, WHO recommended that countries should: ensure that all health facilities were reporting cases to local tuberculosis authorities; target case-finding to high-risk groups; increase community awareness of tuberculosis; and ensure that staff had the necessary information and training in order to detect cases promptly. Although rapid culture methods were available, rapid diagnostic kits for determining drug susceptibility were not. WHO was involved in developing and evaluating such tools, however, and would communicate relevant information to Member States as it became available.

The CHAIRMAN said that the draft resolution would be revised, incorporating the various proposed amendments, and distributed for consideration at a subsequent meeting.

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

The meeting rose at 17:50.

SEVENTH MEETING

Friday, 18 May 2007, at 09:45

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Evidence-based strategies and interventions to reduce alcohol-related harm: Item 12.7 of the Agenda (Documents A60/14 and A60/14 Add.1)

The CHAIRMAN invited the Committee to consider two draft resolutions. The first, proposed by the delegations of Afghanistan, Armenia, Austria, Bahrain, Belarus, Bhutan, Bolivia, Brazil, China, Democratic Republic of the Congo, Denmark, Estonia, Finland, Hungary, Ireland, Israel, Italy, Kenya, Latvia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malawi, Malaysia, Mongolia, Morocco, Mozambique, Namibia, Norway, Pakistan, Poland, Russian Federation, Slovenia, Sri Lanka, Sweden, Switzerland, Thailand, Timor-Leste, Tonga, Viet Nam and Zambia, read as follows:

The Sixtieth World Health Assembly,

Having considered the report on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum, on a global assessment of public-health problems caused by harmful use of alcohol;¹

Reaffirming resolutions WHA32.40, WHA36.12, and recalling that resolution WHA58.26 on Public-health problems caused by harmful use of alcohol requested the Director-General to draw up recommendations for effective policies and interventions to reduce alcohol-related harm, and to develop technical tools that would support Member States in implementing and evaluating recommended strategies and programmes;

Recognizing progress made by the Secretariat, in particular the recommendations of Expert Committee on Problems related to Alcohol Consumption;²

Recognizing that the major global burden of disease is currently attributable to noncommunicable diseases, and that the harmful use of alcohol is likely to cause a significant increase in this burden;

Noting the urgent need to develop strategic measures effectively to counteract the harmful use of alcohol in order to complement existing strategies to prevent and control noncommunicable diseases that target other avoidable determinants;

Expressing profound concern that harmful use of alcohol was responsible for more than 2.3 million premature deaths worldwide in 2002,³ that is one of the major avoidable determinants of the disease burden, and that it is increasingly affecting populations worldwide;

¹ Documents A60/14 and A60/14 Add.1.

² WHO Technical Report Series No. 944, 2007.

³ Document A60/14 Add.1.

Noting that IARC (Group 1 agent),¹ has categorized ethanol in alcoholic beverages as carcinogenic to humans and that the occurrence of various malignant tumors, including of colorectum and female breast, are causally related to alcohol consumption;

Mindful that harmful use of alcohol can seriously harm people other than the drinker;

Recognizing the need to protect those individuals and groups who are at risk of being negatively affected by the drinking of others, in particular partners and children in families with alcohol problems and persons at workplaces, and to assure transport safety;

Noting the complexity of alcohol-related problems, and the need for comprehensive evidence-based policy measures and cost-effective interventions to reduce alcohol-related harm;

Acknowledging that effective strategies and interventions that target both the population at large and specific groups are available and should be optimally combined in order to reduce alcohol-related harm;

Stressing that such strategies and interventions must be implemented in a balanced and appropriate way according to existing religious, cultural and traditional contexts;

Noting with appreciation the positive results in reducing harmful use of alcohol obtained in all WHO regions;

Firmly convinced that global leadership to combat alcohol-related harm is urgently needed;

Recognizing WHO's leadership in global public-health policies on reducing harmful use of alcohol,

1. URGES Member States:

(1) to collaborate with WHO in developing a global plan to reduce harmful use of alcohol based on evidence and best practices, with special emphasis on an integrated approach to protect at-risk populations and people harmed by the drinking of others;

(2) to strengthen national responses, as appropriate, to public-health problems caused by harmful use of alcohol, taking advantage of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm;²

(3) to determine national alcohol strategies and programmes, including plans for implementation, and to establish, sustain or reinforce as appropriate national targets to reduce the harmful use of alcohol;

(4) to establish or to develop appropriate national monitoring systems on alcohol consumption and its health and social consequences, linked to WHO global and regional information systems, in order to guide adequate national responses and to measure progress in reducing harmful use of alcohol at regional and global levels;

2. CALLS UPON international organizations and bodies concerned with harmful use of alcohol to engage in global efforts to reduce alcohol-related harm;

3. REQUESTS the Director-General:

(1) to ensure a significant strengthening of prevention and control of noncommunicable diseases as an overarching priority in the work of WHO;

(2) to strengthen and intensify the work of the Secretariat on developing and implementing global and regional strategies and plans, as appropriate, and to provide technical support to Member States when requested for reducing public-health problems caused by harmful use of alcohol, taking into account the full range of its health, social and economic consequences;

¹ IARC *Monograph on the Evaluation of Carcinogenic Risks to Humans*. Lyons, International Agency for Research on Cancer, Vol. 96, 2007.

² Document A60/14, paragraphs 5 and 6.

- (3) to ensure appropriate active engagement and commitment free from conflict of interest of concerned organizations within the United Nations system, international nongovernmental organizations, private-sector entities and other relevant stakeholders;
- (4) to submit to the Sixty-second World Health Assembly a global plan on reduction of alcohol-related harm that takes into account evidence on cost-effective interventions and is drawn up after consultation with Member States, nongovernmental organizations, private-sector entities and other relevant stakeholders.

The second draft resolution, proposed by the delegations of New Zealand and Sweden after consultation in an informal working group, incorporated amendments to the first draft resolution and read as follows:

The Sixtieth World Health Assembly,

Having considered the report on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public-health problems caused by harmful use of alcohol;¹

Reaffirming resolutions WHA32.40 and WHA36.12, recalling that resolution WHA58.26 on Public-health problems caused by harmful use of alcohol requested the Director-General to draw up recommendations for effective policies and interventions to reduce alcohol-related harm, and to develop technical tools that would support Member States in implementing and evaluating recommended strategies and programmes;

Recognizing progress made by the Secretariat in this regard, and the need for additional analysis and work on effective evidence-based interventions;

Recognizing that the major global burden of disease is currently attributable to noncommunicable diseases, and that harmful use of alcohol is likely to cause a significant increase in this burden;

Recognizing further the potential impact of harmful use of alcohol on the spread of infectious diseases;

Recognizing also that neuropsychiatric disorders, including alcohol dependence, as part of the burden of noncommunicable diseases, account for more than one third of the burden of disease attributable to the harmful use of alcohol;

Noting the urgent need to develop strategic measures effectively to counteract the harmful use of alcohol in order to complement existing strategies to prevent and control noncommunicable diseases and to reduce the disease burden from neuropsychiatric disorders and injuries;

Recognizing that alcohol production and consumption patterns vary considerably around the world and include substantial informal and illicit production, distribution and consumption;

Expressing profound concern that harmful use of alcohol was responsible for more than 2.3 million premature deaths worldwide in 2002,² that it is one of the major avoidable determinants of the disease burden, and that it is increasingly affecting populations worldwide;

¹ Documents A60/14 and A60/14 Add.1.

² Document A60/14 Add.1.

Noting that IARC has categorized ethanol in alcoholic beverages as carcinogenic to humans (Group 1 agents),¹ and that the occurrence of various malignant tumors, including of the colorectum and female breast, are causally related to alcohol consumption;

Mindful that harmful use of alcohol can seriously harm people other than the drinker;

Recognizing the need to protect those individuals and groups who are at risk of being negatively affected by the harmful drinking of others, in particular partners and children in families with alcohol problems and persons at workplaces, and to assure transport safety;

Noting the complexity of alcohol-related problems, and the need for comprehensive evidence-based policy measures and cost-effective interventions to reduce alcohol-related harm;

Acknowledging that effective strategies and interventions that target both the population at large and specific groups are available and should be optimally combined in order to reduce alcohol-related harm;

Stressing that such strategies and interventions must be implemented in a balanced and appropriate way according to existing religious, socioeconomic, cultural and traditional contexts;

Noting with appreciation the positive results in reducing harmful use of alcohol obtained in all WHO regions;

Firmly convinced that global leadership to combat alcohol-related harm is urgently needed;

Recognizing WHO's leadership in global public-health policies on harmful use of alcohol,

1. URGES Member States:

(1) to collaborate with WHO in developing a draft global strategy on harmful use of alcohol based on evidence and best practices, with special emphasis on an integrated approach to protect at-risk populations and people hurt by the harmful drinking of others;

(2) to strengthen national responses, as appropriate, to public-health problems caused by harmful use of alcohol, taking advantage of evidence on effectiveness and cost-effectiveness of strategies and interventions to reduce alcohol-related harm;²

(3) to determine comprehensive, multisectoral national alcohol strategies and programmes, including plans for implementation, taking into account the substantial role of informal alcohol production, distribution and consumption, and to establish, sustain or reinforce as appropriate national targets to reduce the harmful use of alcohol;

(4) to establish or to develop appropriate national monitoring systems on alcohol consumption and its health and social consequences, linked to WHO global and regional information systems, in order to guide adequate national responses and to measure progress in reducing harmful use of alcohol at national, regional and global levels;

2. CALLS UPON international organizations and bodies concerned with harmful use of alcohol to engage in global efforts to reduce alcohol-related harm;

3. REQUESTS the Director-General:

(1) to address the public-health problems caused by harmful use of alcohol in the context of the priority given to prevention and control of noncommunicable diseases;

(2) to strengthen and intensify the work of the Secretariat on developing and implementing global and regional strategies and plans, as appropriate, and to provide technical support to Member States when requested for reducing public-health problems

¹ *IARC Monograph on the Evaluation of Carcinogenic Risks to Humans*. Lyons, International Agency for Research on Cancer, Vol. 96, 2007.

² Document A60/14, paragraphs 5 and 6.

caused by harmful use of alcohol, taking into account the full range of its health, social and economic consequences;

(3) to continue to collaborate with Member States and concerned intergovernmental organizations, health professionals, nongovernmental organizations, and other relevant stakeholders in order to promote implementation of effective policies and programmes to reduce harmful use of alcohol, and to develop a draft global strategy;

(4) to continue consulting with the private sector, particularly the alcoholic beverage industry, on ways it could contribute to reducing harmful use of alcohol;

(5) to submit to the Sixty-second World Health Assembly a draft global strategy on reducing the public-health problems caused by harmful use of alcohol, based on evidence and best practices, with special emphasis on an integrated approach to protecting at-risk populations and people harmed by drinking of others.

The financial and administrative implications of the draft resolution were as follows:

1. Resolution Global action on the harmful use of alcohol	
2. Linkage to programme budget	
Biennium 2008–2009	Expected result
Strategic objective: 6	4. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution will strengthen and intensify the Secretariat's work on developing and implementing strategies and plans and providing technical support to Member States for reducing public-health problems caused by harmful use of alcohol. It will also lead to the development of a global plan on reduction of alcohol-related harm in consultation with Member States, nongovernmental organizations, private-sector entities and other relevant stakeholders.	
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\$ 18 830 000	
(b) Estimated cost for the biennium 2008–2009 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 12 830 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 10 400 000	
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 mainly take place at the global level, but consultations with Member States will be organized in the six regions.	

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

For the biennium 2008–2009, two additional staff in the professional category, and one additional general service staff member will be required at headquarters. No additional staff will be required at regional level.

(c) Time frames (indicate broad time frames for implementation and the evaluation)

Activities will be concentrated on preparing for the report that is to be submitted to the Sixty-second World Health Assembly. Work will then focus on follow-up activities and evaluation until the end of 2013.

Ms NILSSON-KELLY (Sweden), introducing the draft resolution, said that the adoption of resolution WHA58.26 had marked a significant step towards improving the health of millions of people suffering from the harmful use of alcohol. Since then, however, many Member States had moved towards health advocacy as an approach. WHO regional committees had demonstrated awareness, growing concern, and willingness to explore ways of reducing the harmful use of alcohol. Moreover, the Secretariat had reported to the Executive Board at its 120th session in January 2007 that further consultations were needed in order to draft additional recommendations and to construct a framework for global activities. The intention of the draft resolution was to provide guidance on such a framework.

Progress had been made by WHO in tackling risk factors and determinants for noncommunicable diseases, yet strategic directions for combating the harmful use of alcohol was lacking. The proposed draft resolution was a step forward. Several Member States had expressed their support for the draft resolution, but wished to see clearer, sharper language.

The second draft resolution reflected the amendments discussed in an informal working group convened by New Zealand and was intended to facilitate discussion in the Committee. If it had caused more confusion than clarity, she apologized.

Dr BLOOMFIELD (New Zealand) said that coordinated global action was essential, and he strongly supported the draft resolution. The informal working group had made available in all six official languages the proposed amendments that some delegations had been expected to discuss. He stressed that the group did not have a negotiating mandate, nor did the second draft resolution replace the earlier one.

As convener of the informal working group, he summarized the main proposals raised: in the third preambular paragraph, to amend or delete the reference to the recommendations of the Expert Committee on Problems Related to Alcohol Consumption; to include a preambular paragraph on the illicit production and consumption of alcohol; to include a reference to infectious diseases and their relationship with harmful alcoholic use; to change the word “plan” to “strategy” in the relevant paragraphs, so that Member States and the Director-General would be requested to develop a draft global strategy; and to be clearer about the roles of different stakeholders, in particular that of the private sector or industry, including with respect to developing and implementing the proposed draft strategy.

Dr HUWAIL (Iraq) said that the harmful use of alcohol was not a significant health problem in Iraq. Nevertheless, planning for the integration of mental health services into primary health care had taken into account the need for prevention of harmful use. Sustainable development and the integration of health issues into economic and social development were essential to overcoming the problem.

Dr PANTELEEVA (Russian Federation) said that the harmful use of alcohol and its social consequences were topical matters in her country. The anti-alcohol campaign conducted from 1985 to 1987 had had positive but short-lasting effects, and the reforms of the 1990s had led to an increase in

alcohol use. Although drinks with low alcoholic content had been introduced, alcoholism was emerging among young people and would have epidemiological consequences. WHO should adopt a strategy that took account of the complexities involved at individual and societal levels and that enabled each country to adopt policies tailored to national conditions. Her country would not accept measures to increase the price of alcoholic drinks, which would simply lead to the production of illicit alcohol and potent liqueurs and spirits. She recognized the need for further research into the harmful effects of alcohol use and for a global strategy based on experience already gained, especially in the European Region.

Mr JAKSONS (Latvia) supported the second draft resolution although it could be more precise. Drinking behaviours were a key aspect of the problem. He drew attention to the important distinction between the “harmful use of alcohol” and “alcohol-related harm”, the term previously used, stressing the much broader approach it implied. “Alcohol – less is better”, the strong message in the European Charter on Alcohol adopted by the European Conference on Health, Society and Alcohol (Paris, 12-14 December 1995), was the basis on which WHO should build the strategy to reduce the harmful use of alcohol. He endorsed the proposal to reduce the availability of alcohol, especially to young people.

Dr AYDINLI (Turkey) emphasized the need to strengthen education and for global information and regional surveillance systems, particularly for young people. Technical support and cooperation between organizations would be required. Manufacturers and distributors should be encouraged to join the effort to reduce the harmful effects of alcohol consumption. Countries should draw up national strategies and programmes.

Dr PRAK Piseth Raingsey (Cambodia) said that the availability and consumption of all types of alcohol, including home-made and locally produced beverages, had increased in Cambodia. Numerous deaths had resulted from consumption of drink contaminated with cheap lethal ingredients, such as methanol, or pesticides. There were no restrictions on the sale or advertising of alcohol and no requirement for health warnings. The economic loss to society resulting from the harmful consumption of alcohol was likely to be substantial when the impact on health, productivity and economic development was taken into account. She urged the Health Assembly to adopt the resolution.

Mr SEGURA (Dominican Republic) pointed out that alcohol was used not only to produce beverages but for other purposes, including medicines and cosmetics. He suggested, therefore, that the term “harmful use of alcohol” should be replaced in the draft resolution by the term “harmful effect of the misuse of alcohol”. He proposed deleting the tenth preambular paragraph of the first draft resolution because, apart from the claims of one monograph, there was as yet no conclusive evidence to support the theory that ethanol in alcoholic beverages was carcinogenic to humans.

Dr MUSTAFA (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region was the least affected by the burden of harmful alcohol use because, for religious reasons, alcohol was banned in most countries. Nevertheless, alcohol consumption by vulnerable young people had become a concern. The report emphasized global surveillance systems. However, most global data were estimated, and their reliability in many countries was questionable. Moreover, most questionnaires used in routine surveillance did not record illicit alcohol consumption or the more unusual medical complications of alcohol abuse. Data collection systems must be appropriate for all countries.

Most strategies to combat alcohol misuse had been elaborated in countries where alcohol was sold freely, and focused on regulatory mechanisms such as taxation, price, minimum age for purchasing alcohol and opening hours of sales outlets. However, such strategies would not work well in countries where most of the alcohol consumed was obtained unofficially or produced illicitly in the local area or in the home. Countries must develop their capacity to control unofficial and illicit alcohol consumption through initiatives centred on the community, and on awareness-raising and educational

programmes. The health systems of many countries would need to expand their capacity to manage alcohol dependence and alcohol-related health problems.

The report should have stressed the need to increase capacity at the regional and country levels for the management of alcoholism and other alcohol-related problems. The comprehensive policy framework referred to in paragraph 11 should use customized surveillance, which would also apply to countries where most alcohol was obtained unofficially. The monitoring tools referred to in paragraph 12 should be adapted in order to take both global uniformity and local differences into account. Global leadership and advice on responding to public health problems caused by alcohol should adapt global strategies to the local level. The report should also have highlighted the need to support the prevention of alcohol problems through educational programmes for young people. The regional differences he had described should be reflected in the draft resolution.

Dr DEGROOF (Belgium) said that it was unclear which draft resolution was being considered. Belgium was preparing a national action plan on alcohol that gave priority to activities aimed at young people. Measures already taken included a ban on the sale of spirits to minors; campaigns to raise awareness among young people; and campaigns aimed at drivers, combined with increased alcohol testing, which had reduced drink-driving.

WHO's work on prevention and control of noncommunicable diseases in general should be scaled up. However, he doubted whether data on the social and health consequences of the misuse of alcohol were comparable and reliable, as called for in paragraph 1(4) of the draft resolution. He proposed the following amendment to that subparagraph: "to establish or develop appropriate monitoring systems on alcohol consumption and its adverse effects using uniform definitions, indicators and methods developed by WHO".

Ms REITENBACH (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as Ukraine and the Republic of Moldova aligned themselves with her statement. Europe was greatly affected by the consequences of the harmful use of alcohol. A draft strategy on reducing alcohol-related harm, which included a comprehensive account of the risks and consequences, had been adopted by the European Union.

Member States should promote a cross-sectoral approach to the prevention of alcohol-related harm, involving coordinated strategies and actions at municipal, regional and national levels. She emphasized the enforcement of existing legal provisions, for drink-driving or the serving of alcoholic drinks to minors, as well as the promotion of healthy choices through marketing, product information and consumer education.

Reports on the implementation of the strategy would be available from 2008, and a forum for alcohol and health would be set up for all interested stakeholders. WHO should take the lead in devising a strategy for combating alcohol-related harm, based on science, evidence and best practice. National targets, monitoring systems and implementation plans needed to be established or reinforced.

She supported the first draft resolution, but with an amended third preambular paragraph that read: "Recognizing progress made by the Secretariat and noting the recommendations of the Expert Committee on Problems Related to Alcohol Consumption".

Dr LEVENTHAL (Israel) said that the harmful use of alcohol had only been a problem in his country for about 15 years. The associated increase in road traffic accidents, violence and premature deaths affected young people particularly. There was an urgent need for a global strategic plan of action, as recommended in the second draft resolution.

Dr HIGUCHI (Japan) said that every Member State must respond to the problems caused by the harmful use of alcohol by choosing evidence-based and cost-effective policies appropriate to its own economic, social and cultural situation and the nature of the problems caused by harmful use of

alcohol. He also stressed the significance of exchanging information, including basic data on alcohol consumption and on the nature and precise causes of and responses to alcohol-related problems.

He supported the draft resolution in principle, although some points from the revised version might be taken into account. In the former, “plan” in paragraphs 1(1) and 3(4) should be replaced by “strategy”, giving Member States more flexibility. A definition of the term “global strategy” should be added, indicating that it was a guide to help Member States to promote and implement their own responses to problems caused by the harmful use of alcohol. Paragraph 3(1) should be deleted, as it referred to noncommunicable diseases in general and not specifically to problems caused by harmful use of alcohol. A new subparagraph should be added to paragraph 3, requesting the Director-General to report periodically to the Health Assembly on the global situation relating to the harmful use of alcohol, policy responses and progress made.

Dr BLOOMFIELD (New Zealand), speaking also on behalf of Sweden, formally withdrew the second draft resolution, since it had clearly caused confusion among delegates.

Dr THAKSAPON THAMARANGSI (Thailand) said that policy on alcohol control must be evidence-based, relevant and cover both population-based and individual interventions. He had noted that recommended cost-effective strategies included taxation and control over the availability of alcohol. In trade and economic terms, alcohol was treated like any other commodity, but the negative health and economic impact of alcohol misuse far outweighed any benefits. WHO should lead in raising awareness outside the health sector of the harm which alcohol could cause. Alcohol had never been a theme for World Health Day, for example.

The consumption of alcohol had increased greatly in the developing world. The South-East Asia Region had adopted policy options relating to alcohol in 2006. The recommendations of the Expert Committee on Problems related to Alcohol Consumption should be adopted as the basis for global action.

Consultation with the alcoholic beverage industry would help implementation, but it must not be allowed to influence policy formulation. Like the tobacco industry, the alcoholic beverage industry considered that effective policies such as taxation and the regulation of availability of its products were not in its best interests. He supported the draft resolution of which his delegation was a sponsor.

Mr STRAWCZYNSKI (Canada) said that evidence from his own country suggested that reducing alcohol-related harm required a multifaceted approach, with strategies such as social marketing, community information campaigns, regulation and enforcement.

In the third preambular paragraph of the draft resolution, the reference to the Expert Committee on Problems related to Alcohol Consumption should be removed, since those recommendations had not been circulated widely enough to allow full consideration of their implications. A new preambular paragraph should be added, reading: “Recognizing the harm caused by drinking during pregnancy;” and the tenth preambular paragraph should be amended to read: “Noting the complexity of alcohol-related problems, the need to address the underlying causes of the harmful use of alcohol, and the need for comprehensive evidence-based policy measures ...”. Paragraph 3(4) should be amended to read: “... a draft global plan that can be adapted to national circumstances as appropriate ...”.

Dr MAOATE (Cook Islands) said that legislation had been drafted in his country to deal with the negative effects of alcohol use; the extensive social consequences included the deaths of young people in road traffic accidents and poor health. Strategic measures were needed. He supported the draft resolution and any additional amendments that would strengthen it.

Mr EINARSSON (Iceland) urged Member States to adopt the draft resolution by consensus. Meaningful results on the question could only be achieved through international consensus.

Mr VOLJČ (Slovenia) called for more public and political attention to the harmful use of alcohol often demonstrated by adults or young people. Such models could lead to harmful drinking

habits, sometimes resulting in fatal or serious injuries. With birth rates decreasing and societies ageing, every young life lost represented the loss of a future parent, a loss for society. Reducing harmful drinking among young people required collaboration between the sectors and with interested nongovernmental organizations. Slovenia would highlight the issue of intentional and unintentional injuries related to alcohol, particularly among young people, during its forthcoming presidency of the European Union.

Turning to the draft resolution, he suggested inserting the word “youngsters” in the ninth preambular paragraph, after “in particular”.

Ms JOHRI (India) commented that policies and interventions targeting vulnerable populations could prevent alcohol-related harm. She endorsed the strategies outlined in document A60/14, and supported the draft resolution as amended by the delegates of Afghanistan, Norway and other Member States.

Professor PEREIRA MIGUEL (Portugal) observed that alcohol consumption was high in his country, resulting in considerable alcohol-related harm. He supported the draft resolution.

Mr GARBANZO (Costa Rica) agreed that the harmful use of alcohol was a public health problem with serious social and economic repercussions, necessitating policies aimed at the general public as well as vulnerable groups. Although alcohol consumption per capita was relatively low in Costa Rica, the harmful use of alcohol was prevalent among young people aged between 18 and 30 (40%), and those between 12 and 24 years (24%).

Effective policies to counteract the harmful use of alcohol should focus on supply and demand, and should target those who drank to excess and places where high quantities of alcohol were consumed. The accessibility, availability and marketing of alcoholic beverages should be regulated in order to reduce supply and the social acceptability of alcohol consumption. Marketing, advertising and sponsorship should be regulated in order to protect those under 18, together with inter-institutional approaches to the control, prevention and treatment of alcohol-use disorders.

The need to reduce alcohol-related harm in order to protect individuals and groups negatively affected by others' drinking was particularly relevant to road traffic accidents, as highlighted by the Declaration of San José of September 2006. In 2000, Latin America and the Caribbean had had the highest average incidence of fatalities from road traffic accidents in the world, and most were related to excessive alcohol consumption. His Government was seeking examples of best practice that it could adapt to the problem in Costa Rica. He supported the draft resolution.

Dr TANGI (Tonga), speaking as a sponsor of the draft resolution, supported the proposal to delete the third preambular paragraph, and suggested amending the fifth preambular paragraph to begin “Noting the urgent need to develop effective strategic measures”. The word “of” before “colorectal” in the seventh preambular paragraph should be deleted. He supported the proposal to replace the word “plan” by “strategy” in paragraphs 1(1) and 3(4).

Following adoption of resolution WHA58.26, there had been wide consultation in the Western Pacific Region. The resulting regional strategy, adopted in September 2006, emphasized reducing the risk and minimizing the impact of the harmful use of alcohol, regulating the accessibility and availability of alcohol, and implementation of the strategy. Although he had no objection to the current discussions, he failed to understand why a global strategy was under consideration when all the regions were implementing strategies in response to resolution WHA58.26.

(For resumption of the discussion, see section 3 below.)

2. DRAFT MEDIUM-TERM STRATEGIC PLAN, INCLUDING PROPOSED PROGRAMME BUDGET 2008–2009: Item 11 of the Agenda (continued)

Draft Medium-term strategic plan 2008–2009: Item 11.1 of the Agenda (Documents A/MTSP/2008–2013/PB2008–2009, A/MTSP/2008–2013/PB2008–2009 Corr.1 and Corr.2) (continued from the fourth meeting)

Proposed programme budget 2008–2009: Item 11.2 of the Agenda (Documents A/MTSP/2008–2013/PB2008–2009, A/MTSP/2008–2013/PB2008–2009 Corr.1 and Corr.2) (continued from the fourth meeting)

Real estate: draft capital master plan: Item 11.3 of the Agenda (Documents A60/5 and A60/INF.DOC./3) (continued from the fourth meeting)

Mrs PRADHAN (Assistant Director-General) said that the Medium-term strategic plan 2008–2013 had been based on detailed discussions of the Eleventh General Programme of Work. Technical teams from the six regions and headquarters had worked together on the strategic objectives. Member States had provided guidance and support through technical discussions at the regional level for the General Programme of Work and the strategic plan, as had the six regional committees and the Programme and Budget Advisory Committee and the Executive Board.

Responding to questions and comments, she said that strategic objective 6 dealt with the six major risk factors that accounted for more than 60% of mortality and 50% of morbidity by focusing on a core set of intersectoral population strategies. Strategic objective 3 addressed primary prevention efforts aimed at other risk factors for noncommunicable diseases, injuries, violence and mental disorders. Visual impairment had been added to strategic objective 3, in line with the advice of several Member States.

Strategic objective 4 covered most of the current programmes affecting sexual and reproductive health, but aspects of the topic were also addressed through other strategic objectives, such as 2 and 6. The Secretariat had noted the comments by the delegates of El Salvador, Kuwait, Malta, Paraguay, Saudi Arabia and the United States of America.

The Secretariat recognized the need to maintain the funding level for the Codex Alimentarius Commission, and to ensure more transparent reporting on the WHO contribution to the Codex budget. Strategic objective 9 had a strong focus on normative work relating to nutrition, food safety and food security.

The Secretariat had consolidated the proposed objectives related to health systems into one single strategic objective with a comprehensive approach to improving performance. The scope of strategic objective 10 reflected that approach; by aligning the work to be undertaken, the large number of expected results had been significantly reduced. However, the Secretariat had noted the need for further alignment and greater clarity.

The level of the budget for health financing and social protection in the Proposed programme budget 2008–2009 was US\$ 116 million.

Public health innovation and intellectual property were integral to the Organization's work under several strategic objectives. Most of that work, however, fell under the Organization-wide expected result 11.1. Expected results with relevant budgets would be developed, in the light of the outcome of the Open-ended Intergovernmental Working Group and decisions taken at the Sixty-first World Health Assembly.

The reference in strategic objective 11 to UNITAID not funding work on promoting the rational use of medicines would be removed from the final document.

WHO was working on trade and health, with WTO, the World Bank and other relevant partners, in accordance with resolution WHA59.26.

A draft plan of action responded specifically to a recommendation from the Joint Inspection Unit of the United Nations System on multilingualism, and would be further discussed by the

Executive Board at its 121st session. The plan of action, costing about US\$ 20 million over the six years 2008–2013, would be included under strategic objective 12.

The Director-General had recently committed herself to a full review of WHO publications, including an assessment of expenditure on publishing. The review would lead to a comprehensive publication policy for discussion at the Programme and Budget Advisory Committee in 2008, including recommendations on possible cost efficiencies.

Regarding WHO's participation in the United Nations harmonization and coordination processes, the country coordination strategy was being better integrated into the United Nations Development Assistance Framework and the health programmes of other United Nations agencies. She agreed that WHO's work with United Nations partners should be reflected throughout the strategic plan and the strategic objectives, and that would be taken into account in the workplans.

As requested by the Executive Board, the capital master plan requirements for 2008–2009 were budgeted as an integral part of the programme budget, and were included in strategic objective 13.

She emphasized gender mainstreaming throughout the Organization's programmes. In her address to the Health Assembly, the Director-General had stated that she was asking all programmes to collect and report data disaggregated by sex, and had given instructions for gender mainstreaming to be considered in all activities. All strategic objectives would incorporate the gender perspective and WHO would be guided by the new gender strategy in that regard.

With regard to the financing of the programme budget, the Secretariat and Member States were working to increase the mobilization of negotiated core contributions. Mechanisms were being designed for that purpose. The Secretariat was also considering the level of programme support costs needed to cover the costs inherent in programme implementation.

Activities would be scaled down or phased out once completed or when new priorities emerged. In accordance with the Director-General's instructions, greater budgetary discipline would be exercised.

The CHAIRMAN drew attention to the draft resolution on the appropriation for the financial period 2008–2009, which read:

The Sixtieth World Health Assembly,

1. NOTES the total effective budget under all sources of funds of US\$ 4 227 480 000;
2. RESOLVES to appropriate for the financial period 2008–2009 an amount of US\$ 1 038 840 000, financed by net assessments on Members of US\$ 928 840 000, estimated Miscellaneous Income of US\$ 30 000 000, and transfer to Tax Equalization Fund of US\$ 80 000 000, as shown below:

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income Amount US\$
1	To reduce the health, social and economic burden of communicable diseases	85 368 000
2	To combat HIV/AIDS, malaria and tuberculosis	48 996 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence, injuries and visual impairment	45 215 000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	55 909 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	17 631 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	39 077 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	14 427 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	32 736 000
9	To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	23 054 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	139 630 000
11	To ensure improved access, quality and use of medical products and technologies	31 244 000

Appropriation section	Purpose of appropriation	Appropriations financed by net assessments and Miscellaneous Income Amount US\$
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	139 448 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	286 105 000
	Effective working budget	958 840 000
14	Transfer to Tax Equalization Fund	80 000 000
	Total	1 038 840 000

3. FURTHER RESOLVES that:

(1) notwithstanding the provisions of Financial Regulation 4.3, the Director-General is authorized to make transfers between the appropriation sections of the effective working budget up to an amount not exceeding 10% of the amount appropriated for the section from which the transfer is made; all such transfers shall be reported in the financial report for the financial period 2008–2009; any other transfers required shall be made and reported in accordance with the provisions of Financial Regulation 4.3;

(2) amounts not exceeding the appropriations voted under paragraph 1 shall be available for the payment of obligations incurred during the financial period 1 January 2008 to 31 December 2009 in accordance with the provisions of the Financial Regulations; notwithstanding the provisions of the present paragraph, the Director-General shall limit the obligations to be incurred during the financial period 2008–2009 to sections 1 to 13;

(3) the amount of the contribution to be paid by individual Members shall be reduced by the sum standing to their credit in the Tax Equalization Fund; that reduction shall be adjusted in the case of those Members that require staff members to pay income taxes on their WHO emoluments, taxes which the Organization reimburses to said staff members; the amount of such tax reimbursements is estimated at US\$ 11 284 310 resulting in a total assessment on Members of US\$ 940 124 310;

4. DECIDES:

(1) that the Working Capital Fund shall remain at the level of US\$ 31 000 000, as earlier decided under resolution WHA56.32;

5. NOTES that the expenditure in the programme budget for 2008–2009 to be financed by voluntary contributions is estimated at US\$ 3 268 640 000 as shown below:

	Purpose	Amount US\$
1	To reduce the health, social and economic burden of communicable diseases	808 675 000
2	To combat HIV/AIDS, malaria and tuberculosis	657 936 000
3	To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence, injuries and visual impairment	112 889 000
4	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals	303 924 000
5	To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	200 782 000
6	To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex	122 980 000
7	To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	51 478 000
8	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	97 720 000
9	To improve nutrition, food safety and food security throughout the life-course and in support of public health and sustainable development	103 880 000
10	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research	374 424 000
11	To ensure improved access, quality and use of medical products and technologies	102 789 000

	Purpose	Amount US\$
12	To provide leadership, strengthen governance and foster partnership and collaboration with countries, the United Nations system, and other stakeholders in order to fulfill the mandate of WHO in advancing the global health agenda as set out in the Eleventh General Programme of Work	74 896 000
13	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiently and effectively	256 267 000
	Total	3 268 640 000

The draft resolution was approved.¹

The CHAIRMAN drew attention to the draft resolution on the Medium-term strategic plan 2008–2013, which read:

The Sixtieth World Health Assembly,
 Recalling resolution WHA59.4 on the Eleventh General Programme of Work 2006–2015;
 Recognizing that the Eleventh General Programme of Work sets forth a global health agenda and charts the broad strategic framework and direction for the work of WHO;

Noting that the Medium-term strategic plan provides a flexible multiannual framework to guide and ensure continuity in the preparation of biennial programme budgets and operational plans over three bienniums in line with the global health agenda established in the Eleventh General Programme of Work;

Acknowledging that more specific priorities are set out in the Medium-term strategic plan 2008–2013, defined as strategic objectives, and in the two yearly Programme budget, as expected results;

Noting the proposed programme budgets 2010–2011 and 2012–2013 will be submitted to the Sixty-second World Health Assembly and Sixty-fourth World Health Assembly, respectively, for decision;

Welcoming the cross-cutting nature of the strategic objectives that create synergies and promote collaboration between different programmes by capturing the multiple links among determinants of health, health outcomes, health policies, systems and technologies;

Acknowledging that the Medium-term strategic plan, by moving away from narrowly defined areas of work to strategic objectives, provides a more strategic and flexible programme structure that better reflects the needs of countries and regions, and facilitates more effective coordination and collaboration across the Organization and with Member States, organizations of the United Nations system and other stakeholders;

1. ENDORSES the Medium-term strategic plan 2008–2013;
2. CALLS UPON Member States to identify their role and actions to be taken in order to achieve the strategic objectives contained in the Medium-term strategic plan;

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA60.12.

3. INVITES concerned organizations of the United Nations system, international development partners, and agencies, international financial institutions, nongovernmental organizations and private-sector entities to consider their contribution in supporting the strategic objectives contained in the Medium-term strategic plan;
4. DECIDES to review the Medium-term strategic plan 2008–2013 every two years in conjunction with the Proposed programme budget with a view to revising the Medium-term strategic plan, including its indicators and targets, as may be necessary;
5. REQUESTS the Director-General:
 - (1) to use the Medium-term strategic plan in providing strategic direction for the Organization during the period 2008–2013 in order to advance the global health agenda contained in the Eleventh General Programme of Work;
 - (2) to use the Medium-term strategic plan to guide preparation of the three biennial programme budgets 2008–2009, 2010–2011 and 2012–2013 and operational plans through each biennium;
 - (3) to collaborate with concerned organizations of the United Nations system, international development partners, and agencies, international financial institutions, nongovernmental organizations and private-sector entities in implementing the Medium-term strategic plan;
 - (4) to recommend to the Health Assembly through the Executive Board, with the Proposed programme budgets 2010–2011 and 2012–2013, revisions to the Medium-term strategic plan as may be necessary;
 - (5) to report to the Sixty-second World Health Assembly through the Executive Board at its 125th session on implementation of this resolution, and to report biennially thereafter on progress.

The draft resolution was approved.¹

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (resumed)

Evidence-based strategies and interventions to reduce alcohol-related harm: Item 12.7 of the Agenda (Documents A60/14 and A60/14 Add.1) (resumed)

Dr KAMWI (Namibia) said that his Government regarded the abuse of alcohol as a serious public health concern. Statistics showed that alcohol was the most widely abused substance in Namibia. Most road traffic accidents were caused by drunk driving, particularly during the festive season. At the President's initiative a national policy on alcohol was being finalized. A Coalition on Responsible Drinking had been set up by the Ministry of Health and Social Services, with participants including United Nations organizations, trade and industry, and road traffic authorities. The Coalition was spearheading awareness about responsible drinking, discouraging the advertising of alcoholic beverages during sports events, and broadcasting promotional messages by radio. Alcohol abuse could lead to irresponsible behaviour and the transmission of diseases, including HIV infection. In some towns, there was a hotline which intoxicated drivers could telephone in order to be taken home, rather than driving themselves. He supported the draft resolution.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA60.11.

Ms TOELUPE (Samoa), supporting the draft resolution, suggested inserting the text “gender responsive” after “balanced” in the twelfth preambular paragraph. The global strategy or plan should reflect policies already adopted at the regional and country levels. She was grateful for the assistance of the Regional Office for the Western Pacific and other partners.

Dr WANGCHUK (Bhutan) said that, in spite of many activities in the countries of the South-East Asia Region, including the adoption of legislation, in response to earlier Health Assembly resolutions on the subject, the harmful use of alcohol continued to have serious consequences for health and an adverse impact on the fabric of society. WHO was providing strategic guidance and was maintaining the momentum on the subject.

Dr ALLEN-YOUNG (Jamaica), speaking on behalf of a working group of member countries of the Caribbean Community, expressed concern at the reference in the draft resolution to the recommendations of the Expert Committee on Problems related to Alcohol Consumption. Those recommendations were not official, and the Technical Report containing them, also referred to, had not been translated or made available to delegations. The Executive Board had not discussed that Report nor had the Secretariat responded to it. The Report should be made available to delegations and be submitted to the Executive Board for discussion at its next session.

Member States should devise strategies to deal with the abuse of alcohol in their countries, including illegal production and sale. Additional evidence on the relationship between alcohol and noncommunicable diseases was also needed as a basis for policy decisions.

The draft resolution submitted by the delegations of New Zealand and Sweden, and subsequently withdrawn, presented a more accurate approach than the remaining draft resolution, which needed changes for accuracy and procedure. She suggested establishing a drafting group in order to produce a better text.

Dr GONZÁLEZ (Cuba) said that his country had introduced a programme of strategies in order to prevent the harmful use of alcohol, aimed at priority groups such as young people and pregnant women. A network of community mental health centres had been set up. Primary health-care institutions were also involved in preventive work and treatment. The family was a major focus of efforts, given its important role in combating excessive alcohol consumption. A postgraduate course in community mental health aimed at family physicians and other health-care workers had been completed by more than 500 professionals. The mass media were also involved in discouraging the excessive use of alcohol. Regulations governing the sale of alcoholic drinks to minors in the vicinity of schools and during festivals had been drawn up. Cuba had undertaken joint activities with Panama, the Dominican Republic and the Bolivarian Republic of Venezuela through PAHO, and would welcome a broader exchange of experience between countries.

In Cuba’s experience, national activities focusing on prevention, health promotion and treatment were the basic tools for preventing the excessive use of alcohol. The most cost-effective methods were those recommended for avoiding noncommunicable diseases, namely, the promotion of healthy lifestyles, health education and community participation. A global plan should recognize national strategies tailored to the specific socioeconomic conditions of each country. Primary health care systems should be given a leading role.

He agreed with the delegate of Jamaica that the reference in the draft resolution to a technical report not available to Member States should be omitted.

Dr VIOLAKI-PARASKEVA (Greece) drew attention to the link between alcohol and the danger of violence, particularly in the family.

Mrs DAVID-ANTOINE (Grenada), speaking on behalf of the member countries of the Caribbean Community, said that a commitment to global action on the harmful use of alcohol should be guided by all the evidence available. She supported the proposal to delete the reference, in the third preambular paragraph of the draft resolution, to the recommendations of the Expert Committee on

Problems related to Alcohol Consumption. In the twelfth preambular paragraph, the words “institutional and socioeconomic” should be inserted before “religious”. The draft resolution should include a reference to the risks associated with the illicit production and sale of alcohol. The reference in paragraph 3 to different stakeholders could be misconstrued; it should reflect the wording of resolution WHA58.26. A global strategy to reduce alcohol-related harm would be better than a global plan. She suggested referring the draft resolution to a drafting group for further consideration.

Dr CHITUWO (Zambia), speaking on behalf of the 46 Member States of the African Region, said that the proportion of deaths in the Region attributable to harmful use of alcohol was on the rise. People who misused alcohol and drugs were more likely to engage in risk-taking behaviours, thereby contributing to the spread of HIV. There was also clear evidence of the harmful effects of alcohol on the unborn child, and of the links with increased domestic violence, road traffic accidents and poverty. He supported the measures being implemented by the Regional Office for Africa, such as capacity building for the prevention, management and treatment of harmful use of alcohol and other psychoactive substances, especially at the community level. Guidelines should be prepared for key stakeholders on the effective implementation of policies and interventions. A global strategy should be formulated on reduction of harmful use of alcohol and substance abuse. A regional network should be established to collect, analyse and disseminate data in order to counter any opposition to such a strategy. Supporting the draft resolution, he proposed adding to the preamble a further paragraph to read, “Recognizing the high association between harmful use of alcohol and HIV infection”.

Mr MENESES (Mexico) said that in Mexico the harmful use of alcohol accounted for 9% of mortality, 60% of traffic accidents, 70% of incidents of domestic violence and a high proportion of morbidity, premature deaths and absenteeism from work and school. He supported the draft resolution, suggesting the addition of a paragraph urging Member States to ensure that regulatory and health promotion activities should involve the private sector in efforts to reduce the harmful use of alcohol. The global strategy should be submitted to the Sixty-first World Health Assembly, rather than the Sixty-second.

Mr HOHMAN (United States of America) said that the discussion on the complex draft resolution, which had appeared in two different versions, had underscored the need to respect the procedure recommended by the Health Assembly that all draft resolutions should be submitted through the Executive Board. It was regrettable that the sponsors of the draft resolution had not followed that procedure, and that the delegates of New Zealand and Sweden had withdrawn their version, since it represented a significant improvement. He requested guidance on how the Chairman proposed to proceed. He wished to propose several amendments, but if an open-ended drafting group was to be established it might be better to submit them to the drafting group first.

Mr SAMO (Federated States of Micronesia) said that harmful use of alcohol represented a threat to public health worldwide and often affected young people. A strategy would have to include community-based interventions targeted towards all the population. He endorsed the views expressed by the delegate of Tonga.

Dr SHRESTHA (Nepal) said that harmful use of alcohol was a major public health problem in Nepal, especially in rural areas and among poor people. More than two thirds of road traffic accidents, and incidents of domestic and street violence were attributable to alcohol use. The various factors involved should be taken into account in a holistic manner, and integrated measures developed. He supported the draft resolution, suggesting that paragraph 3(1) should become paragraph 3(3).

Dr SOLOFONIRINA (Madagascar) said that the harmful use of alcohol was a growing public health problem in Madagascar where 24.5% of the population drank to excess. The advertising of beverages with an alcohol content of more than 1% by volume had been banned, and activities in schools were raising awareness of the risks of tobacco and alcohol use.

Dr MACHAGE (Kenya), speaking as a sponsor of the draft resolution, urged Member States to support it, underlining the principle that only they could determine national policies. He supported the proposal by the delegate of Thailand that the private sector should be confined to policy implementation, not policy formulation. The Director-General had taken a firm stand in refusing to engage with the tobacco industry, and should do likewise in respect of the alcohol industry.

Ms NKURUNZIZA (Burundi) said that Burundi's measures to reduce the harmful use of alcohol included early closing of bars and a ban on selling beer to minors in clubs. She supported the draft resolution, as amended by the delegate of Zambia. Burundi would cooperate with all relevant partners in implementing its provisions. Since the harmful use of alcohol could lead to the spread of communicable diseases, paragraph 3(1) should include a reference to them.

Ms MCCONNEY (Barbados) shared concerns about the manner in which the draft resolution had been submitted. She supported the establishment of an open-ended drafting group. The reference to the recommendations of the Expert Committee should be deleted since the Committee's report had not been circulated. The words "in order to complement existing strategies to prevent and control noncommunicable diseases" in the fifth preambular paragraph should be deleted. In paragraph 3(1) the reference to noncommunicable diseases should be deleted; in paragraph 3(2) "and implementing" should be deleted; in paragraph 3(3) "and commitment free from conflict of interest" should be deleted; and in paragraph 3(4) "plan" should be replaced by "strategy", and "all" should be inserted before "evidence".

Barbados had a code of conduct for the advertising, distribution and sale of alcohol, and sales to and by minors were prohibited. The Ministry of Public Works had led a campaign to promote responsible drinking and driving, and breathalyser tests were planned. Similar campaigns were conducted by other government and nongovernmental organizations.

Mr FRANCIS (Trinidad and Tobago) said that in his country measures to promote behavioural change and reduce the harmful use of alcohol had included increased duties on alcohol, legislation to introduce breathalyser tests and a coherent policy for sponsorship of sporting events.

Turning to the draft resolution, he also regretted the unavailability of the report of the Expert Committee on Problems Related to Alcohol Consumption; it would have provided a valuable contribution to the debate. The report by the Secretariat indicated that further research was needed on the effect of the harmful use of alcohol on health, especially in respect of noncommunicable diseases. He emphasized that the global strategy must take account of national and regional strategies tailored to specific socioeconomic and cultural conditions. All relevant stakeholders should have a say in determining such strategies. He supported the proposal to establish a drafting group.

The meeting rose at 12:20.

EIGHTH MEETING

Friday, 18 May 2007, at 14:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Evidence-based strategies and interventions to reduce alcohol-related harm: Item 12.7 of the Agenda (Documents A60/14 and A60/14 Add.1) (continued)

Mr LOPEZ GARCÍA (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that in some regions alcohol accounted for more than 20% of deaths in the 15–29 year age group. Evidence suggested that in many countries alcohol was consumed at an increasingly young age. The harmful use of alcohol placed a heavy burden on society in terms of health care and economic and social costs. Medical students had a duty to combat alcohol abuse and to make people aware of the harmful consequences of excessive alcohol consumption. Combating at once the problems caused by the excessive use of alcohol would create hope for the young people of the future. The aim of the draft resolution was not to prejudice any particular sector or industry, but to reduce mortality and morbidity caused by the harmful use of alcohol. He therefore urged Member States to support the draft resolution.

Dr DANZON (Regional Director for Europe), responding to the comments made by the delegate of Tonga about the existence of several draft resolutions on the same subject, said that the harmful use of alcohol in his Region was as serious a problem as in other regions, if not more so, since it was responsible for more than 60 000 deaths a year, contributing significantly to the Region's burden of noncommunicable diseases. With the aim of preventing or reducing alcohol-related harm, the Regional Committee for Europe had adopted resolution EUR/RC55/1, "Framework for alcohol policy in the WHO European Region" in September 2005. Its text was fully consistent with that of the draft resolution.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that she had noted the interest in the setting up of an information system on local patterns of alcohol consumption, including informal consumption (which was inadequately covered by current systems), and on the impact of harmful use of alcohol on health. The strategies and interventions to reduce alcohol-related harm contained in the report were based on the best evidence currently available. Resolution WHA58.26 had also requested the Director-General to draw up recommendations for effective policies and interventions to reduce alcohol-related harm. An Expert Committee had met in Geneva in October 2006 to examine alcohol-related problems and the Secretariat would submit its report to the Executive Board for consideration at its forthcoming session. The text of that report had been posted on the Organization's web site in English only, but would be published in the other official languages as soon as possible.

The CHAIRMAN suggested that the Secretariat should prepare a revised draft resolution incorporating the proposed amendments and that a drafting group should be set up that would meet the following day in order to reconcile those amendments. A revised version of the draft resolution would then be circulated for consideration by the Committee subsequently.

Mr HOHMAN (United States of America) said that a drafting group meeting the following morning, Saturday, was not acceptable to his delegation: delegates would need time to consider a text incorporating the various amendments proposed before they were examined by the drafting group. With regard to the Expert Committee's report, it was also unacceptable that the Executive Board should be provided with a report that was available only in English and only on the Internet. He therefore requested that a printed copy be made available and that it include the names of the members of the Expert Committee.

Dr BLOOMFIELD (New Zealand) suggested that, in order to secure the full participation of delegations in the drafting group, the meeting should be held on Monday morning.

Ms BELLO DE KEMPER (Dominican Republic) asked whether it was appropriate to try to reach a consensus on the draft resolution before the Executive Board had considered the Expert Committee's report.

Mr BURCI (Legal Counsel), in reply to the comments made by the delegates of the United States of America and the Dominican Republic, explained that the Executive Board did not consider the reports of expert committees as such, but a report for information by the Director-General on the expert committee meetings held since the Board's previous session, containing his or her observations on the recommendations made and their implications for the Organization's work; the expert committees' recommendations were summarized in that report. Since the publication of expert committees' reports was a lengthy process, the practice had been that the Director-General's report did not wait for the full reports to become available.

Mr HOHMAN (United States of America) asked whether the report available on the Internet in English only was the full report of the Expert Committee or the report of the Director-General, and why the report of the Expert Committee, which had met in October 2006, had still not been made available to Member States in all the official languages.

Dr LE GALÈS-CAMUS (Assistant Director-General) confirmed that the complete text of the Expert Committee's report had been posted on WHO's web site. Because of the lengthy publishing processes involved, including editing and translation, it had not been possible to make several reports available in all languages. However, every effort would be made in order to ensure they were issued as quickly as possible.

Mr LEÓN GONZÁLEZ (Cuba) expressed concern that Member States had not yet been able to consider the Expert Committee's report since it had only recently been made available, and in only one language. He questioned the appropriateness of discussing a subject about which not all the information was to hand.

The CHAIRMAN said that he took it that the Committee agreed that the drafting group should meet on Monday, 21 May 2007.

It was so agreed.

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

Control of leishmaniasis: Item 12.3 of the Agenda (Documents EBSS-EB118/2006/REC/1, resolution EB118.R3 and A60/10) (continued from the third meeting)

The CHAIRMAN drew attention to the revision of resolution EB118.R3 incorporating amendments proposed by the delegations of Brazil, India, Iraq, Kuwait, Morocco and Thailand which read:

The Sixtieth World Health Assembly,

Having considered the report on control of leishmaniasis;¹

Recognizing that leishmaniasis is one of the most neglected tropical diseases, and that more than 12 million people worldwide are currently infected, with two million new cases each year;

Noting with concern that 350 million people are considered at risk and the number of new cases is on the increase;

Recognizing the lack of accurate information on the epidemiology of the disease for better understanding of the disease and its control;

Noting with concern that the disease affects the poorest populations in 88 countries, placing a heavy economic burden on families, communities and countries, particularly developing countries;

Noting the burden that treatment can place on families;

Bearing in mind that malnutrition and food insecurity are often identified as major causes of disposition to, and severity of, leishmaniasis;

Acknowledging the significant support extended by Member States and other partners and appreciating their continuing cooperation,

1. URGES Member States where leishmaniasis is a substantial public-health problem:
 - (1) to reinforce efforts to set up national control programmes that would draw up guidelines and establish systems for surveillance, data collection and analysis;
 - (2) to strengthen prevention, active detection and treatment of cases of both cutaneous and visceral leishmaniasis in order to decrease the disease burden;
 - (3) to strengthen the capacity of peripheral health centres **to deliver primary and secondary care, [Thailand]** so that they provide appropriate affordable diagnosis and treatment and act as sentinel surveillance sites;
 - (4) to conduct epidemiological assessments in order to map foci, and to calculate the real impact of leishmaniasis through accurate studies of prevalence and incidence, socioeconomic impact and access to prevention and care, and the extent of the disease in those affected by malnutrition and HIV;
 - (5) **to strengthen collaboration between countries that share common foci or disease threats, [Kuwait]** to establish a decentralized structure in areas with major foci of disease, strengthening collaboration between countries that share common foci, increasing the number of WHO collaborating centres for leishmaniasis and giving them a greater role, and relying on initiatives taken by the various actors **and interagency collaboration at national and international levels in all aspects of leishmaniasis control, detection and treatment, with national control programmes encouraging these initiatives with the private sector; [Kuwait]**
 - (6) **to promote the sustainability of surveillance and leishmaniasis control; [Brazil]**
 - (6 bis) **to improve knowledge about, and skills to prevent, leishmaniasis among people in the rural areas, including information on their socioeconomic status; [Thailand]**
 - (7) **to support studies on the surveillance and control of leishmaniasis;**
 - (8) **to share experiences in the development of studies of, and technologies on, the prevention and control of leishmaniasis; [Brazil]**

¹ Document A60/10.

2. FURTHER URGES Member States:
 - (1) to advocate high quality and affordable medicines, and appropriate national drug policies;
 - (2) to encourage research on leishmaniasis control in order:
 - (a) to identify appropriate and effective methods of control of vectors **and reservoirs; [Morocco]**
 - (b) to find alternative safe, effective and affordable medicines for oral, parenteral or topical administration involving shorter treatment cycles, less toxicity, and new drug combinations, and to define appropriate doses and duration of therapy schedules for these medicines;
 - (c) to determine mechanisms to facilitate access to existing control measures, including socioeconomic studies and health-sector reform in some developing countries;
 - (d) to evaluate and improve sensitivity and specificity of serological diagnostic methods for canine and human visceral leishmaniasis, including assessment of standardization and effectiveness;
 - (e) to evaluate effectiveness of alternative control measures such as use of bednets impregnated with long-lasting insecticide;
3. CALLS ON partner bodies to maintain and expand their support for national leishmaniasis prevention and control programmes and, as appropriate, to accelerate research on, and development of, leishmaniasis vaccine;
4. REQUESTS the Director-General:
 - (1) to raise awareness of the global burden of leishmaniasis, and to promote equitable access to health services for prevention and disease management;
 - (2) to draft guidelines on prevention and management of leishmaniasis, with emphasis on updating the report of WHO's Expert Committee on Leishmaniasis,¹ with a view to elaborating regional plans and fostering the establishment of regional groups of experts;
 - (3) to strengthen collaborative efforts among multisectoral stakeholders, interested organizations and other bodies in order to support the development and implementation of leishmaniasis control programmes;
 - (4) to frame a policy for leishmaniasis control, with the technical support of WHO's Expert Advisory Panel on Leishmaniasis;
 - (5) to promote research pertaining to leishmaniasis control and dissemination of the findings of that research;
 - (6) to monitor progress in the control of leishmaniasis in collaboration with international partners, **WHO regional offices and Member States affected by leishmaniasis; [Thailand]**
 - (7) to report to the Sixty-third World Health Assembly on progress achieved, problems encountered and further actions proposed in the implementation of leishmaniasis control programmes;
 - (8) **to promote action with the major laboratories in order to reduce the costs of medicines to developing countries;**
 - (9) **to promote and support:**
 - (a) **evaluation of the efficacy of new medicines,**
 - (b) **evaluation of dosage and length of treatment for existing medicines, and**
 - (c) **standardization of diagnostic reagents, in particular for visceral leishmaniasis;**

¹ WHO Technical Report Series, 1990, No. 793.

- (10) to facilitate improved coordination among multilateral institutions and international donors concerned with leishmaniasis; [Brazil]**
(11) to promote and support the development of safe, effective and affordable vaccines, diagnostic tools and medicines with less toxicity for leishmaniasis control. [Thailand]

Ms JOHRI (India) proposed, in line with her delegation's previous comments, the inclusion of a new paragraph at the end of the preambular part, to read: "Acknowledging that relevant Member States from the South-East Asia Region have committed themselves to collaborate in efforts to eliminate leishmaniasis kala-azar from the Region by 2015".

Dr ASLANYAN (Canada), noting that paragraphs 4(5) and 4(11) were repetitive and made no mention of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, even though leishmaniasis was one of its 10 focus diseases, proposed, on behalf of Belgium, Denmark, Iran, Norway and Sweden, that they should be combined into a single paragraph 4(5) which would read: "to promote research pertaining to leishmaniasis control, including in the areas of safe, effective and affordable vaccines, diagnostic tools and medicines with less toxicity, and dissemination of the findings of that research, notably through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases".

Dr SHRESTHA (Nepal) said that leishmaniasis was endemic in 12 Nepalese districts bordering India and that about 5.5 million people were at risk. In 2001–2005, 9084 cases had been reported, but the actual number could be much higher. In 2005, Bangladesh, India and Nepal had signed a Memorandum of Understanding committing themselves to efforts to eliminate leishmaniasis from the region by 2015. His Government was also committed to the regional strategy to eradicate the disease. He therefore supported the draft resolution, with the addition proposed by the delegate of India.

Professor FAIZ (Bangladesh) also expressed support for India's proposal.

Dr PHUSIT PRAKONGSAI (Thailand) supported the amendment proposed by the delegate of Canada. His delegation's proposed amendment, in paragraph 1(6 bis), had not been reflected correctly: the intention was to improve the socioeconomic status of the population in rural areas in order to combat leishmaniasis. He also wondered why that amendment had been numbered (6 bis): did that indicate that a choice must be made between subparagraphs (6) and (6 bis), when their subject matter was completely different?

Mr AITKEN (Representative of the Director-General), recapitulating the various proposals, said that the delegate of India had proposed inserting an additional paragraph after the final preambular paragraph of the revised resolution that would read: "Acknowledging that relevant Member States from the South-East Asia Region have committed themselves to collaborate in efforts to eliminate leishmaniasis kala-azar from the Region by 2005". The delegate of Canada had proposed merging paragraphs 4(5) and 4(11) into a new paragraph 4(5), to read: "to promote research pertaining to leishmaniasis control, including in the areas of safe, effective and affordable vaccines, diagnostic tools and medicines with less toxicity, as well as dissemination of the findings of that research, notably through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases". The delegate of Thailand suggested the following new wording for paragraph 1(6 bis): "to improve knowledge about, and skills to prevent, leishmaniasis among people in rural areas, as well as the socioeconomic status of people in rural areas".

The draft resolution, as amended, was approved.¹

Poliomyelitis: mechanism for management of potential risks to eradication: Item 12.4 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R1, and A60/11) (continued from the third meeting)

The CHAIRMAN drew attention to a revision of the draft resolution on poliomyelitis: mechanism for management of potential risks to eradication, incorporating amendments to resolution EB120.R1, proposed by Greece, India, Japan and Thailand, which read:

The Sixtieth World Health Assembly,
 Having considered the report on eradication of poliomyelitis;²
 Recalling resolution WHA59.1, urging Member States in which poliomyelitis is endemic to act on their commitment to interrupting transmission of wild poliovirus;
 Recognizing that the occurrence of endemic poliovirus is now restricted to geographically limited areas in four countries;
 Recognizing the need for international consensus on long-term policies to minimize and manage the risks of re-emergence of poliomyelitis in the post-eradication era;
 Recognizing that travellers from areas where poliovirus is still circulating may pose a risk of international spread of the virus;
Noting that the maintenance of high routine immunization coverage in poliomyelitis-free countries contributes to reducing the risk of outbreaks of disease due to wild poliovirus and minimizes the risk of outbreaks due to vaccine-derived poliovirus; [Japan]
 Noting that planning for such international consensus must commence in the near future,

1. URGES all Member States where poliomyelitis is still prevalent **in certain geographical areas, [India]** especially the four countries in which poliomyelitis is endemic:
 - (1) to establish mechanisms to enhance political commitment to, and engagement in, poliomyelitis eradication activities at all levels, and to engage local leadership and members of the remaining poliomyelitis-affected populations in order to ensure full acceptance of, and participation in, poliomyelitis immunization campaigns;
 - (2) to intensify poliomyelitis eradication activities in order rapidly to interrupt all remaining transmission of wild poliovirus;
2. URGES all Member States:
 - ~~(1) to protect against importations and international spread of wild polioviruses by reviewing and, if appropriate, updating national policy to recommend full immunization against poliomyelitis for travellers to areas in which poliovirus is circulating; [India]~~
 - ~~(2) to revise national policy and legislation on immunization of travellers from countries in which poliovirus is circulating in accordance with temporary or standing recommendations that may be established under the International Health Regulations (2005) once they enter into force; [India]~~
 - (1) to review and, if appropriate, update national recommendations on immunization against poliomyelitis in order to reduce the risk of international spread of disease; [India]**
 - ~~(3) to reduce the potential consequences of importation international spread [India]~~ of wild poliovirus by achieving and maintaining routine immunization coverage against poliomyelitis greater than 90% and, where appropriate, conducting supplementary

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA60.13.

² Document A60/11.

poliomyelitis immunization activities **through additional campaigns in close collaboration with mass media and involvement of the general public; [Greece]**

(43) to strengthen active surveillance for acute flaccid paralysis in order rapidly to detect any circulating wild poliovirus and prepare for certification of poliomyelitis eradication;

(54) to prepare for the long-term biocontainment of polioviruses by implementing the measures set out under phases 1 and 2 in the current edition of the WHO global action plan for laboratory containment of wild polioviruses;¹

3. REQUESTS the Director-General:

(1) to continue to provide technical support to the remaining Member States where poliomyelitis is still prevalent in their efforts to interrupt the final chains of transmission of wild poliovirus, and to Member States at high risk of an importation of poliovirus;

(2) to assist in mobilizing financial resources to eradicate poliomyelitis from the remaining areas where poliovirus is circulating, to provide support to countries currently free of poliomyelitis that are at high risk of an importation of poliovirus, and to minimize the risks of re-emergence of poliomyelitis in the post-eradication era;

(3) to continue to work with other organizations of the United Nations system on security issues, through mechanisms such as “days of tranquillity”, in areas where better access is required to reach all children;

(4) **to continue to examine and disseminate measures that Member States can take for reducing the risk and consequences of international spread of polioviruses, including, if and when needed, the consideration of temporary or [India] initiate the process for a potential standing recommendations, under the International Health Regulations (2005), on the immunization against poliomyelitis of travellers from areas where poliovirus is circulating; [India]; if such a recommendation were made, the financial and operational issues arising from its implementation, and lessons drawn, should be reported to the Health Assembly; [Thailand]**

(5) to submit proposals to the Sixty-first World Health Assembly with a view to minimizing the long-term risks of reintroduction of poliovirus or re-emergence of poliomyelitis in the post-eradication era, by establishing international consensus on the long-term use of poliomyelitis vaccines and biocontainment of infectious and potentially infectious poliovirus materials.

The CHAIRMAN said, that in the absence of any objections, he would take it that the Committee wished to approve the draft resolution.

The draft resolution, as amended was approved.²

Tuberculosis control: progress and long-term planning: Item 12.6 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R3, and A60/13) (continued from the sixth meeting)

The CHAIRMAN drew attention to a revision of the draft resolution on tuberculosis control: progress and long-term planning, incorporating amendments to resolution EB120.R3 proposed by Ethiopia, Germany, Japan, Kenya, Kuwait, Micronesia (Federated States of), Netherlands, Swaziland and Thailand, which read:

¹ Document WHO/V&B/03.11 (second edition).

² Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA60.14.

The Sixtieth World Health Assembly,

Having considered the report on tuberculosis control: progress and long-term planning;¹

Noting the progress made since 1991 towards achieving the international targets for 2005, and more recently following the establishment, in response to resolution WHA51.13, of the Stop TB Partnership;

Aware of the need to build on this progress and overcome constraints in order to reach the international targets for tuberculosis control for 2015 set by the Stop TB Partnership – in line with the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

Noting the development of the Stop TB strategy as a comprehensive approach to tuberculosis prevention and control that incorporates the internationally agreed tuberculosis control strategy (DOTS strategy) and represents a significant expansion in the scale and scope of tuberculosis-control activities;

Welcoming the Partnership’s Global Plan to Stop TB 2006–2015, which sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control for 2015;

Aware of the need to increase the scope, scale and speed of research needed to achieve the international targets for tuberculosis control for 2015 and the goal of eliminating tuberculosis as a global public-health problem by 2050;

Concerned that delays in implementing the Global Plan will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant (and extensively drug-resistant) tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recognizing the importance of the situation and the trends of multidrug-resistant and extensively drug-resistant tuberculosis as barriers to the achievement of the Global Plan’s objectives by 2015, and the need for an increased number of Member States participating in the network of the Global Project on Anti-Tuberculosis Drug Resistance Surveillance and for the required additional resources to accomplish its task; [Thailand]

Recalling that resolution WHA58.14 encouraged Member States to fulfil their commitments to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Welcoming the contribution to the mobilization of resources for development by voluntary innovative financing initiatives taken by groups of Member States and, in this regard, noting the International Drug Purchase Facility (UNITAID), the International Finance Facility for Immunisation and the commitment to launch a pilot project within the advance market commitments initiatives, [Germany]

1. URGES all Member States:

(1) to develop and implement long-term plans for tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, in the context of overall health development plans, in collaboration with other programmes (including those on HIV/AIDS, child health and strengthening of health systems), and through national Stop TB partnerships where appropriate, with the aim of:

¹ Document A60/13.

- (a) accelerating progress towards the international targets for tuberculosis control for 2015 through full and rapid implementation of the Stop TB strategy **with specific attention to vulnerable groups highly at risk, such as poor people, migrants and ethnic minorities; [Netherlands]**
 - (b) accelerating improvement of health-information systems, **both in general and for tuberculosis in particular, [Japan]** in order to serve the assessment of national programme performance;
 - (c) **ensuring high-quality implementation of the DOTS strategy by tuberculosis programmes as the first and foremost step in full implementation of the Stop TB strategy; [Japan]**
 - (d) ~~limiting~~ **controlling [Micronesia (Federated States of)]** the emergence and transmission of multi-drug-resistant tuberculosis, including extensively drug-resistant tuberculosis, **by ensuring the high-quality implementation of the DOTS strategy and by [Japan]** prompt implementation of infection-control precautions;
 - (d bis) if affected, immediately addressing extensively drug-resistant tuberculosis **and HIV-related tuberculosis [Ethiopia]** as part of the overall Stop TB strategy, as the highest health priorities; **[Ethiopia]**
 - (e) enhancing laboratory capacity in order to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, **where resources are available, [Thailand]** and promote access to quality-assured sputum smear microscopy;
 - (f) increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Partnership's Green Light Committee;
 - (g) **accelerating collaborative interventions against HIV infection and tuberculosis; [Kenya]**
 - (h) **fully involving the private sector in national tuberculosis control programmes; [Swaziland]**
- (2) to use all possible financing mechanisms in order to fulfil the commitments made in resolution WHA58.14, including that to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;
- (3) to declare, where appropriate, tuberculosis as an emergency and to allocate additional resources in order to strengthen activities aimed at stopping the spread of extensively drug-resistant tuberculosis;
2. REQUESTS the Director-General:
- (1) to intensify support provided to Member States in expanding implementation of the Stop TB strategy by developing capacity and improving the performance of national tuberculosis-control programmes, particularly the quality of DOTS activities, and by implementing infection-control precautions within the broad context of strengthening health systems in order to achieve the international targets for 2015;
 - (1 bis) **to continue to provide support for the network of the Global Project on Anti-Tuberculosis Drug Resistance Surveillance by increasing the number of Member States in the network in order to inform the Global Plan to Stop TB 2006–2015 through determination of the extent and trend of multidrug-resistant and extensively drug-resistant tuberculosis; [Thailand]**
 - (2) to strengthen urgently WHO's support to countries affected **by multidrug-resistant tuberculosis and especially [Swaziland]** extensively drug-resistant tuberculosis, **particularly where related to HIV; [Ethiopia]**
 - (3) to enhance WHO's leadership within the Stop TB Partnership in its coordination of efforts to implement the Global Plan to Stop TB 2006–2015 and to facilitate long-term

commitment to sustainable financing of the Global Plan through improved mechanisms for increased funding;

(4) to strengthen mechanisms to review and monitor estimates of impact of control activities on the tuberculosis burden, including incidence, prevalence and mortality **with specific attention to vulnerable groups highly at risk, such as poor people, migrants and ethnic minorities; [Netherlands]**

(5) to support Member States in developing laboratory capacity to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, **to develop consensus guidelines for rapid drug-susceptibility test methods and appropriate measures for laboratory strengthening, and to mobilize funding; [Thailand]**

(6) to enhance WHO's role in tuberculosis research in order to promote the applied research necessary to reach the international targets for tuberculosis control for 2015 and the basic research necessary to achieve the goal of eliminating tuberculosis by 2050; and to increase global support for those areas of tuberculosis research that are currently underresourced, **especially enhancing research and development of new anti-tuberculosis agents and the relevance of nutrition to, and its interaction with, tuberculosis; [Kuwait]**

(7) to report to the Sixty-third World Health Assembly through the Executive Board on:

(a) progress in implementation of the Global Plan to Stop TB 2006–2015, including mobilization of resources from domestic and external sources for its implementation;

(b) progress made in achieving the international targets for tuberculosis control by 2015, using the “proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)” (Millennium Development Goal indicator 24) as a measure of the performance of national programmes, and tuberculosis incidence and “prevalence and death rates associated with tuberculosis” (Millennium Development Goal indicator 23) as a measure of the impact of control on the tuberculosis epidemic.

Dr AL-SALEH (Kuwait) said that the amendment proposed by his delegation in paragraph 2(6) would be clearer if the words “new detection, new drugs, and new vaccines” were inserted in brackets after “new anti-tuberculosis agents”.

Dr MESSELE (Ethiopia) said that paragraph 2(2) did not accurately reflect the amendment proposed by Ethiopia and should be revised so that the final phrase read: “and to countries highly affected by HIV-related tuberculosis”.

Mr HOHMAN (United States of America) proposed that the final preambular paragraph should end after the words “Member States”, as there was a risk of not being inclusive if examples of initiatives were listed. Phrases such as that proposed by Thailand, “where resources are available,” in paragraph 1(1)(e), could be inserted in every paragraph of every resolution relating to areas where Member States were asked to take action. That would obviously be counterproductive and he wondered whether Thailand had a specific reason for using that phrase with reference to the enhancement of laboratory capacity.

Dr PHUSIT PRAKONGSAI (Thailand) said that, ideally, every person who had culture-positive tuberculosis should be tested for drug-susceptibility, as long as countries could afford to provide that service.

Mr HOHMAN (United States of America) said that such qualifiers could result in different levels of access to culture testing, thereby limiting the original intent of the subparagraph.

Mr GAUDÊNCIO (Brazil) said that he had a problem with the proposal by the United States to omit references to specific initiatives. Such initiatives had been listed in other resolutions.

Dr ASSOGBA (Benin) said that he had some difficulty with the wording of Thailand's proposal in paragraph 2(5) and he wondered whether there was some difference between the French and English texts.

Mr AITKEN (Representative of the Director-General) recapitulated that the delegate of Kuwait had proposed inserting the words "new detections, new drugs and new vaccines" in paragraph 2(6). The delegate of Ethiopia had proposed adding at the end of paragraph 2(2): "and countries highly affected by HIV-related tuberculosis". The Secretariat would verify whether the French version of paragraph 2(5) corresponded to the other language versions. With regard to the proposal by the United States, he noted that Brazil had expressed concerns about omitting the reference to various initiatives.

Mr HOHMAN (United States of America) stated that the delegate of Brazil had been referring to the draft resolution on malaria control, which did contain a reference to various initiatives. However, no agreement had been reached on that resolution. He therefore suggested leaving the issue open pending a decision on the draft resolution on malaria control.

Mr GAUDÊNCIO (Brazil) supported that suggestion.

Dr NAKATANI (Assistant Director-General) said that, from a technical standpoint, Kuwait's proposal in paragraph 2(6) might more usefully be worded "new diagnostics, drugs and vaccines".

The CHAIRMAN proposed that, in accordance with the proposal by the United States seconded by Brazil, the Committee would return to the resolution at a later stage.

It was so decided.

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

Prevention and control of noncommunicable diseases: implementation of the global strategy: Item 12.8 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R17, and A60/15)

Dr LARSEN (Norway) said that the Fifty-seventh World Health Assembly had identified marketing to children as an important issue in the Global Strategy on Diet, Physical Activity and Health. Diets high in energy, saturated fat, free sugars and salt, and low in certain nutrients were putting children at risk of overweight, obesity and diet-related diseases such as diabetes. Food and beverage marketing to children was extensive in both developed and developing countries. Several recent scientific reviews had raised that issue, as had the WHO Forum and Technical Meeting on the Marketing of Food and Non-Alcoholic Beverages to Children (Oslo, 2–5 May 2006), which had recommended that WHO should lead in developing an international code. He therefore suggested that the words "including developing an international code on marketing of foods and non-alcoholic beverages to children" should be inserted in paragraph 2(6) of the draft resolution contained in resolution EB120.R17, between the words "responsible marketing" and "in order to reduce".

Mrs REITENBACH (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries, Croatia, The former Yugoslav Republic of Macedonia, Turkey, and the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, Iceland, member of the European Free Trade Area and the European Economic Area, the Republic of Moldova and Ukraine, aligned themselves with her statement. She noted with satisfaction that the prevention and control of

noncommunicable diseases was a priority for WHO. The proposed action plan referred to in the draft resolution contained in resolution EB120.R17, incorporating clear priorities, actions, a time frame and performance indicators, would encourage implementation of the global strategy. At the 120th session of the Executive Board in January 2007, the Portuguese member speaking on behalf of the European Union had proposed that an outline of the action plan should be submitted to the Sixtieth World Health Assembly as a basis for debate and preparation of a comprehensive plan.¹ The outline contained in the Annex to document A60/15 might have contained more specific proposals, including options for the main areas of focus. A strong plan, which included ways of tackling the main risk factors and health determinants of noncommunicable diseases, should be presented the following year. The plan should also propose guidance on optimizing national health systems and multisectoral collaboration, with special focus on primary health care in order to meet the challenges presented by the global epidemic of noncommunicable diseases.

Dr HAO Yang (China) noted that chronic diseases and poverty were locked in a vicious circle and had a heavy economic impact on many countries. Surveillance, prevention and control in the countries most affected still needed much work, particularly for high-risk populations. Many developing countries were faced with the double burden of noncommunicable and communicable diseases, and limited budgets meant that the prevention and control of infectious diseases were given precedence. In recent years, China had increased its focus on the prevention and control of noncommunicable diseases and would continue that work for the period 2008–2013.

Dr GEORGE (Barbados) said that in the Caribbean chronic noncommunicable diseases accounted for more deaths than HIV/AIDS, tuberculosis and other infectious diseases combined. Diabetes, hypertension, obesity and cardiovascular disease represented a major disease burden and had serious socioeconomic implications. The Summit of Caribbean Community Heads of Government on Chronic Disease, to be held in Trinidad and Tobago in September 2007, would focus on strengthening health information systems and the implications for economic development, and the growing regional commitment to meeting the public-health challenge of noncommunicable diseases. The Caribbean countries already encouraged food labelling and insisted that imported foods met the highest standards in order to regulate consumption of *trans*-fatty acids, sugars and salt; however, they believed that WHO had a responsibility to support the poorer and smaller island States that were vulnerable under the current trade rules and regulations.

The countries of the Caribbean Community were signatories to the WHO Framework Convention on Tobacco Control, and many were banning smoking in public places. Barbados and the other members of the Caribbean Community supported the draft resolution.

Professor TLOU (Botswana) said that in Botswana the increase in the number of reported cases of noncommunicable diseases had created an extra burden on overworked health systems. A programme for noncommunicable diseases and a national cancer register had been established and efforts were being made to integrate surveillance of other noncommunicable diseases into a well-established disease surveillance and response programme. The Ministry of Health, with relevant stakeholders, was implementing the WHO STEPwise Approach to Chronic Disease Risk Factor Surveillance. A multisectoral plan would be aligned with the global strategy.

There were still challenges, in establishing data on the baseline disease burden and tackling the lack of skilled human resources, and she called on WHO and other partners for technical assistance in those areas. She supported the draft resolution.

Dr AYDINLI (Turkey) said that, although many countries had programmes for tackling noncommunicable diseases, funding remained low. Nationally, the issue of chronic noncommunicable

¹ Document EB119/2006–EB120/2007/REC/2, summary record of the fourth meeting of the 120th session.

diseases would be incorporated into the strategic plan. Working groups would focus on the risk factors of those diseases, and had the support of several nongovernmental organizations. Turkey had hosted the WHO European Ministerial Conference on Counteracting Obesity (Istanbul, 15–17 November 2006), at which a landmark European Charter on Counteracting Obesity had been signed.

Professor MWAKYUSA (United Republic of Tanzania) said that his country's Adult Morbidity and Mortality Project, launched in the early 1980s, had shown that mortality from diabetes was comparable to rates in Mauritius and the United States of America. The average yearly cost of diabetic patient care was estimated at US\$ 4 million, a huge sum for a poor country. As a result, prevention and control of noncommunicable diseases had been incorporated into health plans, a noncommunicable diseases focal point established, and national guidelines formulated. The WHO Framework Convention on Tobacco Control had been ratified, a law regulating tobacco use had been promulgated, and special institutions for cancer, nutrition and diabetes had been set up.

He expressed appreciation for the support received from WHO and other development partners, and urged Member States to adapt their budgets for prevention and control of noncommunicable diseases to the burden of disease they represented. He supported the draft resolution.

Mr CHAOUKI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that noncommunicable diseases accounted for 52% of the disease burden in the Region, a figure that was expected to rise to 60% by 2020. Most of the diseases were the result of lifestyle behaviour and social and economic status; conventional risk factors possibly accounted for 75% of chronic conditions.

Eastern Mediterranean countries were working towards the objectives outlined in the draft resolution through the formulation of strategies at the regional level. They recommended investment in chronic disease management at the national and global levels; setting a global goal to reduce deaths related to chronic noncommunicable diseases by 2% yearly for the next 10 years; adopting advocacy tools for preventive measures; and investing in evidence-based tools for prevention and control.

Dr SCALLY (United Kingdom of Great Britain and Northern Ireland) acknowledged the Norwegian amendment of the draft resolution and agreed that WHO could take the lead in developing an international code on the marketing of food and beverages to children in order to restrict the advertising and promotion of foods high in fat, salt and sugar.

The recently announced new and voluntary restrictions in the United Kingdom were expected to prevent children from being overexposed to advertising for less healthy foods in the media. That, coupled with new front-of-pack labelling, was believed to have created a positive environment for healthy food choices and the active promotion of healthy foods for children. In order to assess any change in the nature and balance of food promotion, an interim review of the new voluntary measures would be conducted in the autumn of 2007 and a more detailed review in collaboration with regulators and industry partners in 2008. It would then be decided whether further action, such as legislation, was required.

Dr SADRIZADEH (Islamic Republic of Iran) stated that noncommunicable diseases, including cardiovascular diseases, cancer, diabetes and chronic respiratory infections, were becoming a significant health problem in his country. The first pilot study on chronic diseases and their risk factors had been initiated in 1998. The Tehran Lipid and Glucose Study was a long-term, community programme to prevent and control noncommunicable diseases by reducing risk factors and developing a healthy lifestyle, involving changes in diet, smoking and physical activity. Three-yearly evaluations were conducted in order to assess the effect of the different changes on the intervention group as compared to the control group. The incidence of noncommunicable diseases due to metabolic influences had decreased significantly in the intervention group.

Furthermore, two large-scale surveillance surveys in 2005 and 2006 had provided information on the major risk factors for planning the prevention and control of noncommunicable diseases

countrywide. Those activities were integrated into primary health-care services, together with national workshops for promoting capacity building and generating resources.

His country was increasing political and financial commitment, collaboration and community involvement, and partnerships with the private sector. He supported the draft resolution.

Dr SOLOFONIRINA (Madagascar), speaking on behalf of the 46 Member States of the African Region, said that the Health Assembly had recognized that noncommunicable diseases were a major obstacle to development, especially in Africa. Many resolutions had already been passed, drawing attention to the need for global preventive action; the Organization should take the lead in implementing strategies for healthy eating and lifestyles, and cancer prevention. Some 80% of deaths from noncommunicable diseases occurred in developing countries, with Africa bearing the highest levels of morbidity. Through healthy diet, physical activity and limiting alcohol consumption, 80% of cardiovascular cases, 80% of diabetes cases and 40% of cancer cases could be avoided. Violence, injuries and disabilities had also risen significantly in Africa in 2004–2005, with a high number of deaths caused by road accidents in addition to the problems of drug addiction and mental illness.

Many Member States had responded by setting up departments and introducing policies to treat noncommunicable diseases. Twenty-seven African countries had begun to put in place surveillance systems based on the STEPwise approach with support from the Regional Office for Africa. Technical assistance from WHO had included regional workshops, initiatives, exchanges, policies and guidelines. The creation of online tools such as WHO's Global InfoBase had allowed access to information from some 11 000 surveys.

Preventive action had focused on risk-reduction factors such as unhealthy diet, tobacco use, sedentary lifestyles and excessive consumption of alcohol. WHO had assisted in developing technical tools to create a strategic framework for prevention and treatment of high-risk populations. Africa faced significant challenges in combating both communicable and noncommunicable diseases with limited resources. Noncommunicable diseases had also to be covered by surveillance networks. Failing decisive and concerted action, the scale of the problem would become overwhelming. Noncommunicable diseases were no longer confined to developed countries, but threatened Africa too. She called on all Member States to support the draft resolution.

Mr KESSLER (Switzerland) welcomed the draft resolution without amendment. In regard to the proposal to draft an international code of conduct for marketing of food and non-alcoholic drinks to children, that was a domain best regulated at national level. Drafting an international code would take a disproportionate amount of the Secretariat's time as against the results it would achieve. Time would be better spent learning from current experiments before any conclusions were drawn. He was therefore unable to agree to the proposed amendment although, in a spirit of compromise, he could agree to a submission of best practices and recommendations to Member States for their consideration.

Dr HUWAIL (Iraq) said that noncommunicable diseases constituted a great threat to health in terms of death and disability, and an economic burden on health facilities. A nationwide study in 2006 had shown that more than 60% of Iraqis were overweight or obese, 40% suffered from hypertension, 10% had diabetes, more than 30% had high cholesterol levels and more than 20% smoked. Integrated care of noncommunicable diseases in Iraq at the primary health-care level should be strengthened; screening systems for hypertension and diabetes, and integrated eye care in order to detect cataracts and glaucoma should also be part of primary health-care services. Development of a national surveillance system for noncommunicable diseases and their contributory risk factors was recommended. Promoting healthy lifestyles should be enhanced and national guidelines established. Tobacco control activities needed to be upgraded in Iraq and the referral and feedback between different levels of care strengthened. He supported the draft resolution.

Dr UGRID MILINTANGKUL (Thailand) appreciated the draft resolution as it broadened the strategies used to control noncommunicable diseases. Thailand had already initiated a financing

mechanism with revenue from a 2% excise on alcohol and tobacco tax being channelled to the Health Promotion Foundation whose primary goal was to reduce risks and promote healthy activities. A recent campaign had, for example, encouraged children to cut their sugar consumption. Thailand had adopted a policy to limit the marketing of chemicals used in agricultural products.

In order to meet the target of reducing death rates from noncommunicable diseases, the death registration process should be amplified to ensure full and reliable reporting. Thus, the thirteenth preambular paragraph, beginning “Recognizing that greater efforts are required”, should emphasize the importance of restricting marketing activities and of providing consumers with clear, precise and relevant information. In paragraph 1(5), the harmful use of alcohol consumption in addition to tobacco should be mentioned. In the second preambular paragraph after the reference to resolution WHA53.17, a reference to “WHA54.18 on Transparency in tobacco control process” should be inserted.

Mr DANKOKO (Senegal) said that noncommunicable diseases were increasingly prevalent in Senegal, causing disability, poverty and death and threatening the country’s economy and social well-being. Focal points had been established in order to control specific noncommunicable diseases, each with a multidisciplinary committee responsible for devising a control programme. Centres providing specialized care, including cancer and renal units, were planned. A diabetes control centre had already been set up. The measures would bring health care closer to people and reduce treatment costs, which most households could not afford. He emphasized prevention, which was integrated into all the country’s disease control programmes. He supported the draft resolution.

Professor KEVAU (Papua New Guinea) said that his country’s experience of noncommunicable diseases went back only some three decades, yet they had already claimed the lives of many people in the prime of life. Papua New Guinea ranked second among the Pacific island countries in regard to prevalence of diabetes, while strokes, coronary heart disease, hypertension and dyslipidaemia were increasing. The country had a doctor-to-population ratio of 1:15 000 and a high prevalence of infectious diseases such as tuberculosis and HIV/AIDS. Therefore, the emergence of noncommunicable diseases posed a significant public health problem owing to the lack of laboratories and acute care medication.

He acknowledged WHO’s lead in drawing attention to noncommunicable diseases, and its efforts in promoting evidence-based advocacy, surveillance tools, population-based prevention methods and guidelines on prevention and management of high-risk populations; and the Organization’s work in identifying the challenges in its Proposed programme of work and draft Medium-term strategic plan 2008–2013. He supported the draft resolution.

Mr GAUDÊNCIO (Brazil) supported the proposals contained in resolution EB120.R17, especially those for more investment in prevention and control. The measures were highly relevant given the significant threat posed by noncommunicable diseases. Efforts should focus on monitoring diseases and their risk factors, education, developing guidance policies and supporting health promotion, prevention and control activities. He supported the amendment proposed by the delegate of Norway.

Dr SUGIURA (Japan) supported the draft resolution, but noted that paragraphs 1(6) and 1(8) both emphasized the relationship between noncommunicable diseases and primary health care. In order to avoid overlap, he proposed that they should be combined, with appropriate modification. Bearing in mind that medicines were not the only measure for prevention and control of noncommunicable diseases, he suggested that paragraph 1(10) should be amended to read: “to increase access to appropriate health care, including medicines, for high-risk populations in low- and middle-income countries”. In paragraph 2(6), the words “and healthy eating habits” should be inserted after “promoting healthy diets”.

Dr DUQUE III (Philippines) fully supported the draft resolution and reiterated his Government’s commitment to the prevention and control of noncommunicable diseases through integrated risk management, promotion of healthy lifestyles and behaviour modification, with 2005–2015 proclaimed

the decade of healthy lifestyle in the Philippines. He recommended amending paragraph 1(2) to include “and local coalition” after “national coordinating mechanism”, and that “low-price, quality” should be inserted before “medicines” in paragraph 1(10).

He also recommended the adoption of a treaty similar to the WHO Framework Convention on Tobacco Control aimed at tackling consumption of unhealthy foods and beverages; increasing the availability of healthy foods; promoting healthy diets and encouraging responsible marketing in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars and salt.

Dr GOPEE (Mauritius) supported the draft resolution, in particular the request to the Director-General to prepare an action plan for submission to the Sixty-first World Health Assembly. Noncommunicable diseases were a serious problem in Mauritius, accounting for over 80% of deaths, with diabetes a particular concern. Mauritius ranked third in the world in terms of diabetes prevalence, with 1 in 5 adults over 30 years of age and 1 in 2 over 50 years of age suffering from the disease. A national service framework aimed at improving prevention of and care for diabetes at the primary, secondary and tertiary levels had been prepared together with three national action plans – on tobacco control, nutrition, and cancer prevention and control; an action plan on physical activity was also being finalized. Mauritius offered screening for noncommunicable diseases at workplaces and educational institutions. He appealed to WHO and other international partners to continue assisting Mauritius, an economically fragile small-island developing State.

Dr PANTELEEVA (Russian Federation) acknowledged the progress made in implementing WHO’s global strategy for the prevention and control of noncommunicable diseases. Her country was working towards the strategy’s global targets, which should be further developed using the results of research and new technologies, balancing prevention and improved diagnosis and treatment. Under the Biennial Collaborative Agreement with the Regional Office for Europe for 2006–2007, Russia was developing a national strategy on noncommunicable diseases, based on existing documents and many years of experience, including initiatives such as the 20-year Countrywide Integrated Noncommunicable Diseases Intervention programme. Owing to lack of funding work had halted, as it had under the WHO Mega Country Health Promotion Network.

She proposed inserting a new paragraph in the draft resolution, worded:

to develop mechanisms of interaction of Member States in preventing and controlling noncommunicable diseases; in particular, to recognize as an effective means of cooperation and implementation of the Global Strategy for the prevention and control of noncommunicable diseases the regional and global network programmes for such prevention and control; to support their development through coordination, organization and funding at the regional and global levels.

Mr SAMO (Federated States of Micronesia) supported the global strategy for the prevention and control of noncommunicable diseases, in particular through attention to their risk factors. Micronesia had adopted integrated management as its main strategy, but risk factors such as obesity and hypertension remained prevalent. He supported the draft resolution.

Mr MSELEKU (South Africa) supported the amendment proposed by the delegate of Norway concerning an international code on marketing of foods and beverages to children. Advertising of food products had to be accurate and age-appropriate. South Africa was developing strategies to promote healthy lifestyles, which included working with the food industry to encourage the production and marketing of healthy foods.

Dr GONZÁLEZ (Cuba) highlighted the link between chronic noncommunicable diseases and population ageing. The battle against such diseases had to begin early in life. Instilling healthy habits during childhood and adolescence was effective in preventing noncommunicable diseases in adulthood and ensuring a long and healthy life. Cuba’s Health and Quality of Life Programme addressed noncommunicable diseases and other causes of death, disability and demand for specialized services

through integrated action. Disease prevention and health promotion, with special emphasis on primary health care, were employed as part of an integrated health system that addressed the double burden of infectious and noncommunicable diseases. He supported the draft resolution.

Mr ROSALES (Argentina) said that noncommunicable diseases should continue to be prioritized by the Secretariat and all Member States. Despite the progress noted in the report, the resources allocated for prevention and control of chronic noncommunicable diseases remained insufficient and surveillance systems needed to be improved. Systematization of international experiences might prove extremely useful. It might also be helpful to complement the progress report on implementation of the Global Strategy on Diet, Physical Activity and Health with recommendations on concrete interventions, their feasibility and potential impact. The draft plan of action might be strengthened through greater emphasis on regional integration. Interventions should be based on the best available evidence, with greater systematization of experiences; increased availability of tools for countries that were in the early stages of dealing with noncommunicable diseases; and greater emphasis on the role of evidence, cost-effectiveness and surveillance in prioritization and decision making.

Professor WYSOCKI (Poland) said that the report rightly stressed evidence-based advocacy, surveillance and population-based prevention. Health promotion programmes and techniques could also reduce the death and disease burden from noncommunicable diseases in high-risk populations. However, health promotion was not explicitly mentioned in the report or the draft resolution. He therefore proposed that the words “health promotion” should be inserted in paragraph 2(2) following the words “surveillance mechanisms”. He also supported the amendment proposed by the delegate of Norway.

Dr AL-SAIF (Kuwait) said that in Kuwait specialized committees had been established for individual diseases. Work on cancer, diabetes and obesity-related disorders was being expanded. The various committees were also engaged in raising awareness of the dangers associated with certain products and encouraging people to undergo screening for particular conditions, which was provided free at clinics around the country. He supported the draft resolution.

Mr SOK Yong Guk (Democratic People’s Republic of Korea) said that, with expected mortality and morbidity rates of 60% and 73% respectively by 2020, noncommunicable diseases posed a significant problem, particularly in developing countries. WHO’s STEPwise approach to surveillance, linked to the Global Strategy on Diet, Physical Activity and Health and the South-East Asia Region’s strategy on the prevention and control of noncommunicable diseases, were together a powerful tool. Identifying and managing the risk factors common to the most widespread noncommunicable diseases was the most cost-effective way of tackling the problem. His country had carried out various prevention and control activities and introduced the STEPwise approach, with survey findings used to formulate public health policies. It was important to adapt the STEPwise approach to each country’s situation, and to collect and use the information obtained.

Mr MENESES (Mexico) drew attention to the high prevalence of obesity and diabetes mellitus among adults and to the growing prevalence of overweight children under five years of age in the world. He proposed a new subparagraph in paragraph 1 of the draft resolution, urging Member States to incorporate into their national health programmes intervention strategies aimed at reducing the incidence of obesity in children and adults and preventing and controlling diabetes mellitus. He also proposed a new subparagraph in paragraph 2, requesting the Director-General to promote dialogue among Member States with a view to developing a global strategy to combat obesity and diabetes mellitus.

Ms TOELUPE (Samoa) said that her country, as one of the many receiving assistance from WHO and development partners to tackle noncommunicable diseases, demonstrated political

commitment in support of promotion and prevention programmes, particularly in the light of the shocking results of a survey conducted as part of the STEPwise approach.

She expressed confidence that, with the help of the Regional Office for the Western Pacific and other partners, more stringency would be exercised in the practical application of global and regional strategies, including the promotion and implementation of the WHO Framework Convention on Tobacco Control. Health reforms had been encouraging stronger engagement of sectoral groups in the implementation of the national strategy for the prevention and control of noncommunicable diseases. She supported the draft resolution, while agreeing with the delegate of Poland that health promotion should be highlighted.

Professor FAIZ (Bangladesh) noted that various studies in Bangladesh had revealed that noncommunicable diseases were the cause of 30% of hospital admissions in the country. Bangladesh faced a double burden of communicable and noncommunicable diseases. Certain factors were peculiar to Bangladesh, such as the high proportion of carbohydrates in the diet and the consumption of smokeless tobacco (the latter having recently been made punishable by law). No single measure could prevent noncommunicable diseases. The absence in middle- and low-income countries of optimal facilities for treating noncommunicable diseases made preventive measures all the more important. His Government's strategic plan of action for surveillance and prevention, taking account of diet and physical activity, would require much support.

Professor PEREIRA MIGUEL (Portugal), supporting the draft resolution as amended by the delegate of Poland to highlight health promotion, said that the global epidemic of noncommunicable diseases affected all population groups but particularly the underprivileged and vulnerable, such as migrants, thereby contributing to inequity. The growing impact of such diseases on development should be tackled and efforts should be scaled up, among other means through full implementation of the WHO Framework Convention on Tobacco Control, and support for the Global Strategy on Diet, Physical Activity and Health.

Cross-cutting approaches were important for tackling the causes of noncommunicable diseases, which were mainly related to lifestyle. Portugal sought "health in all policies", following one of the three pillars of the future European Union health strategy. Inspired by the European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, 15–17 November 2006), the Minister of Health had established a programme to counteract obesity, based on public–private partnership. He hoped that the programme would yield significant results.

Ms PANTAZOPOULOU (Greece) said that globalization had affected lifestyles, increasing the prevalence of some noncommunicable diseases to the point where they could be considered communicable diseases. In Europe, noncommunicable diseases represented 77% of the disease burden, in terms of disability-adjusted life years. In addition to the commonly cited diseases, musculoskeletal disorders should also be borne in mind.

With regard to the draft resolution, she proposed the addition of a new final preambular paragraph, to read: "Recognizing the heavy social and economic burden of musculoskeletal disorders, especially among the workforce and the elderly". She further proposed that the words "to strengthen capacity of health systems for prevention" should be inserted at the beginning of paragraph 1(6).

Dr YEARWOOD (Trinidad and Tobago) described the high morbidity and mortality rates for noncommunicable diseases in her country, particularly cardiovascular diseases, cancer, diabetes, hypertension and cerebrovascular diseases. Measures taken included a health promotion plan for healthy lifestyles; a national policy for the prevention and control of chronic noncommunicable diseases, based on integrated management, health promotion, standardized guidelines and protocols, community empowerment and intersectoral collaboration; a chronic disease assistance programme for the control of diabetes and hypertension, with medications provided to patients free of charge; and a National Oncology Programme for reducing the number of deaths from cancer, and improving the quality of life of patients. The National Oncology Centre would serve as the focal point for cancer

treatment within the Caribbean region; and a tobacco control bill was before a legislative review committee, with taxation on tobacco products already increased.

Curbing chronic noncommunicable diseases enjoyed strong support at the highest level; in September 2006, a national consultation had been convened under the direct patronage of the Prime Minister, and later expanded to a regional Heads of Government conference. She supported the draft resolution.

Dr GARGOURI (Jordan) said that Jordan was seeing a change in the pattern of diseases, with communicable diseases having been stabilized but more patients suffering from chronic conditions. Studies indicated that risk factors, especially smoking, were on the increase, as was the incidence of diabetes. Anti-smoking policies were in place and people were being encouraged to take physical exercise. Funds from the regular budget of the Ministry of Health had been earmarked for the control of noncommunicable diseases. Noting that all countries were seeing a rise in noncommunicable disease rates, she stressed the importance of dealing with the issue.

Dr SHRESTHA (Nepal) said that chronic noncommunicable diseases, which accounted for 60% of deaths in Nepal, were on the increase. A survey in accordance with WHO's STEPwise approach had been conducted in three districts in 2005, revealing a high prevalence of risk factors, such as alcohol and tobacco use, physical inactivity, low fruit and vegetable intake, obesity and hypertension. A national survey of risk factors was under way. From the survey's findings, community-based interventions, integrated into the general health system, were being planned. A focal point for noncommunicable diseases had been designated within the Ministry of Health, and national policies and strategies were being finalized. Anti-tobacco legislation was being drafted, in line with Nepal's ratification of the WHO Framework Convention on Tobacco Control. He supported the draft resolution, as amended by the delegate of Japan.

Mr BENKACI (Algeria) suggested the establishment of a computerized surveillance system for noncommunicable diseases with support from WHO, particularly in the area of standardization of the corresponding information system. That would enable effective prevention and control strategies to be put in place. Algeria had its own programme on noncommunicable diseases, with additional national programmes on specific conditions such as cancer and hearing impairment. It had also set up centres in all regions for treating and monitoring diabetes patients, collecting biological data, providing health education and ensuring faster access to specialized medical care, particularly in ophthalmology and cardiology.

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

The meeting rose at 17:30.

NINTH MEETING

Saturday, 19 May 2007, at 09:00

Chairman: Dr A. BALBISI (Jordan)

1. SECOND REPORT OF COMMITTEE A (Document A60/56)

Mrs BU FIGUEROA (Honduras), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Prevention and control of noncommunicable diseases: implementation of the global strategy: Item 12.8 of the Agenda (Documents EB119/2006-EB120/2007/REC/1, resolution EB120.R17, and A60/15) (continued from the eighth meeting)

Dr BLOOMFIELD (New Zealand) welcomed WHO's adoption of a range of policy approaches, backed by a strong evidence base, to noncommunicable diseases. Action must be well integrated into health care systems and primary health care, and must seek to influence the environment in which people lived. In his own country, the food industry and the media were contributing to efforts to reduce obesity levels. He supported the amendment by the delegate of Norway to the draft resolution contained in resolution EB120.R17.

Dr ASLANYAN (Canada) strongly supported the Global Strategy on Diet, Physical Activity and Health and the WHO Framework Convention on Tobacco Control. Canada would provide technical support and share its expertise with the Secretariat and Member States, particularly through the WHO Collaborating Centre on Non Communicable Disease Policy, based at the Public Health Agency of Canada. The links between related resolutions on noncommunicable diseases should be strengthened, in order to bring about a comprehensive approach to prevention and control.

Mr HOHMAN (United States of America) expressed his surprise that the delegation of Norway had proposed such a radical amendment to a resolution already approved by the Executive Board; the proposed international code of marketing would apply to thousands of products, and the work involved in developing and monitoring such a code would have enormous resource implications for WHO. Moreover, the amendment had been submitted with little prior consultation. He had no instructions from his Government on the matter, so could not support the proposed amendment.

Mr JØRGENSEN (Denmark) recalled that his delegation had first brought the issue of marketing of foods to children to the Executive Board. He fully supported the draft resolution; a strong form of words should be adopted in order to pave the way for a future plan of action.

¹ See page 310.

Dr JUNG Tong-ryoung (Republic of Korea) said that his Government had strengthened monitoring and evaluation to support evidence-based decision-making. National surveillance of noncommunicable diseases and their risk factors had been carried out every three years since 1995, with national health goals to be achieved by 2010. It had also implemented a 10-year cancer control plan and a comprehensive plan for the prevention of cardiovascular disease and stroke. He supported the draft resolution, with the amendments proposed by the delegate of Japan.

Mr SANNE (Norway) revised his delegation's amendment to the draft resolution by substituting the words "a set of recommendations" for "an international code".

Ms ALLAIN (Consumers International), speaking at the invitation of the CHAIRMAN, urged Member States to support the development of an international code of marketing of foods to children, as part of a broader strategy to prevent noncommunicable diseases and implement the Global Strategy on Diet, Physical Activity and Health. At least 2.6 million people died every year as a result of being obese or overweight, and about 22 million children under five years of age were already overweight.

One of the issues identified for action in the Global Strategy was food marketing, advertising, sponsorship and promotion. The WHO Forum and Technical Meeting on Marketing of Food and Non-alcoholic Beverages to Children (Oslo, 2–5 May 2006) had concluded that exposure to commercial promotion of energy-dense, micronutrient-poor foods and beverages could adversely affect children's nutritional status. Children were influenced by commercial promotion, which undermined recommendations for a healthy diet and had a harmful effect on children's food knowledge, attitudes, purchasing behaviour and consumption. The techniques used to target children included television advertising, the Internet, sponsorship and commercial activities in schools.

International action was needed in order to ensure a more responsible approach to food marketing to children around the world. Action at the national or regional level alone would create inconsistencies, and result in marketing activity shifting to the areas with the fewest controls where consumers were most vulnerable. WHO should develop an international code on marketing of foods to children, as originally proposed by the delegate of Norway. She also supported the suggestion by the delegate of the Philippines for an international treaty on the marketing of foods to children.

Ms LINNECAR (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, and on behalf of the International Baby Food Action Network and Churches Action for Health, said that evidence showed that, among many other benefits for children, breastfeeding reduced neonatal mortality by 22% and mortality among under-fives by 13%. It also reduced the risk later in life of cardiovascular disease and celiac and inflammatory bowel disease and resulted in lower cholesterol levels. For mothers, it reduced the risk for mothers of developing breast cancer, ovarian cancer, osteoporosis and diabetes.

Despite such evidence, however, breastfeeding was not always seen as the key element in reducing the incidence of noncommunicable diseases. It did not always appear on the list of suggested interventions for that purpose, and parents and health professionals were continually misinformed. The problem was exacerbated by marketing practices that violated the International Code of Marketing of Breast-milk Substitutes.

The Global Strategy for Infant and Young Child Feeding, endorsed in resolution WHA55.25, established guiding principles for the protection, promotion and support of breastfeeding. Exclusive breastfeeding for six months and continued breastfeeding for two years or beyond gave the best possible start for a healthy life. It was imperative to take that into account when planning for prevention and control of noncommunicable diseases.

She welcomed the proposal for an international code on the marketing of food and beverages to children, and recommended introducing a binding instrument to ensure that the code would be followed.

Ms STERKEN (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, said that obesity and related noncommunicable diseases threatened the health of increasing numbers of children and adults worldwide, in developed and developing countries. Obesity had increased the burden of preventable chronic diseases, including type 2 diabetes and cardiovascular disease. Children were the target of marketing strategies that promoted diets high in fat, sugar and salt. Such techniques undermined the global nutrition strategies endorsed by the Health Assembly. The level of concern over marketing to children was reflected in the consultations convened by WHO on the subject, and by the United Nations Committee on the Rights of the Child, the Committee on World Food Security and the United Nations Standing Committee on Nutrition. A legacy of poverty affected a large proportion of the world's children, who were vulnerable to obesity and related disorders when exposed to westernized diets. Children needed international standards and protection from commercial practices that promoted unhealthy consumption patterns and hindered the efforts of parents, governments and society to improve children's diets. She fully supported the proposal by the delegate of Norway for an international code of marketing. It should establish global standards for all promotional activities affecting children, including marketing through the Internet and mobile communications.

She called on the food, beverage, media and advertising industries to support an international code; and to promote healthy nutritional standards by helping to reduce consumption of products with a high fat, salt or sugar content. If the trend in obesity was to be reversed in line with the goal set by European health ministers in November 2006, much more effort was needed. The prevention and control of chronic diseases should begin with protecting children.

Dr LHOTSKA (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, commended the inclusion in the draft resolution of several references to avoiding potential conflicts of interest. The commitment to protect public health policy from industry interference had been clearly established in resolution WHA54.18 and Article 5.3 of the WHO Framework Convention on Tobacco Control. Transnational tobacco companies were attempting to undermine national health policies and implementation of the Convention worldwide. The Network for Accountability of Tobacco Transnationals would continue to monitor those tactics and would expose them at the second Conference of the Parties (Bangkok, 30 June–6 July 2007).

The interests of the food industry could also conflict with public health objectives. Resolution WHA57.17 recognized the need to avoid potential conflicts of interest in implementing the Global Strategy on Diet, Physical Activity and Health. Nongovernmental organizations were important in revealing industry influence and activities, and in calling for transparency in health policies. Policies for healthy nutrition should include enforceable limits on the marketing of unhealthy foods.

She supported the draft plan of action outlined in the report and the draft resolution as amended by the delegations of Norway and Thailand. The Secretariat and WHO's Member States should ensure that the plan of action included strong, clear guidelines on avoiding potential conflicts of interest.

Dr LE GALÈS-CAMUS (Assistant Director-General) noted the importance attached by several Member States to coordinating the implementation of strategies on the prevention and control of noncommunicable diseases previously approved by the Health Assembly. That was particularly relevant to primary prevention, tobacco use, and risk factors linked to diet and lack of physical exercise. The strategies would be coordinated through synergies, and by focusing on relevant multisectoral approaches. She also noted the emphasis placed by the Member States on strengthening primary health-care systems in order to equip them better for integrating the prevention and treatment of noncommunicable diseases.

The CHAIRMAN proposed that further consideration of agenda item 12.8 should be deferred pending a revision of the draft resolution.

It was so agreed.

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

Oral health: action plan for promotion and integrated disease prevention: Item 12.9 of the Agenda (Documents EB119/2006-EB120/2007/REC/1, resolution EB120.R5, and A60/16)

Dr ANTEZANA ARANÍBAR (representative of the Executive Board) said that the Executive Board had discussed principles for strengthening work on oral health at country, regional and global levels. The Board had adopted resolution EB120.R5 which recommended a draft resolution that emphasized integrating the prevention of oral diseases into the prevention of chronic diseases, taking the common risk factors into account. It had also drawn attention to the need for building capacity in health systems at national, regional and global levels.

Dr SOLOFONIRINA (Madagascar), speaking on behalf of the Member States of the African Region, said that poor oral health was a major public health problem in Africa. It was inseparable from general health, as stated in the Nairobi Declaration on Oral Health in Africa (2004). Several infections and diseases, such as HIV/AIDS and diabetes, had oral manifestations. Periodontal disease was also a serious problem. Maxillo-facial injuries resulting from traffic accidents and oral cancers due to excessive alcohol and tobacco consumption had become familiar problems. Noma also occurred among young children in many African countries.

Reliable epidemiological data were needed in order to plan oral health-care provision. Africa lacked qualified staff and equipment. The Regional Office for Africa emphasized prevention, and oral health was being integrated into school, maternal and child health-care programmes. Thirty-three African countries had oral health policies, but they were poorly implemented for lack of funds.

She supported the draft resolution. Governments should implement national oral health programmes, coordinated through a focal point in the health ministries in all the Region's countries. Oral health should be incorporated into primary health care, in order to eliminate inequalities between population groups.

She requested a technical note on the rise in reported cases of noma for the forthcoming Regional Committee meeting, preparatory to the drawing up of a regional strategy for the eradication of noma. Oral health should be included in programmes for the prevention of noncommunicable diseases, and integrated into the Medium-term strategic plan 2008–2013.

Ms KOIVISTO (Finland) said that oral diseases were among the most common chronic diseases. Tobacco, particularly when used in combination with alcohol, was a risk factor for oral cancer, the eighth most common cancer worldwide. The increased incidence of smoking among young people would affect the oral health of future generations. The oral health of lower social groups had been slow to improve. More emphasis should be placed on integrating oral health into health promotion strategies. Reducing exposure to risk factors was a major element in the global strategy for the prevention and control of chronic noncommunicable diseases. Why were sweet dispensers being installed at schools at a time when dental decay among children was increasing? Awareness of the determinants of oral and general health should be raised, and preventive health care promoted. WHO had to encourage and promote healthy alternatives and lifestyles. She endorsed the draft resolution.

Dr TAKAHASHI (Japan) welcomed WHO's acknowledgement of the intrinsic link between oral health, general health and quality of life. The challenge of oral health, such as care of HIV/AIDS patients or the management of noma, had shown the need for coordination among poverty reduction, nutrition management and infectious disease control. Community personnel should be deployed for

prevention, for example in promoting oral care in schools. WHO should continue to provide a forum for Member States to exchange experience.

Mr ABD00 (United States of America) said that dental caries was the single most common chronic childhood disease, and could affect a child's ability to learn and develop. In the United States of America, poor children suffered from dental caries twice as much as their more affluent peers, with less chance of having it treated. More than 51 million school hours were lost each year to dental-related illness in children, together with over 164 million hours of work by adults because of dental disease or dental visits. Good oral hygiene therefore made sound sense for socioeconomic reasons. Oral health was a key component of the Health Secretary's strategy for health diplomacy in Central America, with dental and preventive care provided by commissioned United States' public health officers and military, medical, and humanitarian personnel, and through planned collaboration with government-funded nongovernmental organizations.

He welcomed the efforts to provide Member States with evidence and information to integrated oral health into broader national health systems and programmes. He supported the draft resolution.

Dr HUWAIL (Iraq) said that progress had been made in Iraq in oral health, which had become an integral part of primary health-care programmes. However, access to oral health services was limited and teeth were often left untreated or extracted. Many people saw tooth loss as a natural consequence of ageing, and the proportion of edentulous adults aged 65 years and older remained high in many countries in the Eastern Mediterranean Region. He supported the draft resolution, but drew attention to the importance of investment by WHO of more financial and human resources in oral health promotion; strengthening surveillance of oral health diseases; bringing oral health under primary health-care activities at all levels; and raising community awareness about oral health.

Mr VOLJČ (Slovenia) agreed that oral health promotion and disease prevention remained an isolated component of national health programmes, even in high-income countries. The importance of oral health would grow with increasing care for disadvantaged populations and the ageing of societies. Oral health should remain at the centre of WHO's activities. He supported the draft resolution. Slovenia would support WHO's activities.

Dr SOPIDA CHAVANICKUL (Thailand) fully supported the streamlining of national oral health-care policies through primary health-care services. She endorsed the suggestion by the delegate of Madagascar to incorporate oral health in the Medium-term strategic plan, and supported the draft resolution.

Dr DEMIRALP (Turkey) said that oral diseases as a group were the fourth most expensive to treat but were preventable. Since most oral and chronic diseases had common risk factors, noncommunicable disease prevention programmes should include oral disease. Turkey was about to implement a preventive education programme for 6.5 million primary school pupils, and their teachers and families, under which toothbrushes and toothpaste would be distributed to the pupils free of charge. Turkey's integrated oral-health surveillance system was based on the WHO Global InfoBase and WHO's STEPwise surveillance methods. He welcomed WHO's collaboration with nongovernmental organizations. Turkey supported WHO's efforts to have oral health strategies and policies included in national and community health programmes.

Dr MAZHANI (Botswana) welcomed WHO's technical support in developing communication and advocacy tools. Botswana had established programmes for oral health promotion in primary schools, and was procuring four mobile dental clinics for rural communities. A national oral health policy that took account of common risk factors for oral diseases and noncommunicable diseases was under development. He supported the draft resolution.

Mrs PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that some 20 million people nationally had received dental care since 2004. A strategy had been put in place to help the many people in the country who had lost teeth by providing them with dental prostheses. A factory to manufacture dental prostheses using material derived from petrochemicals was being considered. The Ministry of Health was continuing its salt fluoridation programme, education and training activities, and epidemiological monitoring.

Mr SAMO (Federated States of Micronesia) supported the draft resolution but proposed that paragraph 2(1) should be amended by inserting the words “and unique” after “specific” and by replacing “low-income” with “low- and middle-income” to reflect the information provided in the report. His Government would implement the resolution with support from development partners.

Dr ASLANYAN (Canada) said that, since the two most common oral diseases, dental decay and gum disease, were almost entirely preventable, WHO’s focus on a health promotion, disease prevention and wellness model was to be commended. Oral diseases tended to be chronic, and the identification and reduction of chronic disease risk factors would improve oral health. He supported the draft resolution.

Dr MAOATE (Cook Islands) said that oral health activities had been incorporated in the Cook Islands’ 2006 national health strategy and included workforce development. He supported the draft resolution as amended by the delegate of the Federated States of Micronesia.

Mr PETTERSSON (Sweden) supported the draft resolution. Oral health was a crude indicator of general health status and inequalities in health. The retention of teeth throughout life contributed to autonomy and quality of life. The role of dental systems in disease prevention should be strengthened. Dental staff could urge patients to give up smoking, promote improved diet and eating habits, and advocate for healthy environments in education facilities. However, increasingly expensive dental services were leading vulnerable people to drop out of regular dental care. Those factors should be taken into consideration when the resolution was implemented.

Dr MACHAGE (Kenya) proposed that the draft resolution should be amplified by amending paragraph 1(13), replacing “to consider increasing” with “to increase, as appropriate”, and by adding at the end of paragraph 2(5) “including increasing budgetary and human resources at all levels”.

Dr SALANIPONI (Malawi) said that oral disease, especially dental caries in children and oral Kaposi sarcoma associated with AIDS, was increasing in Malawi and was exacerbated by poverty and poor social conditions and dietary habits. Malawi was therefore carrying out an oral health action plan, with decentralization of oral health to first-level health facilities, and provision of oral health education in primary schools. Challenges included a lack of awareness of the importance of oral health. Given the shortage of qualified dental surgeons in the country, training was being given to dental therapists, who would provide services in clinics, and a dental school was planned. He supported the draft resolution and urged the Director-General to mobilize more resources.

Dr OLIVEROS (Philippines) said that the proposed strategies would contribute to a holistic approach to oral health promotion and integrated disease prevention. The Philippines’ plans incorporated similar strategies, including a primary health-care approach, evidence-based practice, partnerships, a life-course perspective and integrated action.

Paragraph 1(1) of the draft resolution should be amended by inserting the words “into policy of maternal and child health and” after “incorporated” and by inserting “and communicable” after “noncommunicable”. In paragraph 1(9), “maternal care” should be inserted after “childhood illness”. A new paragraph 1(14) should be added to read: “to strengthen partnerships and shared responsibility among stakeholders to maximize resources in support of national oral health programmes”.

Professor PEREIRA MIGUEL (Portugal) welcomed the draft resolution. The improvement of oral health was of major concern and it was several years since the Health Assembly had adopted a resolution on the subject. Portugal had seen a sharp decline in tooth decay in children in recent years thanks to strong prevention policies. Activities should target vulnerable population groups, including people with disabilities and HIV/AIDS, smokers, pregnant women and elderly people.

Mr DANKOKO (Senegal) said that Senegal had made considerable progress in training and recruiting dental staff, with 1 per 22 000 inhabitants in 2007 compared with 1 per 56 000 in 1999. There were two training schools, one for dental surgeons, the other for dental assistants and technicians. Since the recruitment undertaken between 2002 and 2007, dental staff were available in all districts, and more than 100 licences for private dental practice had been issued since 2001. Public oral health services had been decentralized and incentives encouraged dental staff to work in remote rural areas. A division of oral health, with an operational and capital budget, had been established, with emphasis on oral health promotion and disease prevention. Senegal was implementing a noma control programme covering information, education, communication and training. He supported the draft resolution.

Professor KEVAU (Papua New Guinea), supporting the draft resolution, said that oral diseases represented a substantial public health problem in developing countries. National and international private entities whose products contributed to oral diseases should support national oral health programmes, which often faced resource constraints. In Papua New Guinea, use of tobacco and alcohol was frequently associated with chewing of betel nut, together with slaked lime. Oral cancer was the leading cancer and its prevalence was rising. However, facilities for early detection and timely intervention were limited. Research was needed to confirm and clarify evidence that the alkaloid arecoline, the main ingredient of betel nut, contributed to ischaemic heart disease and cardiac arrest.

Dr ALLEN-YOUNG (Jamaica), speaking on behalf of the 14 member countries of the Caribbean Community, supported the draft resolution. Many countries were applying successful oral health strategies that included oral health promotion, and oral health care was integrated into primary health-care programmes. In Jamaica the salt fluoridation strategy, undertaken with the private sector, was considered a best practice, and the HIV/AIDS control programme included oral health promotion. As demographic profiles in the Community's countries changed, there was a need to target other vulnerable groups such as elderly people. In Barbados, emphasis was on people with disabilities. Oral health promotion should also be incorporated in activities to promote healthy lifestyles and prevent noncommunicable diseases. The countries of the Community, which suffered from the emigration of health-care workers, welcomed increased capacity for the training of oral health personnel and the expansion of dental school curricula.

Ms SIBUL (Estonia), endorsing the remarks made by the delegate of Finland, said that as oral health was essential to general health her Government gave it priority. She supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) said that it was essential to reduce the risk factors for oral and other noncommunicable diseases; to focus on the most vulnerable population groups; to promote oral health care in schools and among elderly people; and to provide oral health care through primary health-care services. She supported the draft resolution. In relation to paragraph 1(4), on fluoridation programmes, she requested further information about recently published evidence that fluoridation might be associated with teratogenic effects in teeth.

Dr SULEIMAN (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, reported that diseases of the oral cavity were prevalent in the Region. The burden of oral diseases, people's needs, and oral health systems and scientific knowledge were changing rapidly. Public health-care decision-makers needed the tools, capacity and information to

assess health needs, choose intervention strategies, design policies and improve oral health systems. Oral health promotion had been neglected because of the scarcity of resources. Oral health promotion would work only if it was made part of broader health promotion initiatives and integrated into primary health care. In some parts of the Region access to oral health services was limited and teeth were often left untreated or else extracted. The proportion of edentulous adults aged 65 years and older remained high.

He noted with satisfaction that the draft resolution built on the 10 priority areas identified in The world oral health report 2003.¹ WHO should provide technical support for the integration of oral health promotion into primary health care, and WHO country and regional offices should have sufficient technical capacity to provide guidance to Member States. WHO should support countries with oral health disease surveillance, an item which should be included in the resolution. The STEPwise approach to surveillance was not sufficient. Oral health diseases had to be included in the existing health information system, from primary to tertiary care level. He wholeheartedly supported the draft resolution.

Professor FAIZ (Bangladesh) observed that many oral diseases and conditions could be prevented by making basic knowledge available to community health-care professionals. Despite resource limitations, Bangladesh had taken steps to improve oral health care, including school health programmes, provision of fluoride toothpaste and oral care education for diabetic patients, but they fell short of needs.

Dr SEKAJUGO (Uganda) reported that in response to an increasing burden of oral disease, Uganda had embarked on the recommended preventive, screening and treatment strategies. Implementation of the resolution would lead to improved oral health in developing countries.

Dr BOUAKAZ (Algeria) said that oral and dental health in Algeria was an integral part of general health care. The emphasis was on prevention in schools at primary, secondary and tertiary level, as the impact of oral conditions on health had been conclusively demonstrated. He supported the draft resolution.

Dr CHITUWO (Zambia) said that the report on oral health had highlighted the need to do more to promote oral health. Zambia had seen an increase in oral diseases associated with HIV/AIDS and linked to the aggressive marketing of sugary drinks. Efforts to improve oral health included promotion activities in schools and the installation of dental equipment at various health-care levels. A school of dentistry should open soon in order to help to meet the serious shortage of oral health specialists in all categories, and his country was pressing ahead with preventive work. He supported the draft resolution.

Professor OKONOFUA (Nigeria) welcomed the draft resolution. Nigeria had strengthened its oral health services by promoting primary prevention. Oral health was important to the Government's comprehensive health promotion strategies. Nigeria had six dental schools but, largely owing to the "brain drain", not enough dental workers provided optimal oral health services. Training and improvements to delivery of oral health services, especially in rural areas, would continue and the integration of oral health into primary health care was planned.

Dr MAKUBALO (South Africa) agreed that oral health-care promotion should be part of primary health care. It should encompass oral hygiene, exposure to fluoride, a healthy diet and the prevention of trauma to the face and mouth. South Africa had programmes aimed at improving oral hygiene and oral health services in general. He endorsed the draft resolution.

¹ Document WHO/NMH/NPH/ORH/03.2.

Dr AERDEN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said the draft resolution sent a clear signal to the international health community that oral diseases needed urgent and sustained attention from all stakeholders. It was important to tackle the pandemic of untreated childhood caries, but also to take a holistic life-course approach to oral health and to recognize different disease patterns and health needs. The Federation endorsed the central role of oral health professionals; workforce planning and human resources for oral health were an essential part of every national health plan. Best practice models for the successful integration of oral health in primary health care existed and all people should have equal access to basic oral health care and preventive care.

She urged the Health Assembly to adopt the draft resolution; to include oral health in the Medium-term strategic plan 2008–2013; and to use technical support from WHO and her organization to implement affordable oral care at realistic cost at all levels of the health care system.

Dr BARNARD (International Association for Dental Research), speaking at the invitation of the CHAIRMAN, said that oral health was a necessary ingredient of total health and contributed to a healthy immune system. Researchers in his Association were defining strong oral-systemic linkages. The sharing of knowledge across Member States and international agencies would reduce the burden of oral disease. He supported the draft resolution and welcomed the reference to the need for oral health research.

Ms THORSEN (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, and on behalf of the International Lactation Consultant Association, said that the Association welcomed the warning against inadequate exposure to fluoride contained in the report, but highlighted the possible dangers of fluoridation for bottle-fed infants. Parents might lack the information needed concerning what type of water to use for infant formula in order to avoid overexposure to fluorides. She appreciated the recognition given to the role of breastfeeding in promoting oral health, the foundations of which were laid in infancy when decisions about infant feeding were made. Sugary liquids in baby bottles, and sugar consumption in general, were major causes of tooth decay, whereas breastfeeding promoted oral health by preventing tooth decay and ensuring optimum development of the oral cavity.

She would have liked to see a reference in the draft resolution to the Global Strategy on Infant and Young Child Feeding. The link between good oral health and the protection, promotion and support of breastfeeding in health programmes was critical in policy, strategy and implementation. That link would lead to coordinated approaches across the life-cycle and across technical areas.

Dr LE GALÈS-CAMUS (Assistant Director-General) acknowledged the support for the Secretariat's work on oral health, and noted the emphasis on oral health and the need to step up action in the following areas: technical assistance to countries and regions where the disease burden and needs were greatest; primary prevention, especially to combat the main risk factors, many of which were attributable to chronic noncommunicable diseases, and action on other determinants of oral health, especially high-risk and vulnerable groups; reinforced oral health services; the adoption of surveillance activities; and primary health care that gave a proper place to oral health. Those suggestions would guide WHO's work on the issue.

On the question raised by the delegate of Greece, she said that decades of practice had shown that fluoride was an effective means of combating and preventing dental caries. However, programmes in various settings had shown that the possible undesirable health consequences of overexposure to, or overconsumption of, fluorides could be avoided while the preventive effect of fluoride against dental caries was preserved. Decisions on implementing programmes to increase fluoride concentrations must therefore take account of the specific situation in each country. She could make the relevant technical documentation available to the delegate of Greece and other interested delegations.

Mr AITKEN (Representative of the Director-General), recapitulating the amendments proposed to the draft resolution, said that in paragraph 1(1), the words “and communicable” would be inserted after “noncommunicable” and the words “as well as maternal and child health policy” would be added at the end of the subparagraph. In paragraph 1(9), the words “and maternal care” would be inserted after “childhood illness”. In paragraph 1(13), the words “to consider increasing” would be replaced by “to increase, as appropriate,” and an additional subparagraph (14) would be added to paragraph 1, reading: “to strengthen partnerships and shared responsibility among stakeholders to maximize resources in support of national oral health programmes”.

In paragraph 2(1) the words “needs of low-income countries” would be replaced by “and unique needs of low- and middle-income countries”. The words “including increasing budgetary and human resources at all levels” would be inserted at the end of paragraph 2(5).

Mr ABDOO (United States of America) suggested that the words “as appropriate” should be inserted after “increasing” in the amended version of paragraph 2(5).

The CHAIRMAN said that, if he heard no objection, he would take it that the Committee approved the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

Working towards universal coverage of maternal, newborn and child health interventions: biennial report: Item 12.10 of the Agenda (Document A60/17)

Ms KONGSVIK (Norway), speaking on behalf of the Nordic countries, as well as Austria, Belgium, Canada, Estonia, France, Greece, Italy, Latvia, Luxembourg, the Netherlands, New Zealand, Romania, South Africa, Spain, Switzerland and the United Kingdom of Great Britain and Northern Ireland, said that more than 300 million women in the developing world currently suffered from short- or long-term illness and disabilities brought about by pregnancy-related complications. A child died every three seconds and a pregnant woman every minute – a loss of over 11 million lives annually, 98% of them in poor countries. Such lives could be saved by cost-effective and, in most cases, easily implemented health interventions. Resolution WHA58.31 set out a clear mandate for all Member States to work towards universal coverage of maternal, newborn and child health interventions, yet document A60/17 reported only modest progress in improving the situation. It was a matter of serious concern that the goal of universal access to reproductive health by 2015 might not be achieved.

Improving maternal and child health necessitated the empowerment of women: ensuring the right of girls and women to education, to employment opportunities and to making choices concerning their own bodies. It was unethical for women to risk their health and lives when giving birth or terminating a pregnancy. Poor women faced an unacceptably higher risk. Because maternal and child health also depended on safer sex, men’s responsibilities in that regard must be emphasized.

The appropriate response was to provide access to the full range of sexual and reproductive health services, including safe abortions. Some neglected and underfunded issues, such as family planning, adolescent sexual and reproductive health and rights and harmful traditional practices, should also be addressed. She applauded the 18 African countries that had outlawed female genital mutilation and commended countries such as Senegal that had adopted an effective and participatory approach in order to ensure that legal provisions were followed up by practical actions to preserve the integrity of girls’ and women’s bodies.

Political will and accelerated action were required. In that connection, she welcomed the fact that the Special Session of the African Union Conference of Ministers of Health (Maputo, 18–22 September 2006) had reaffirmed political support for sexual and reproductive health rights in

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA60.17.

the African Region and had adopted a plan of action, subsequently endorsed by the African Union in January 2007. She also welcomed the new target for reproductive health under Millennium Development Goal 5. Increased advocacy for maternal and child health was needed in order to reach Millennium Development Goals 4 and 5 and to stimulate national political action at the highest level. In particular, health services must be strengthened at the local level in accordance with national plans by, among other things, addressing human resource constraints. Indicators for maternal and child mortality must be used as a measure for results-based improvements.

Global coordination must also be strengthened and the core functions of international agencies reinforced in line with the United Nations reform agenda. WHO, UNICEF and UNFPA and the new global Partnership for Maternal, Newborn and Child Health were important allies in that initiative. Ensuring appropriate health interventions and achieving the Millennium Development Goals on maternal health and reduction of child mortality needed increased human and financial resources that would be used effectively at the country and district levels.

Mr HOFMANN (Germany), speaking on behalf of the European Union and its 27 Member States, welcomed the report and WHO's continued efforts to improve access to maternal, newborn and child health interventions. However, progress in achieving the Millennium Development Goals relating to child mortality, maternal health and HIV/AIDS, malaria and other diseases was slow. The extreme shortage of human resources for sexual and reproductive health must be tackled. The European Union had established a policy framework and increased commitments in that area. He urged the Organization to include in its report the important links between maternal, child and newborn health and other health issues, such as nutrition, water and sanitation, education on sexual and reproductive health, and non-health issues, such as infrastructure, power, transport and communications.

The European Union would continue to support partners in their commitments to achieving gender equality; however, implementation must be improved. He welcomed the new target in the Millennium Development Goals of universal access to reproductive health by 2015 and urged WHO to implement the maternal and child health strategies on which agreement had already been achieved, particularly its global strategies on reproductive health (2004) and for the prevention and control of sexually transmitted infections (2006–2015), progress on which was crucial for the improvement of maternal, newborn and child health.

Access to sexual and reproductive health care, as recommended by the 1994 International Conference on Population and Development, was still limited. There were acute supply shortages of family planning commodities, including condoms. Given the low level of prevention of mother-to-child transmission of HIV and of effective care of children in the neonatal period, and the fact that the survival of newborns was largely dependent on the mother's survival, how was WHO approaching the issue of primary HIV prevention in relation to preventing mother-to-child transmission, including antenatal care and the care of HIV-infected parents?

Progress by WHO, UNICEF and UNFPA in the context of United Nations reform would contribute to achieving a continuum of care between maternal, newborn, child and adolescent health. Better coverage of maternal, newborn and child health interventions would require firm political commitment on the part of all.

Dr HUWAIL (Iraq) said that a survey conducted in Iraq in 2006 had revealed an improvement in the under-five and infant mortality rates, at 41 and 34 per 1000 live births, respectively. However, Iraq's maternal and child health programmes still needed WHO's support in: introducing and implementing evidence-based guidelines on pregnancy, childbirth, postpartum and newborn care and family planning; improving the quality of services for newborn babies and infants by implementing the Integrated Management of Childhood Illness strategy; improving mortality statistics; establishing an effective health information system and strengthening the national surveillance of health determinants; monitoring implementation; improving access to family planning services and emergency obstetric care at the district level; and increasing community awareness of women's and mothers' health needs.

Mr ABDOO (United States of America) said that priority should be given to improving access to maternal, newborn and child health care as part of a core package of primary health-care services. That would help countries to meet the Millennium Development Goal of reducing child mortality by two thirds by 2015. That core package did not include abortion except when consistent with national and, where applicable, local law, and with full respect for the various religious and ethical values and cultural backgrounds, as was stated in resolution WHA55.19. His Government strongly endorsed the need to reduce child mortality and improve maternal health, as articulated in Millennium Development Goals 4 and 5, which were universally recognized as essential development priorities. However, the United States was opposed to adding new elements to the Millennium Development Goals matrix; as many countries lacked the resources and expertise to gather data that met basic international standards, all should focus on reliable indicators that were appropriate for meaningful global monitoring.

Dr OLIVEROS (Philippines) commended the report's analysis of trends in coverage of maternal, newborn and child health interventions. The Philippines had experienced difficulty in meeting Target 6 of Millennium Development Goal 5 on reducing maternal mortality. Consequently, advocacy for facility-based childbirth assisted by skilled attendants had resulted in a shift from a risk approach to an emergency care approach that considered all pregnancies as high risk. The Health Assembly should support the proposed global fund for maternal, newborn and child health.

Mr DANKOKO (Senegal), speaking on behalf of the 46 Member States of the African Region, acknowledged progress in setting up institutional and regulatory frameworks; increased awareness, knowledge and ownership of programmes; and the adoption of an approach based on equality of access to care. Poverty reduction strategies and national health programmes had been instituted in many African countries with the aim of reducing fertility rates and maternal and infant mortality rates. WHO had assisted in training experts in emergency obstetric and neonatal care and in maternal death audit methods, and in training midwives and nurses and skilled birth attendants. Deliveries and caesarean births had been subsidized, multisectoral approaches adopted and the participation of the community, civil society and especially women, included in the decision-making and planning process.

The Integrated Management of Childhood Illness strategy had been adopted in 44 of the 46 countries in the African Region, an evaluation study in the United Republic of Tanzania having shown that it had contributed to a 15% reduction in mortality among under five-year-olds over a two-year period. A child survival strategy for the African Region, jointly developed by WHO, UNICEF and the World Bank, and adopted by the Regional Committee for Africa at its fifty-sixth session, called for a package of cost-effective core interventions. Twenty-four trained facilitators were supporting countries in integrating prevention of mother-to-child transmission of HIV and in some countries new strategies were being adopted as well for obstetric fistulas, female genital mutilation, adolescent health and sexual abuse. Other initiatives included: capacity building of training establishments and decentralization of paramedic training; increasing the number of health professionals recruited each year and increasing health budgets; revision of the list of essential drugs and medicines for the Integrated Management of Childhood Illness strategy; social mobilization to encourage a wider use of insecticide-treated nets; and coordination of mass vaccination campaigns.

However, the Millennium Development Goals were far from being met. Constraints included: insufficient health coverage, especially in outlying regions; the high cost of services; the lack of qualified personnel, and technical and logistical services; sociocultural factors; insufficient coordination of programmes and integration of services; and lack of resources and management. African countries needed to build efficient and accessible national health care systems; develop, manage and retain human resources for health; develop multisectoral collaboration; and make maternal and child health a priority.

He welcomed the proposal of the Prime Minister of Norway in the third plenary meeting to develop a "global business plan" to accelerate progress towards Millennium Development Goals 4 and

5.¹ WHO should encourage development partners to further assist Africa in achieving adequate coverage in maternal, newborn and child health care.

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that her Ministry of Health was committed to providing free, accessible and universal health care, with the aim of achieving Millennium Development Goals 4 and 5 (Targets 5 and 6). The Government's maternal health project covered sexual and reproductive health, child and adolescent health, breastfeeding and community participation. The strategies included information campaigns on: prenatal and child health care; nutrition during pregnancy; breastfeeding; immunization of children; and recognizing danger signs in order to ensure that postpartum care prevented the death of mothers and newborns. Immunization and vaccination programmes for adults and children had been introduced and vaccination coverage was between 80% and 85%. Emphasis was placed on the provision of quality services and the training of doctors and nurses in obstetric and neonatal care. Free family planning and contraceptive services had been introduced. A law enacted in 2006 gave women the right to a life free from violence, which included the crime of obstetric violence. Another recent law promoted breastfeeding.

Dr HEIDARI (Islamic Republic of Iran) said that investing in maternal and child care services was both rewarding and cost-effective. In his country, such services, including family planning, had been integrated into primary health-care services. More than 95% of the population had access to maternal and child health-care interventions and, as a result, maternal, infant and child mortality had decreased significantly.

Dr RAMATLAPENG (Lesotho) said that a road map had been launched in 2006 in order to: provide better access to family planning services in the community; ensure that women reached a health facility for delivery; and update skills and provide supervisory support for safe deliveries and better post-abortion care. Unless measures were taken to expand child health services, the child health gains made during the 1980s would be reversed. Already, indicators showed a worsening situation: infant mortality had risen from 75 per 1000 live births in 2001 to 91 in 2004. Immunization services had, though, improved and efforts were being made to maintain coverage at over 90% and to remain poliomyelitis-free with active surveillance for imported cases. The Integrated Management of Childhood Illness strategy was followed in all 17 hospitals and 158 health centres, but the country continued to face the challenges of high levels of malnutrition and micronutrient deficiency disorders.

Ms SONG Li (China) endorsed the statement made by the delegate of Norway. Maternal and child health was a priority for her Government, which was working to reduce gaps in health status between women and children, focusing in particular on the poor. A programme launched in 2000 had helped to lower pregnancy-related mortality, increase the hospital delivery rate and reduce the occurrence of neonatal tetanus. However, China still faced many challenges in attaining the Millennium Development Goals relating to maternal and child health, especially in non-urban areas. China urged WHO and the international community to increase financial and technical support for the improvement of women's and children's health and for the achievement of universal coverage of maternal, newborn and child health interventions, especially among poor populations in developing countries.

Ms NGAUNJE (Malawi) said that her country had some of the worst maternal and child health indicators in the world. The Government had taken measures to accelerate the reduction of maternal and child mortality, and was increasing the number of skilled health workers and the number of births attended by skilled health workers. Some health facilities were being upgraded, and resources had been allocated for obstetric and neonatal medicines. Malawi had also developed an action plan for

¹ Document WHA60/2007/REC/2, in press.

preventing mother-to-child transmission of HIV, seeking comprehensive HIV/AIDS prevention services in all of the country's 525 antenatal care clinics. Malawi had begun to implement the Integrated Management of Childhood Illness strategy in the late 1990s. The country had recently embarked on a massive recruitment of health surveillance assistants, in order to achieve a coverage ratio of 1 assistant per 1000 households.

Dr ZAMPALIGRE (Burkina Faso) said that rates of maternal, neonatal and child mortality and morbidity remained high in Burkina Faso. The Government had adopted strategies concerning: the reduction of mortality; the Integrated Management of Childhood Illness strategy; nutrition; immunization over a 10-year period; and subsidies for childbirth and emergency obstetric and neonatal care. However, their implementation was hindered by a shortage of trained personnel, inadequate resources and a lack of community-based interventions.

Dr SUGIURA (Japan), noting that the Integrated Management of Childhood Illness strategy was not mentioned in the report, requested information on its contribution to universal coverage of maternal, newborn and child health interventions. He also asked for clarification of the meaning of "continuum of care", mentioned in paragraph 12 of the report, as it related specifically to maternal, newborn and child health. He looked forward to the second report on universal coverage of maternal, newborn and child health interventions in 2009.

Dr MAAMOURI (Tunisia) shared concerns about the slow progress in some developing countries towards the goal of universal coverage of maternal, newborn and child health interventions. There were, however, improvements, for example in immunization coverage. Maternal, neonatal and child health interventions had increased over the years, and political will for the further expansion existed at the highest levels. Technical support was needed to overcome the various obstacles to improved services and coverage.

Dr BODZONGO (Congo) said that the first sentence in paragraph 5 of the report failed to take account of efforts to improve the coverage of skilled attendance at birth, which was one goal of the road maps that had been developed and used by most sub-Saharan countries. He therefore requested that the words "except in sub-Saharan Africa" should be removed. Furthermore, the issue of maternal mortality could not be addressed without talking about abortion. He agreed with the statement made by the delegate of Norway in that regard, but emphasized that the issue of abortion must be considered in the context of overall health services for women and the laws in each Member State.

Dr MAZHANI (Botswana) emphasized improved maternal, newborn and child health and aligned his country with the statement made by the delegate of Norway. However, access to the full range of sexual and reproductive health services, including safe abortion, should be within the legal framework of each country.

Dr CHITUWO (Zambia) echoed the concern voiced over slow progress towards universal coverage of maternal, newborn and child health interventions. Child and maternal morbidity and mortality remained unacceptably high in some parts of the world and many countries might not achieve Millennium Development Goals 4 and 5. What was needed was well known, and numerous evidence-based interventions existed. Emergency obstetric and newborn care, for example, saved lives, but in many countries such services were non-existent at the primary health-care level. The biggest difficulty was inadequate resources. He welcomed the increase in resources to fight HIV, tuberculosis and malaria, but would welcome even more the integration of efforts to combat those diseases into efforts to enhance maternal and child health. Funding agencies had to be more flexible in the use of funds in order to benefit mothers and children.

Zambia's road map towards reduced maternal and neonatal morbidity and mortality had been integrated into provincial and district plans. Zambia promoted community initiatives for a continuum of care for mothers and children; it also welcomed the Partnership for Maternal, Newborn and Child

Health, which would enable Member States to combine their strengths. Zambia intended to implement the African Union plan of action for achieving universal access to comprehensive sexual and reproductive health care in Africa. In that connection, he welcomed the statement by the delegate of Norway.

Dr AMOS (South Africa) stressed the role of poverty and underdevelopment in maternal, newborn and infant mortality and morbidity, particularly in the African Region. The Secretariat should provide models to assist Member States in tackling the inequalities in service provision, particularly in the most inaccessible communities. Limited human resources and the migration of health workers in particular required attention.

With regard to the first sentence of paragraph 5 of the report, she observed that in South Africa more than 90% of births were professionally assisted and an even higher coverage had been achieved in antenatal care services. Important gains had also been made in improving access to primary health care, in implementing the Integrated Management of Childhood Illness strategy and in immunization coverage, both generally and specifically for childhood illnesses.

Ms DE HOZ (Argentina) said that her country's main child health objectives were to prevent developmental problems, and ensure early detection of diseases. Children's growth and development were followed by medical teams, and guidance was given where necessary. Since 1990, and particularly in the period 2004–2005, the infant mortality rate had decreased.

The most common causes of maternal mortality, which had declined considerably in Argentina, were linked to socioeconomic conditions.

Dr PHUSIT PRAKONGSAI (Thailand) said that in 2001 Thailand had introduced tax-funded health insurance, including interventions in the areas of maternal and child health, for 47 million of its 64 million people. However, he urged the Director-General, Member States and other organizations to tackle the inadequacy and scarcity of infrastructure and human resources in the area of maternal and child health services.

The weakness of vital registration and household surveys on health status and use of health services by people at risk hampered assessment of progress towards universal coverage. Ascertaining inequities in access to health services and the health status of mothers and children in various socioeconomic groups was important, and he urged WHO to support the strengthening of health information systems.

Faster progress towards universal coverage was needed in Africa, Asia and the Caribbean, particularly with regard to family planning and antenatal and postnatal care. Interventions at all levels were crucial for monitoring and evaluating maternal and child health coverage.

Mr NAIEM (Afghanistan) emphasized that his country was in a post-conflict state, with maternal and infant mortality rates among the highest in the world. The Ministry of Public Health had therefore developed a policy document in 2003, focusing on maternal and child health. The US\$ 4.5 per capita available fell far short of the figure of US\$ 34 per capita recommended by a WHO study and only provided minimum services. The Government provided services in three provinces; services in the remaining 31 provinces had been contracted to nongovernmental organizations and volunteers. In 2007, sub-centres had been introduced in an effort to improve access to basic maternal and child health services, but resources were still meagre and Afghanistan would need technical and financial support from the Secretariat and other Member States.

Ms NKURUNZIZA (Burundi) expressed support for the statement made by the delegate of Norway. Burundi's high maternal and infant mortality rates had prompted the Government to provide free health care for children under five and free obstetric services for mothers giving birth in health-care facilities, which had increased the use of such services by 50%.

As a post-conflict country, however, lack of equipment, infrastructure and human resources posed significant problems, as did mother-to-child transmission of HIV, which was still widespread,

despite the existence of effective treatments and strategies. WHO and the international community should therefore increase resources to support health systems, particularly in poor and post-conflict countries.

Dr BOUAKAZ (Algeria) said that a specific strategy was required to improve Africa's alarming maternal and infant mortality rates compared with those of developed countries. Algeria's national plan for neonatal and perinatal health 2006–2009 was aimed at reducing both those rates. The plan focused on the training of health personnel; establishment of neonatal units and services near or within obstetric, gynaecological or maternity facilities; provision of proper equipment for neonatal care, such as resuscitation units and incubators; and the strict monitoring of pregnancies involving risks such as high blood pressure and diabetes.

Professor OKONOFUA (Nigeria) emphasized improved maternal and child health through the delivery of modern, effective and efficient services, rather than the "traditional" services that had been promoted in the past.

In many societies, maternal and child health was not given the priority it deserved. Nigeria, however, had recently launched an integrated partnership for maternal, newborn and child health, which should contribute to reducing maternal and child mortality by 2015, and had introduced a maternal and child health advisory service. Free medical services would be provided to pregnant women and children under five in tertiary health institutions.

Maternal and child health indicators reflected a country's development, and he encouraged greater political priority to reducing maternal and child mortality rates in developing countries.

Dr BISWAS (Bangladesh) affirmed his country's implementation of a health, nutrition and population sector programme, a poverty reduction strategy and a maternal health strategy, in primary health care. However, only 10% of births occurred in care facilities and skilled birth attendance was available for only 13% of the community. A nationwide emergency programme had been established but was not yet yielding the desired results. A voucher scheme had also been introduced for the poorest pregnant women.

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

The meeting rose at 13:00.

TENTH MEETING

Monday, 21 May 2007, at 10:00

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. THIRD REPORT OF COMMITTEE A (Document A60/58)

Mrs BU FIGUEROA (Honduras), Rapporteur, read out the draft third report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Working towards universal coverage of maternal, newborn and child health interventions: biennial report: Item 12.10 of the Agenda (Document A60/17) (continued from the ninth meeting, section 2)

Dr MOOSA (Maldives), while appreciating the improvements made in some areas of maternal and child health, asked the Secretariat to increase provision of support for postnatal care in Member States given the many maternal and infant deaths. She was concerned to read in paragraph 18 of the report that three major donors had decreased their support for maternal, newborn and child health, making achievement of Millennium Development Goals 4 and 5 less likely. It would be useful to identify the funding shortfalls regarding the Goals, and the mechanisms required to ensure efficient use of resources.

Dr MIDZI (Zimbabwe) said that Zimbabwe continued to pursue the Millennium Development Goals related to maternal, newborn and child health, despite enormous challenges. The maternal mortality ratio had fallen by half since 2002 to 555 per 100 000 live births in 2006 and the under-five mortality rate had declined by 20% to 82 per 1000 live births (although both rates remained high). Those improvements resulted from a sustained high vaccination rate averaging 89%, the scaling up of prevention of mother-to-child transmission of HIV, and the provision of free antenatal care services to all women in all public health institutions, resulting in antenatal coverage of 84%. He invited the Director-General to attend the launch of Zimbabwe's maternal, newborn and child road map in June 2007. However, the achievements were seriously threatened by a human resources shortage caused by the exodus of health-care professionals; a shortfall in equipment and vital medicines for emergency obstetric care; an ageing ambulance fleet; too few service vehicles for the outreach services of the Expanded Programme on Immunization; weak health systems; and new and emerging diseases that diverted resources from high-performing programmes. He called on WHO to assist countries such as his in preserving health gains.

¹ See page 311.

Dr GEORGE (Barbados), speaking on behalf of the 14 member countries of the Caribbean Community, said that the health and well-being of mothers and children was indicative of a country's state of development. The 14 countries continued to make gains in vaccine-preventable diseases, safe motherhood and the health of children, with an immunization coverage rate above 90%; and they remained free of poliomyelitis and measles. In seeking to achieve the Millennium Development Goals, the Caribbean countries had placed maternal and child health within the context of a family health strategy. The maternal mortality ratio ranged from zero in Barbados to 910 per 100 000 live births in Haiti. Indirect causes of mortality, such as HIV/AIDS and violence, were increasing. However, innovations such as tracking of high-risk mothers by community health workers were being used, ensuring access to emergency obstetric care. Maternal deaths were systematically reviewed and an audit system had been tested in the field. More than 20% of pregnant women were adolescents, demonstrating the need for interventions to scale up programmes in adolescent reproductive health, pregnancy prevention and building life skills. Although gains had been made in maternal and child health, they were threatened by emerging childhood problems and the rapid loss of the skilled health workforce. He urged the Director-General to make human resources for health a priority, as countries needed to solve the problem of a diminishing health workforce. Initiatives might involve cross-training, gender balancing and greater funding for training.

Dr SOLOFONIRINA (Madagascar) said that, although maternal and child health remained a cause for concern, her country had reduced infant mortality rates from 117 per 1000 live births in 1997 to 94 per 1000 in 2006. Routine activities had been strengthened and mass vaccination campaigns for mothers and children introduced, combining the provision of insecticide-treated nets, vitamin A, iron and zinc supplements, and anti-parasite treatment. A coverage rate of 95% had been achieved and HIV testing introduced. She recommended devoting increased resources to that area of health care.

Mr MABUZA (Swaziland) said that much remained to be done to improve maternal, newborn, child and adolescent health, including access to sexual and reproductive health, if the Millennium Development Goals were to be achieved. Implementation of the Maputo Plan of Action on Sexual and Reproductive Health, which had been adopted by African ministers of health in 2006, would help. Swaziland was improving its maternal health package, which included prevention of mother-to-child transmission of HIV (with currently 50% coverage) and family planning. Child survival programmes in the Integrated Management of Childhood Illness strategy and the Expanded Programme on Immunization were delivered by public-private partnerships. However, challenges were posed by the migration of specially trained health personnel. He supported the statement by the Nordic countries and others, notwithstanding the fact that abortion in Swaziland was governed by national laws.

Dr MUKELABAI (UNICEF) welcomed the report, which would assist countries in attaining the Millennium Development Goals on maternal and child survival. Most maternal, newborn and child deaths could be easily prevented with scaled-up interventions. Sadly, only seven out of 60 countries with the highest mortality rate in children under five years old were on track to reach the Millennium Development Goal on child survival. Likewise, in many countries with high maternal mortality ratios, more than 80% of pregnant women delivered without assistance of skilled attendants, thus increasing their chances of dying of labour and delivery complications. In 2005, UNICEF had joined WHO and other partners to form the Partnership for Maternal, Newborn and Child Health, which was working with several countries in maternal and child survival. Further initiatives included a child survival strategy for the African Region proposed by WHO, UNICEF and the World Bank, from which a road map for child survival was being developed. Member States should sustain the highest political commitment and allocate resources to maternal, newborn and child health programmes. UNICEF appreciated the increasing commitment of donor countries, foundations and the private sector, and welcomed the proposal for a "global business plan" to accelerate achievement of Millennium Development Goals 4 and 5, put forward by the Prime Minister of Norway. UNICEF endorsed WHO's biennial report and looked forward to more countries achieving the Goals.

Ms CALDWELL (International Council of Nurses), speaking at the invitation of the CHAIRMAN and on behalf of the International Confederation of Midwives, commended the wider availability of professional assistance in childbirth, but noted with concern the higher rates of maternal mortality in sub-Saharan Africa and called for greater efforts to scale up skilled midwifery and nursing services. It was also troubling that pregnancy was increasing in 15- to 19-year-old young women. As stated in *The world health report 2005*,¹ every mother and baby needed care that was close to where people lived and close to their birth culture, but at the same time safe and given by a skilled professional. She urged that efforts be continued to extend the coverage of care given by midwives and nurse-midwives where it was most needed, thus helping to achieve Millennium Development Goals 4 and 5.

The report detailed progress in immunization coverage, although the poor coverage rates of low-cost practices, such as exclusive breastfeeding for babies up to six months of age and provision of insecticide-treated nets, were disappointing. Effective care in the neonatal period reached too few children, reflecting a failure to provide a continuum of care from family planning, pregnancy and childbirth to post-partum and newborn care. The bodies she represented were committed to working towards universal coverage and supported national and global initiatives aimed at increasing access to health care for women, babies and children.

Ms STERKEN (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN and on behalf of the International Baby Food Action Network, Churches' Action for Health and Consumers International, noted that, according to a report on newborn survival, appropriate breastfeeding could reduce mortality in children under five, even in the context of HIV/AIDS. With 50% or more of children under six months of age being exclusively breastfed in 10 countries and breastfeeding rates of 20% or less in 23 countries, the biennial report showed that WHO's recommendation of exclusive breastfeeding for six months and continuation for up to two years was far from being implemented. Out of 10.9 million deaths in children under five, four million were of babies in the first month of life. A study of 10 000 neonates in Ghana had reported that the risk of neonatal death was four times higher in children given animal formula or solids in addition to breastfeeding, and that a delay in breastfeeding initiation beyond the first hour or first day was associated with an increased risk of newborn mortality; further studies should be done to confirm those findings.

Early initiation of breastfeeding was a key element of the UNICEF/WHO Baby-Friendly Hospital Initiative and some 20 000 hospitals worldwide had achieved Baby-Friendly accreditation, as part of WHO's Global Strategy for Infant and Young Child Feeding, adopted in 2002. Meanwhile, the nongovernmental community, on behalf of which she spoke, requested the assistance of health ministers in celebrating World Breastfeeding Week 2007 under the theme "Initiation of breastfeeding during the first hour after birth".

Ms SACKSTEIN (International Alliance of Women), speaking at the invitation of the CHAIRMAN, said that 95% of the 529 000 maternal deaths each year occurred in Africa and most could be avoided through a few simple interventions. The burden fell mainly on women in low-income countries and those living in poverty in affluent societies. Family planning programmes were increasingly scarce, often driven out of developing countries' health funding for ideological reasons. Skilled attendance in delivery, backed up by emergency obstetric care, would reduce maternal deaths by 75%; family planning could also reduce maternal and child deaths. Maternal mortality exposed profound global, ethnic and gender inequalities that were both health and human rights issues. It deserved more attention, despite WHO's many efforts such as its "Make every mother and child count" campaign in 2005. Combating maternal mortality could become both a powerful motor for

¹ *The World Health Report 2005: Make every mother and child count*. Geneva, World Health Organization, 2005.

strengthening health systems accessible to all and pivotal to attaining most Millennium Development Goals.

Mrs MAFUBELU (Assistant Director-General) commended the many measures Member States had taken to provide universal coverage of maternal, newborn and child health interventions. The Secretariat shared concerns at the slow pace of progress towards Millennium Development Goals 4 and 5. With renewed commitments from Member States and development partners, progress could be accelerated and the Goals achieved on time. In that regard, she welcomed the plan of action adopted at the African Union Conference of Ministers of Health (Maputo, September 2006) and the global business plan proposed by the Prime Minister of Norway, which should ensure that more resources were allocated to that important area of work.

She welcomed development partners' financial support in that area, such as the European Union's funding to six African countries and two South American countries. WHO's collaboration with relevant partners would continue, in order to harmonize efforts within the United Nations system to increase technical support to Member States.

WHO's programmes on maternal, child and reproductive health, with UNICEF, UNFPA, the World Bank, development partners, nongovernmental organizations and professional bodies, were scaling up activities and prevention of mother-to-child transmission of HIV, particularly in Africa. WHO, with its partners, was tackling malaria in pregnancy, as antenatal care provided a unique opportunity to deal with mother-to-child transmission of HIV and malaria in pregnancy. Although the Integrated Management of Childhood Illnesses strategy was not specifically referred to in the report, specific interventions were, including management of diarrhoea and pneumonia, and newborn care. The strategy remained central to the key interventions to reduce under-five mortality, and would be covered in the forthcoming biennial report to the Health Assembly.

Although professional assistance in childbirth in sub-Saharan Africa was insufficient, progress had been made in Botswana, Cape Verde, Congo, Gabon, Mauritius and South Africa. The proportion of births assisted by skilled birth attendants in those countries currently exceeded 80%. She expressed regret that the report had failed to acknowledge that achievement.

Continuum of care had two dimensions within the context of the report. At the service level, it ensured the necessary linkages between care at the community and primary levels and care at the secondary and tertiary levels, such as dealing with complications during pregnancy and providing certain types of family planning. It also referred to interventions during key stages of the life course.

WHO would hold an expert committee meeting in 2007, to address the issue of post-partum care, with the aim of improving the coverage of post-natal care.

She had taken note of the invitation from the delegate of Zimbabwe.

WHO would continue to implement key health strategies to improve maternal, newborn and child health, notably the global strategy on reproductive health and the global strategy on prevention and control of sexually transmitted infections. The Director-General was committed to ensuring that the achievements of the Organization were measured by their impact on the health of the people of Africa and the health of women. It was in that context that efforts to improve the health of women, newborns and children were being intensified.

The Committee noted the report.

Malaria, including proposal for establishment of World Malaria Day: Item 12.5 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R16, EB120.R16 Corr.1 and A60/12) (continued from the fifth meeting, section 3)

The CHAIRMAN invited the Committee to consider the following draft resolution, as revised by an informal drafting group:

The Sixtieth World Health Assembly,
Having considered the report on malaria, including a proposal for the establishment of Malaria Day;¹

Concerned that malaria continues to cause more than one million preventable deaths a year;

Noting that the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank Global Strategy and Booster Program, the Bill & Melinda Gates Foundation, the Malaria Initiative of the President of the United States of America, and other donors have made substantial resources available;

Welcoming the contribution to the mobilization of resources for development of voluntary innovative financing initiatives taken by groups of Member States and, in this regard, noting the activities of the International Drug Purchase Facility (UNITAID);

Recalling that combating HIV/AIDS, malaria and other diseases is included in internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Mindful that the global burden of malaria needs to be decreased in order to reach the Millennium Development Goal of reducing the mortality rate among children under five by two thirds by 2015 and to help to achieve the Millennium Development Goals of improving maternal health and eradicating extreme poverty,

1. URGES Member States:

(1) to apply to their specific contexts the evidenced-based policies, strategies and tools recommended by WHO, and performance-based monitoring and evaluation in order to expand coverage with major preventive interventions in populations at risk and curative interventions for patients suffering from malaria and to assess programme performance and the coverage and impact of interventions in an effective and timely manner, particularly with use of the WHO country-profile database;

(2) to assign national and international resources, both human and financial, for the provision of technical support in order to ensure that the most locally and epidemiologically appropriate strategies are effectively implemented and target populations are reached;

(3) to cease progressively the provision in both the public and private sectors of oral artemisinin monotherapies, to promote the use of artemisinin-combination therapies, and to implement policies that prohibit the production, marketing, distribution and the use of counterfeit antimalarial medicines;

(4) to intensify access to affordable, safe and effective antimalarial combination treatments, to intermittent preventive treatment in pregnancies, with special precautions for HIV-infected pregnant women who are receiving co-trimoxazole chemotherapy, to insecticide-treated mosquito nets, including through the free distribution of such nets where appropriate, and indoor residual spraying for malaria control with suitable and safe insecticides, taking into account relevant international rules, standards and guidelines;

¹ Document A60/12.

- (5) to provide, whenever necessary, in their legislation for use, to the full, of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to pharmaceutical products;¹
 - (6) to use all necessary administrative and legislative means, including, where appropriate, the use of provisions in international agreements, including the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to preventive technologies against malaria;
 - (7) to aim at reducing or interrupting malaria transmission, wherever feasible, through integrated vector management, promoting improvement of local and environmental conditions and healthy settings, and increasing access to basic health services, antimalarial medicines, diagnostics and preventive technologies in order to reduce the disease burden;
 - (8) to implement integrated approaches to malaria prevention and control through multisectoral collaboration and community responsibility and participation;
2. REQUESTS international organizations and financing bodies:
 - (1) to provide support for the development of capacities in developing countries in order to expand use of: reliable diagnostics, artemisinin-based combination therapies that are appropriate for local drug-resistance conditions, integrated vector management including long-lasting insecticide-treated nets and larvicidal measures, indoor residual spraying with appropriate and safe insecticides as indicated by WHO and in accordance with the Stockholm Convention on Persistent Organic Pollutants,² and monitoring and evaluation systems, including use of the country database developed by WHO;
 - (2) to increase funding for malaria control, so that the relevant agencies can continue providing support to countries, and to channel additional resources into technical support so that the financial resources can be absorbed and used effectively in countries;
 - (3) to provide support for malaria elimination in areas where feasible and sustainable;
 - (4) to adjust their policies so as progressively to cease to fund the provision and distribution of oral artemisinin monotherapies, and to join in campaigns to prohibit the production, marketing, distribution and use of counterfeit antimalarial medicines;
 3. REQUESTS the Director-General:
 - (1) to take steps to identify gaps in knowledge about malaria control and elimination; to provide support for the development of new tools for diagnostics, therapy, prevention and control, and strategies; to estimate more accurately the global burden of disease and determine trends; to develop new tools and methods for assessing impact and cost-effectiveness of interventions; to build up WHO's current research on malaria, including that of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases; to provide technical support to countries for conducting operational and implementation research; and to mobilize resources and increase support for research in the development of new tools and strategies for prevention and control of malaria;

¹ "The WTO General Council in its Decision of 30 August 2003 on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health decided that "pharmaceutical product" means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included".

² The Stockholm Convention on Persistent Organic Pollutants (Annex B, Part II, paragraphs 1–5) allows for temporary DDT use for the purpose of malaria vector control while maintaining the goal of reducing and ultimately eliminating the use of DDT and calls for the development of alternatives.

(2) to strengthen and rationalize human resources for malaria by deploying staff to country level, thus improving the capacity of WHO's country offices to provide technical guidance to national health programmes;

(2bis) to provide support to coordinating partners and countries for malaria control in refugee camps and in complex emergencies;

(3) to improve the coordination between different stakeholders in the fight against malaria;

(3bis) to support the sound management of DDT use for vector control in accordance with the Stockholm Convention on Persistent Organic Pollutants,¹ and to share data on such use with Member States;

(4) to report to the Health Assembly biennially through the Executive Board on progress made in implementation of this resolution;

4. RESOLVES that:

(1) World Malaria Day shall be commemorated annually on 25 April, or on such other day or days as individual Member States may decide, in order to provide education and understanding of malaria as a global scourge that is preventable and a disease that is curable;

(2) World Malaria Day shall be the culmination of year-long intensified implementation of national malaria-control strategies, including community-based activities for malaria prevention and treatment in endemic areas, and the occasion to inform the general public of the obstacles encountered and progress achieved in controlling malaria.

The draft resolution was approved.²

Tuberculosis control: progress and long-term planning: Item 12.6 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R3, and A60/13) (continued from the eighth meeting)

The CHAIRMAN invited the Committee to consider the following draft resolution, as revised by an informal drafting group:

The Sixtieth World Health Assembly,

Having considered the report on tuberculosis control: progress and long-term planning;³

Noting the progress made since 1991 towards achieving the international targets for 2005, and more recently following the establishment, in response to resolution WHA51.13, of the Stop TB Partnership;

Aware of the need to build on this progress and overcome constraints in order to reach the international targets for tuberculosis control for 2015 set by the Stop TB Partnership – in line with the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration to “have halted by 2015 and begun to reverse the incidence of major diseases” – of halving tuberculosis prevalence and death rates by 2015 compared with 1990 levels;

¹ The Stockholm Convention on Persistent Organic Pollutants (Annex B, Part II, paragraphs 1–5) allows for temporary DDT use for the purpose of malaria vector control while maintaining the goal of reducing and ultimately eliminating the use of DDT and calls for the development of alternatives.

² Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA60.18.

³ Document A60/13.

Noting the development of the Stop TB strategy as a comprehensive approach to tuberculosis prevention and control that incorporates the internationally agreed tuberculosis control strategy (DOTS strategy) and represents a significant expansion in the scale and scope of tuberculosis-control activities;

Welcoming the Partnership's Global Plan to Stop TB 2006–2015, which sets out the activities oriented towards implementing the Stop TB strategy and achieving the international targets for tuberculosis control for 2015;

Aware of the need to increase the scope, scale and speed of research needed to achieve the international targets for tuberculosis control for 2015 and the goal of eliminating tuberculosis as a global public-health problem by 2050;

Concerned that delays in implementing the Global Plan will result in increasing numbers of tuberculosis cases and deaths, including those due to multidrug-resistant (and extensively drug-resistant) tuberculosis and to the impact of HIV, and therefore in delays in achieving by 2015 the international targets for tuberculosis control and the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Recognizing the importance of the situation and the trends of multidrug-resistant and extensively drug-resistant tuberculosis as barriers to the achievement of the Global Plan's objectives by 2015, and the need for an increased number of Member States participating in the network of the Global Project on Anti-Tuberculosis Drug Resistance Surveillance and for the required additional resources to accomplish its task; [Thailand]

Recalling that resolution WHA58.14 encouraged Member States to fulfil their commitments to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Welcoming the contribution to the mobilization of resources for development by voluntary innovative financing initiatives taken by groups of Member States and, in this regard, noting the International Drug Purchase Facility (UNITAID), the International Finance Facility for Immunisation and the commitment to launch a pilot project within the advance market commitments initiatives, [Germany]

or

Welcoming the contribution to the mobilization of resources for development by voluntary innovative financing initiatives taken by groups of Member States [United States of America]

1. URGES all Member States:
 - (1) to develop and implement long-term plans for tuberculosis prevention and control in line with the Global Plan to Stop TB 2006–2015, in the context of overall health development plans, in collaboration with other programmes (including those on HIV/AIDS, child health and strengthening of health systems), and through national Stop TB partnerships where appropriate, with the aim of:
 - (a) accelerating progress towards the international targets for tuberculosis control for 2015 through full and rapid implementation of the Stop TB strategy **with specific attention to vulnerable groups highly at risk, such as poor people, migrants and ethnic minorities; [Netherlands]**
 - (b) accelerating improvement of health-information systems, **both in general and for tuberculosis in particular, [Japan]** in order to serve the assessment of national programme performance;
 - (c) **ensuring high-quality implementation of the DOTS strategy by tuberculosis programmes as the first and foremost step in full implementation of the Stop TB strategy; [Japan]**
 - (d) ~~limiting~~ **controlling [Micronesia (Federated States of)]** the emergence and transmission of multi-drug-resistant tuberculosis, including extensively drug-

resistant tuberculosis, **by ensuring the high-quality implementation of the DOTS strategy and by [Japan]** prompt implementation of infection-control precautions;

(dbis) if affected, immediately addressing extensively drug-resistant tuberculosis **and HIV-related tuberculosis [Ethiopia]** as part of the overall Stop TB strategy, as the highest health priorities; **[Ethiopia]**

(e) enhancing laboratory capacity in order to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, **where resources are available, [Thailand]** and promote access to quality-assured sputum smear microscopy;

(f) increasing access to quality-assured second-line medicines at affordable prices through the Stop TB Partnership's Green Light Committee;

(g) accelerating collaborative interventions against HIV infection and tuberculosis; [Kenya]

(h) fully involving the private sector in national tuberculosis control programmes; [Swaziland]

(2) to use all possible financing mechanisms in order to fulfil the commitments made in resolution WHA58.14, including that to ensure sustainable domestic and external financing, thereby filling the funding gaps identified in the Global Plan to Stop TB 2006–2015;

(3) to declare, where appropriate, tuberculosis as an emergency and to allocate additional resources in order to strengthen activities aimed at stopping the spread of extensively drug-resistant tuberculosis;

2. REQUESTS the Director-General:

(1) to intensify support provided to Member States in expanding implementation of the Stop TB strategy by developing capacity and improving the performance of national tuberculosis-control programmes, particularly the quality of DOTS activities, and by implementing infection-control precautions within the broad context of strengthening health systems in order to achieve the international targets for 2015;

(1bis) to continue to provide support for the network of the Global Project on Anti-Tuberculosis Drug Resistance Surveillance by increasing the number of Member States in the network in order to inform the Global Plan to Stop TB 2006–2015 through determination of the extent and trend of multidrug-resistant and extensively drug-resistant tuberculosis; [Thailand]

(2) to strengthen urgently WHO's support to countries affected **by multidrug-resistant tuberculosis and especially [Swaziland]** extensively drug-resistant tuberculosis, ~~particularly where related to HIV~~; **and to countries highly affected by HIV-related tuberculosis; [Ethiopia]**

(3) to enhance WHO's leadership within the Stop TB Partnership in its coordination of efforts to implement the Global Plan to Stop TB 2006–2015 and to facilitate long-term commitment to sustainable financing of the Global Plan through improved mechanisms for increased funding;

(4) to strengthen mechanisms to review and monitor estimates of impact of control activities on the tuberculosis burden, including incidence, prevalence and mortality **with specific attention to vulnerable groups highly at risk, such as poor people, migrants and ethnic minorities; [Netherlands]**

- (5) to support Member States in developing laboratory capacity to provide for rapid drug-susceptibility testing of isolates obtained from all persons with culture-positive tuberculosis, **to develop consensus guidelines for rapid drug-susceptibility test methods and appropriate measures for laboratory strengthening, and to mobilize funding; [Thailand]**
- (6) to enhance WHO's role in tuberculosis research in order to promote the applied research necessary to reach the international targets for tuberculosis control for 2015 and the basic research necessary to achieve the goal of eliminating tuberculosis by 2050; and to increase global support for those areas of tuberculosis research that are currently underresourced, **especially enhancing research and development of new ~~Anti-Tuberculosis agents~~ diagnostics, drugs and vaccines and the relevance of nutrition to, and its interaction with, tuberculosis; [Kuwait]**
- (7) to report to the Sixty-third World Health Assembly through the Executive Board on:
- (a) progress in implementation of the Global Plan to Stop TB 2006–2015, including mobilization of resources from domestic and external sources for its implementation;
 - (b) progress made in achieving the international targets for tuberculosis control by 2015, using the “proportion of tuberculosis cases detected and cured under directly observed treatment, short course (DOTS)” (Millennium Development Goal indicator 24) as a measure of the performance of national programmes, and tuberculosis incidence and “prevalence and death rates associated with tuberculosis” (Millennium Development Goal indicator 23) as a measure of the impact of control on the tuberculosis epidemic.

Mr AITKEN (Representative of the Director-General) pointed out that those concerned by the final preambular paragraph had expressed a preference for the first option provided in the text of the draft resolution.

Dr METAI (Kiribati) supported the draft resolution. Kiribati had an unacceptably high incidence of tuberculosis, and the concomitant levels of tuberculosis and HIV/AIDS were increasing. The presence of a drug-resistant tuberculosis patient was a serious threat. The inability to conduct a culture and sensitivity test for the *Mycobacterium tuberculosis* at the national level left the country unable to detect cases resistant to tuberculosis drugs. Moreover, negative sputum cases on slide smears that might have been positive if they had been cultured could also be missed. External assistance was required to plug the funding gap for the national tuberculosis strategic plan, to provide medicines, and to improve data reporting.

The draft resolution, as amended, was approved.¹

Health promotion in a globalized world: Item 12.11 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R14, and A60/18)

Mrs REITENBACH (Germany), speaking on behalf of the Member States of the European Union, said that Turkey, Croatia, The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, as well as Ukraine and the Republic of Moldova aligned themselves with her statement. She supported the draft resolution on health promotion in a globalized world contained in resolution EB120.R14.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA60.19.

Health was influenced by determinants inside and outside the health sector, including income, education, employment, work environment and housing, which often had impacts that were unequally distributed among population groups. Tackling the wider determinants was the core of health promotion, and would reduce health inequalities in developing and developed countries alike. The project “Closing the Gap – Strategies for Action to Tackle Health Inequalities in Europe”, funded by the European Union, had underlined the need to focus on inequalities in health in all the Union’s Member States.

She welcomed the call for a government-wide approach and the consideration of the wider context of people’s lives in the Bangkok Charter for Health Promotion in a Globalized World. The European Commission’s “Health in All Policies” strategy also aimed to treat health as an intersectoral issue that decision-making systematically took into account. A focus on the determinants of health, investment in health promotion and the active commitment of stakeholders in the field would improve equitable socioeconomic development. The European Union supported WHO in its aim to strengthen the evidence base for health promotion. Strong links were required between WHO’s regular activities and the Commission on Social Determinants of Health. WHO’s health promotion programme should be coordinated with top-level leadership, and the Director-General should emphasize the need for cross-cutting approaches to health in the United Nations reform process.

The German Government had organized a European Union conference on Prevention for Health, Nutrition and Physical Activity – a Key to Healthy Living (Badenweiler, Germany, 26–27 February 2007), which combined behavioural and settings-based prevention with health promotion measures. In its forthcoming Union presidency, Portugal would focus on better health for migrants.

She proposed that, in paragraphs 1(2) and 2(3) of the draft resolution, the words “including interministerial” should be inserted after “multisectoral”, since improved coordination between ministries was one key to strengthening the determinants of health.

She welcomed the Secretariat’s support to European Union Member States for building their capacity for health promotion. WHO should take a lead in activities aimed at putting the principles of health promotion into practice.

Dr ASLANYAN (Canada), supporting the draft resolution, said that health promotion had changed behaviour through social, policy and environmental interventions. It had helped to reduce causes of death and illness such as heart disease, road injuries, infectious diseases and HIV/AIDS. A current priority was to complement programmes that reduced risk factors with policies making for better health among vulnerable groups. He encouraged attendance at the World Conference on Health Promotion and Health Education (Vancouver, British Columbia, Canada, 10–15 June 2007).

Mr HERNÁNDEZ FLEITAS (Cuba) supported the call in the Bangkok Charter to develop a global treaty for health. Cuba’s health promotion policy was reaching all communities through local encouragement of healthy behaviours and lifestyles. A commission established in 2000 focused on risk factors in order to reduce the prevalence of diseases, and took into account factors such as water and air quality, and refuse management. Multisectoral efforts were tackling premature deaths and the burden of disability, and encouraging young people to adopt healthy behaviours and to take preventive measures against drug abuse.

He supported the draft resolution but proposed that it should include a reference to general practitioners’ training in applying health promotion in their community work. It should also mention strengthened training among specific population groups. Paragraph 1(5) should be amended to read “to introduce evidence-based health promotion interventions into current practice”. In paragraph 2(2), the last phrase, “including those caused by noncommunicable diseases” should be deleted and in paragraph 2(4), the word “multisectoral” should be inserted before “national”.

Professor TLOU (Botswana) welcomed the promise of strengthened health systems and the emphasis placed on primary health, which had lost ground to HIV/AIDS, severe acute respiratory syndrome and avian influenza. WHO’s activities to help implement the Bangkok Charter for Health

Promotion in a Globalized World were encouraging, including the framework for the health promotion strategy.

Recognizing the diverse changes in disease patterns and health determinants, Botswana had revised its pre-service health education curriculum, and was developing a new in-service training curriculum for community health workers.

Welcoming resolution EB120.R14, she requested WHO to provide technical assistance for health impact assessments to be carried out in the areas of health promotion and health education.

Mr EL BEY (Algeria), speaking on behalf of the Member States of the African Region, said that threats to public health could no longer be contained within national or regional boundaries, and the international community had to meet the challenges of a globalized world. The countries of Africa were particularly concerned about the emergence of new diseases and the re-emergence of others. A system for early warning and rapid response was needed, and he commended the mandatory reporting requirements of the International Health Regulations (2005). No country could cope alone with the emergencies resulting from epidemics, and natural or environmental disasters. In 2006, 134 million people worldwide had been affected by such disasters, and more than 21 000 people had died as a result.

Welcoming the Director-General's commitment to promote health in Africa, he called for more financial assistance for the Region in order to make health systems flexible and medicines affordable. The African Region needed to strengthen its capacity for health promotion by developing strategies and managing the migration of trained medical personnel – a major challenge. Some African countries required support in preparing for the 7th Global Conference on Health Promotion, to be held in Kenya in 2009. States, international organizations, the private sector, civil society and nongovernmental organizations must work together for health promotion in order to achieve the Millennium Development Goals. He supported the resolution.

Dr MAAMOURI (Tunisia), commending WHO's work on eliminating inequities in health, said that the role of the health sector should be part of a multisectoral approach to health determinants. WHO must devise strategies that recognized the disparities between countries, since these disparities required both increased coordination between WHO and other international organizations, and the classification of countries according to their specific features.

Some countries faced concurrent health problems and needed support to address the many existing and emerging challenges they faced. Advanced monitoring systems would help to identify the determinants of such problems and develop plans to deal with them. He supported the draft resolution and invited countries to examine ways of increasing private sector funding for health sector activities, especially where the private sector exercised a negative impact on health. Within its collaborative programmes, WHO should allocate part of its budget to health promotion.

Dr HUWAIL (Iraq) said that health promotion was essential for sustainable development. The Bangkok Charter for Health Promotion in a Globalized World rightly emphasized the social and economic determinants of health, because more than 60% of the disease burden in the Eastern Mediterranean Region was due to unhealthy lifestyles and high-risk activities. In order to implement effectively the measures in the resolution, health promotion strategies must be brought within existing health systems, and support provided by WHO and donors to build capacity for policies, planning and programme implementation. Mechanisms should be identified to close the gap in health-care provision between developing and developed countries, with particular attention to countries in special situations, such as Iraq.

Dr PHILLIPS (Trinidad and Tobago) said that the strategies of WHO's various health promotion initiatives underpinned her country's approach to health promotion, namely to improve the ability of individuals and communities to control, maintain and enhance their physical, mental, social and spiritual well-being. The basis of the approach was: formulating public health policy; re-orienting health services; empowering communities to achieve well-being; creating supportive environments;

developing and increasing personal health skills; and building alliances, with special emphasis on the media. The approach, together with the strategic actions outlined in the Caribbean Charter for Health Promotion, were integrated into her country's health promotion plan. Best practices were contributing to identifying priorities, developing new interventions and strengthening local and regional initiatives.

Trinidad and Tobago had established a multisectoral health promotion council with responsibility for healthy policies in both public and private sectors. The council was overseeing a new national plan for health promotion, known as "healthy communities and municipalities", which was encouraging greater community involvement. Health promotion had been introduced into the curriculum for training doctors and nurses, and a policy on health and family life education was being implemented in primary schools. For 10 years, public education campaigns had concentrated on raising awareness of smoking, healthy lifestyles, responsible sexual behaviour, exercise and nutrition, self esteem and empowerment, mental health, food safety, and HIV/AIDS. He supported the draft resolution.

Dr HEIDARI (Islamic Republic of Iran) welcomed the renewed attention being given to health promotion. Unless gaps in social justice, responsibility, implementation and knowledge were bridged, the current inequalities in health between and within countries would persist. Only strategies that focused on the social determinants of health could improve the health of the world's most vulnerable people. Many sectors of society should be involved in developing and implementing national policies to address those social determinants.

Iran had experienced improvements in health indicators, but social factors continued to create differences in health status between poor and rich people and between rural and urban communities. The main priority for national health policy was to tackle the social determinants of health inequities, and current health sector reform was expected to address the issues of equity, quality, effectiveness, client satisfaction and fair financing in the health system. It was necessary to maintain the momentum, and provide Iranian policy-makers and civil society groups with the opportunity to draw on international experience and knowledge.

Dr UGRID MILINTANGKUL (Thailand) welcomed WHO's strong commitment to improving health promotion. The Bangkok Charter for Health Promotion in a Globalized World was a significant step towards achieving the Millennium Development Goals.

The marketing of unhealthy products, especially to women and children, should be regulated, and appropriate consumption of healthy products encouraged. In order to raise awareness among stakeholders of the impact of non-biomedical factors on health, forums should be conducted worldwide on the social determinants of health.

He suggested amending the draft resolution by adding at the end of paragraph 1(3) the words "and promoting constructive engagement for mutual interest"; at the end of paragraph 1(4) the words "and report result for improvement of health promotion problems. Publicize and feed into the planning system"; and at the end of paragraph 2(5) the words "as well as make the reports accessible to the public".

Ms GIBB (United States of America) highlighted the importance of health promotion in health and economic development. Her President's Healthier US initiative challenged all levels of stakeholders to take specific steps to eliminate disparities, increase life expectancy and improve the quality of life. Strong public-private partnerships had helped to maximize resources for health promotion; those resources were complemented by WHO initiatives such as the Global Strategy on Diet, Physical Activity and Health and the Global Programme on Health Promotion Effectiveness. Health promotion that empowered people and communities was cost effective and sustainable. Clear data and indicators to evaluate the cost-effectiveness of different health promotion strategies helped policy-makers in allocating resources. She supported the draft resolution.

Dr FAKEYE (Nigeria) said that health promotion could improve health systems by enhancing prevention, reducing the disease burden, alleviating pressure on health facilities and reducing costs,

while making the systems more effective and responsive. In 2006, Nigeria had developed a national policy and strategic plan for health promotion. Assistance from WHO and development partners was needed to implement the plan.

The Secretariat's report should have included a reference to alcoholic drinks.

There was still a wide gap between health promotion initiatives and programmes on disease control, for instance on HIV/AIDS, malaria, tuberculosis and noncommunicable diseases. Collaboration between them should be closer, both within governments and development agencies; this would also increase the chances of revitalizing primary health care.

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that health promotion could only succeed through an intersectoral approach, involving public participation and the re-orientation of health services. Her Government was determinedly pursuing the elimination of social inequities. It encouraged mass outreach health-care programmes, including prevention and health promotion, for people living in poor or isolated areas. Health promotion programmes improved access to health services for marginalized groups, tackled visual impairment and provided better dental care. Such programmes had improved the quality of life, empowered people and expanded access to health services. Venezuela was eager to share that experience and to collaborate with other countries. Another initiative, with the assistance of PAHO and WHO, would promote health and health education within schools; the number of smoke-free environments had also increased.

Commenting on the report, she said that the reduction of health inequalities, mentioned in paragraph 2, was not enough; they must be eliminated. As for the draft resolution, she suggested including in paragraph 1(3) the phrase "through every form of collective organization, including trade unions and employers' and other associations, especially those relating to public health".

Ms SONG Li (China) said that health promotion was a responsibility shared by the whole of society and should be strengthened in order to achieve the goals set out in the Bangkok Charter for Health Promotion in a Globalized World. A global forum should be established to develop a framework for health promotion and to help Member States with capacity building. Even in an era of globalization, there were wide gaps between countries in terms of social and economic development. China would step up its technical exchanges in health promotion, and sought technical support and guidance from WHO. She supported the draft resolution.

Mr ASPLUND (Sweden) suggested amending the sixth preambular paragraph of the draft resolution by inserting the phrase ", notably in noncommunicable diseases," after "Recognizing that the dramatic changes of the global burden of disease".

Ms CAMARGO (Mexico), supporting the draft resolution, suggested including a new paragraph, to read: [URGES all Member States] "which have established national health policies incorporating health promotion as an essential element in addressing the social determinants of health, to exchange their experience in an effective manner with other countries in the process of doing so".

Dr VIOLAKI-PARASKEVA (Greece) said that health promotion was the key to reducing health problems worldwide, and should be accorded greater resources if the goal of health for all were to be achieved. She suggested inserting, after the sixth preambular paragraph of the resolution, a new preambular paragraph reading: "Recognizing that health promotion contributes in achieving health for all".

Dr TAKAHASHI (Japan) said that in 2000 his Government had established a health promotion movement involving the public and private sectors and with targets for 2015, such as reducing risk factors for lifestyle-related diseases. A recent mid-term evaluation had shown that activities needed to be better focused, role sharing clarified, and cooperation with the industrial sector strengthened. WHO should continue to facilitate exchanges of experience. He supported the draft resolution.

Dr NYIKAL (Kenya) expressed concern that no assessment had been made of the impact on health of political and development policies instituted at global, regional and country levels. WHO's advocacy was important for ensuring that such policies did not adversely affect health. He proposed the addition of a new subparagraph to follow paragraph 2(6): "to advocate for the development of political, social and economic policies that impact positively on health".

His country was honoured to have been chosen to host the 7th Global Conference on Health Promotion.

Dr AL-DOUSARI (Kuwait) said that his country had clinics to promote health, as well as to treat disease. Health promotion should be based on sound evidence and data. He suggested including in paragraph 1(3), after "civil society", the words "especially persons or groups of good contribution", and the words "and improve" after "evaluate" in paragraph 1(4).

Mr HAZIM (Morocco) expressed his appreciation of the report, noting that globalization had triggered epidemiological, political and technological changes in the developing world. Growing inequality in the allocation of resources between the North and South heightened tensions and instability. Half the 5000 million people living in the developing world survived on less than US\$ 2 per day. They needed housing, food and a proper standard of living. The mortality rates among women and infants were high; how could WHO promote health in such conditions? Progress so far had been insufficient. In spite of the Doha Declaration on the TRIPS Agreement and Public Health, the provisions of the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights were too inflexible to improve countries' access to medicines under patent. It was unacceptable that the large pharmaceutical companies working on diseases such as tuberculosis should be able to monopolize drug production for certain diseases only. Cooperation between North and South was essential to strengthen human resources, promote transfer of technology and research, and encourage reform in the developing world.

Dr DAHL-REGIS (Bahamas), speaking on behalf of the member countries of the Caribbean Community, supported the draft resolution and adjustments in resource allocation needed to tackle issues related to the social determinants of health, the inclusion of other sectors and partners, and the role of governments in health promotion. The Caribbean Community countries had embraced the tenets of the Ottawa and Bangkok Charters, which had led to the development of the Caribbean Charter for Health Promotion. However, in her area, the budget allocation for health promotion was low – in the Bahamas under 0.2% – and must be increased for health promotion at the global, regional and country levels. Her country had, in 2006, established a healthy lifestyles secretariat in order to tackle the various determinants of health.

WHO should increase support for health promotion in the Region of the Americas, including for work on the social determinants of health, intersectoral collaboration, policy development and strategic planning.

Dr ADDAI (Ghana) said that he welcomed recent efforts to scale up health promotion interventions known to be effective, but was concerned at the lack of investment in health promotion; such programmes in his country were generally underfunded. Healthy lifestyles could reverse or retard the degenerative process and prevent both communicable and noncommunicable diseases. Ghana was implementing a health and nutrition programme to promote healthy lifestyles and environments, and was willing to share its experience. WHO should provide support in that regard and should also develop successful models and approaches to health promotion, and facilitate their adoption by Member States.

He supported the draft resolution, but regretted that it did not focus clearly on the adoption of healthy lifestyles. He suggested the addition of a new subparagraph in paragraph 1, after paragraph 1(3), to read: "to reorient national public health systems towards the promotion and adoption of healthier lifestyles by individuals, families and communities".

Dr SALANIPONI (Malawi), commending the report, said that health promotion in Africa was vital to meeting the health-related development goals, including those contained in the Millennium Declaration. People were entitled to information and education on issues that affected their health, particularly in Africa where literacy was poor. His country had a health promotion policy at the district and community levels of primary health care.

Mr EINARSSON (Iceland) said that health promotion was the basis of primary health care and critical to the prevention and control of diseases. In 2008 the focus would be on health promotion, marking the 30th anniversary of the Declaration of Alma-Ata; furthermore, the theme of World Health Day in 2008 would be primary health care. Activities for health promotion and tackling issues concerning the determinants of health needed to be strengthened in all areas of WHO's work. He therefore supported the draft resolution as amended by the delegates of Germany and Kenya.

Dr CHAKIROU (Congo) said that, despite global efforts to promote health, countries were still facing many challenges. While some diseases, such as smallpox, had been eradicated, Africa, and notably his country, was seeing the emergence of such diseases as monkeypox and Ebola virus haemorrhagic fever. The Director-General had declared that WHO should be judged by its actions in favour of the health of Africans and of women, and he urged the Organization to grant more resources to Africa. He endorsed the draft resolution.

Dr SOLOFONIRINA (Madagascar), commending the comprehensive report, supported the draft resolution. Health promotion was a prerequisite for successful health programmes and for a country's development.

Dr LEVANTHAL (Israel) said that in the Bangkok Charter, health promotion included the important issues of health security and the social determinants of health, both of which were also important for the prevention of noncommunicable diseases. However, the concept of health promotion might have been broadened to a point where it duplicated WHO's work in all fields of health and primary care.

Dr LEAFASIA (Solomon Islands) said that the mass media in his country played an important role in health promotion and health education. The draft resolution should contain an explicit recognition of the role of the media.

Mr CAROLAN (International Federation of Red Cross and Red Crescent Societies) said that his Federation aimed to scale up its health promotion activities by building on its current programmes. First aid and the recruitment of voluntary blood donors were two of the Federation's traditional programmes. Accident prevention and the safety of individuals and communities were integral to first-aid training. The trust built up by Red Cross and Red Crescent Societies, in governments and vulnerable communities, could contribute to the adoption of healthier lifestyles and behaviours. The International Federation's First Aid Day, on 8 September, provided opportunities for expanding health promotion activities.

Voluntary blood donation and health promotion had a natural link: by tapping into a nation's voluntary blood donor panel, authorities were able to include disease prevention and health promotion in the existing blood service infrastructure across all countries. Through such programmes, community organizations could help to implement the Bangkok Charter. His Federation, civil society, nongovernmental organizations and communities should be involved in setting up a global forum to follow up the Bangkok Charter, and prepare for the 7th Global Conference on Health Promotion.

Dr LE GALÈS-CAMUS (Assistant Director-General) acknowledged the many comments on the need to retain both the cross-cutting nature of health promotion, including it in all technical programmes for disease prevention and control, and the link between health promotion and the prevention of noncommunicable diseases, even though neither activity excluded the other. Health

promotion was itself something more than simply preventing risk factors for noncommunicable diseases. Actions to reduce risk factors should complement policies for improving the health of especially vulnerable groups; the results of work done by the Commission on Social Determinants of Health would enable WHO to make progress in that area.

Regarding the delegate of Israel's comment, the adoption of the Organization's long-term strategic plan would avoid any risk of duplication or overlapping activities. She noted that several delegates had asked the Secretariat to address particular needs, especially assessment of the impact of health promotion on health, and had called for national capacities to be strengthened.

The forthcoming World Conference on Health Promotion and Health Education would provide an opportunity for health promoters in the international community to meet. She thanked the Government of Kenya for its support in organizing the 7th Global Conference on Health Promotion.

The CHAIRMAN suggested that, in view of the numerous amendments proposed to the resolution, the Secretariat should produce a revised version that could be discussed at a subsequent meeting.

It was so agreed.

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

Integrating gender analysis and actions into the work of WHO: draft strategy: Item 12.12 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R6, and A60/19)

Dr ANTEZANA ARANÍBAR (representative of the Executive Board) said that, at its session in January 2007, the Board had considered the draft strategy, which had been drawn up on the basis of broad consultation throughout WHO and with ministries of health and external experts. The Board had adopted resolution EB120.R6, which recommended a resolution to the Health Assembly.

Mrs REITENBACH (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina and Serbia, as well as Switzerland, Ukraine and the Republic of Moldova, aligned themselves with her statement. She supported the draft resolution, which was the result of years of hard work by gender experts and others within the Secretariat and Member States.

Gender equality was necessary for economic growth and equitable social development. Gender-based inequities in health were not a natural consequence of biological difference; they were socially governed and therefore amenable to action. Unequal relations between men and women of all ages and their effects on health and access to health services could be transformed. The European Union had progressed towards gender equality, thanks to equal-treatment legislation, gender mainstreaming, specific measures for the advancement of women, action programmes, social and political dialogue and dialogue with civil society. Through the European Pact for Gender Equality and the road map for gender equality, 2006–2010, it had committed itself to action on gender equality in several areas, including health. Gender inequalities continued to damage the health of millions of girls and women globally. Tackling inequalities between women and men called for action outside and inside the health sector.

Health systems did not pay sufficient attention to the different needs of women and men when planning, budgeting for and providing health services. Although women accounted for more than half the formal health-care workforce, they lacked decision-making power and their contributions were often unrecognized and underpaid. Women and girls bore a disproportionate burden of care in the home and the community, frequently with adverse effects for their own health and well-being. Rectifying those inequalities was crucial. In addition, more research was needed into how biological and social differences between men and women influenced the manifestation, diagnosis, treatment, outcome and consequences of disease and ill-health, in order to ensure effective health care. Research

results based on studies of male subjects were often seen as universally applicable to women, which was not always the case.

Gender equality and gender equity in health required the coordinated, active participation of a broad variety of stakeholders at all levels. She strongly supported the strategic directions outlined in the report, especially the plans to use sex-disaggregated data and to conduct gender analysis whenever possible. However, most of the documents presented to the Health Assembly, including the Medium-term strategic plan 2008–2013, still lacked a gender-equality perspective when presenting statistics, analysis or indicators. What plans did the Secretariat have to make sure that governing bodies documents were gender-sensitive and gender-responsive? WHO should report regularly on its progress in implementing the gender strategy.

WHO should cooperate with the European Institute for Gender Equality, which promoted gender equality in all community and national policies by raising citizens' awareness of gender equality, and integrating a gender perspective in all policy areas. WHO should be active in support of the Institute's efforts.

Professor TLOU (Botswana), speaking on behalf of the Member States of the African Region, commended the draft strategy. Over the years, United Nations instruments and conferences had highlighted the gender inequities and inequalities in all spheres of development. The Region had responded by, among other things, tackling gender inequities and inequalities in the context of health and survival for women and children. Many African countries had reviewed their legislation and included women in decision-making and governance. Some countries had also included men in programmes on child health and sexual and reproductive health.

In mitigating the impact of HIV/AIDS, Africa had to confront the influence of gender disparities on health-seeking behaviours, particularly compliance with health advice and adherence to treatment regimens. Involving men was becoming a strategy for increasing uptake in the region of programmes involving prevention of mother-to-child transmission of HIV, and antiretroviral therapy. Men were also participating in community-based care, including for HIV/AIDS, tuberculosis and malaria. Those were positive developments, representing progress towards the three health-related Millennium Development Goals.

She welcomed the tools developed by WHO for preparing legislation, and guiding the development of gender-sensitive programmes and interventions. Progress was often slow because of competing priorities and shortages of financial and human resources, especially gender-related competencies. The integration of gender equality and equity into WHO's strategic and operational planning would help Member States to make progress.

Gender had been misunderstood and misinterpreted by many, and African Member States needed support to develop capacities. She noted the strategic directions set forth in paragraphs 11 to 19 of the draft strategy, and looked forward to implementing it once adopted. She also welcomed the draft resolution but suggested inclusion of a time frame for identifying or recruiting specialist staff at headquarters, regional and country-office levels in order to drive the strategy forward. WHO's capacity for gender analysis and planning was crucial to implementing the strategy.

In Africa, patterns of behaviour, including health-seeking and gender inclusion or exclusion practices, were influenced by cultural and socioeconomic circumstances. Qualitative information would help the African States to develop programmes for different cultural groups. They committed themselves to collecting quality data and monitoring behavioural change in order to assist WHO in integrating gender analysis and action into its work.

Mr ROSALES (Argentina) supported the draft resolution in the light of the Millennium Development Goals. He welcomed WHO's proposals for mainstreaming gender equality and equity in its strategic and operational planning.

Dr MAAMOURI (Tunisia) noted that the report and the draft resolution drew attention to the importance of promoting gender equality through better health, giving women access to all health services and to the special needs of both women and men at all stages of life. His Government

likewise emphasized the importance of women's health, especially reproductive health and gynaecological treatment. Some diseases, especially those that had to be reported, affected men and women equally. It was therefore important to analyse the respective needs of men and women in other areas.

Since 2001, Tunisia had been setting up training courses on health in all provinces, and he was grateful to WHO for its help in that regard, especially in designing strategies, providing reference materials and assisting with assessment.

Dr NYIKAL (Kenya) said that the promotion of gender equity in health and development should guide the programmes of WHO and individual Member States. Gender disparities in health were unjust and were largely avoidable or amenable to change. The African Member States welcomed the draft resolution; however, they believed that there was a need to institutionalize gender analysis within the Secretariat and its Member States by building human capacities. They therefore proposed that in paragraph 3(4), the words "to build their capacity for gender analysis" should be inserted after "Member States".

Dr FAKEYE (Nigeria) welcomed the report and the draft resolution. National and international communities must ensure equal access for women and men of all ages to opportunities for achieving their full health potential. Over the preceding eight years in Nigeria, gender mainstreaming efforts had been made not only in the health sector, but also in the political sphere, with a view to achieving 30% representation of women in the Cabinet. Women had been appointed as ministers in finance, housing, education and defence. Nigeria was a federal country, and gender mainstreaming would only be introduced through consultation at all levels. Paragraph 8 of the report should begin by stating that WHO's support should enable Member States to design policies, plans, as well as health development actions, and that the words "both within WHO and respective Member States" should be inserted before "observed differences" in paragraph 16.

Dr HUWAIL (Iraq) said that gender equity needed to be pursued. Given its prominence in the Millennium Development Goals, there should be a parallel focus on empowerment of women and empowerment of the community as a whole. Social mobilization for primary health care would give greater prominence to gender issues by integrating health development with sustainable social and economic development. Capacity building for community-based initiatives should also take account of gender issues.

Mr DEL PICÓ (Chile) said that integrating gender analysis and actions into health work was a key to social justice. It made it possible to identify previously invisible health inequities and inequalities; clarify phenomena not to be explained otherwise; solve gender-based health problems; and stimulate favourable cultural change among health-sector personnel and the user population. However, the sociocultural construction of gender established an unequal power relationship between the sexes in all areas of life, with men and women at opposite ends of the spectrum. Policies must seek to eliminate that construct in order to achieve equal opportunities for women and men as biologically different entities. It could be confusing to speak of gender equality, and a different term might be needed.

He suggested several provisions in the draft resolution, namely that: Member States should articulate intersectoral policies that treated gender as a social determinant of health and quality of life; Member States should allocate the necessary resources for achieving gender equity in health, which meant applying gender analysis in the overall budgetary process carried out by ministries of finance; Member States should conduct surveys of how time was used, with emphasis on unpaid health care provided within the home, so as to inform policies on benefits that emphasized care in the home and equal sharing of domestic work; Member States should establish mechanisms for monitoring and evaluating gender equity policies in the health area, including resources allocated; Member States should encourage the general public to monitor gender policies in the health area in order to empower excluded groups; and, lastly, an additional subparagraph 3(8) should be inserted at the end of the

resolution, requesting the Director-General to identify and disseminate successful experiences in the area of policy impact, application of indicators, sex-disaggregated information systems, resource allocation research, labour practices and public involvement in policy matters.

Dr ASLANYAN (Canada) expressed support for the draft strategy and resolution and said that the Organization's role of helping Member States to fulfil their Beijing commitments must remain central. He welcomed WHO's efforts to implement the United Nations Economic and Social Council resolution on gender mainstreaming. Equality between women and men, and between girls and boys, was a human rights issue and essential to sustainable development, social justice, peace and security. WHO should develop a cross-cutting plan for putting the strategy into action in its programmes and activities, with a focus on results. He welcomed the Director-General's identification of women's health as a priority issue: it would greatly assist WHO's efforts in implementing the gender strategy.

The meeting rose at 13:00.

ELEVENTH MEETING

Monday, 21 May 2007, at 14:40

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Integrating gender analysis and actions into the work of WHO: draft strategy: Item 12.12 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R6, and A60/19) (continued)

Ms SONG Li (China) supported the goals and strategic directions identified in the report. Incorporating gender considerations into WHO's management and building the Organization's gender analysis and planning capacity would contribute to gender equality and health equity. Despite some progress, women remained a vulnerable group within society, and, in many places, women's health rights were not protected. China, one of the earliest signatories to the Convention on the Elimination of All Forms of Discrimination Against Women, was committed to the advancement of women and the improvement of their political, economic and social status. Her Government had prioritized women's health, and had enacted laws and regulations protecting women's rights to survival, development, education, employment and reproductive health services. Gender was a cross-sectoral issue. Its importance had not been realized by society, and it was necessary to sensitize people to gender issues and to act on the factors affecting and constraining gender equality. China welcomed the integration of gender analysis and planning into all aspects of WHO's work, and supported the draft resolution contained in EB120.R6.

Dr PHUSIT PRAKONGSAI (Thailand) appreciated WHO's commitment to addressing the health inequalities between men and women, and welcomed the goals and objectives, guiding principles and strategic directions set out in the report. Sex-disaggregation of data alone would not provide a full understanding of gender differences: qualitative research on culture, norms and practices was also needed in order to identify the factors underlying those differences. Accordingly, he proposed inserting in paragraph 2(5) of the draft resolution the words "and conduct research on underlying factors leading to gender inequality" between "sex-disaggregated data" and "and use".

Ms VIELMA (Bolivarian Republic of Venezuela) underscored the importance of WHO's decision to mainstream gender perspectives. Gender mainstreaming encompassed the entire planning process at all levels and for all activities. It should address the biological, socioeconomic and ethnic differences between men and women, not just their "concerns and experiences", as suggested in the Economic and Social Council's definition cited in the report. Health care should take account of differences in the risks facing men and women, and in their needs and socioeconomic circumstances. She supported the draft resolution.

Ms HALÉN (Sweden) said that the adoption of the draft resolution would be an important step towards realizing equality between women and men in health. She sought assurance that sufficient resources would be allocated in order to implement the strategy across the Organization. Gender equality was often misunderstood. In the interest of clarity, she proposed, in paragraph 2(4) of the draft resolution, replacing "gender-friendly health care" with "a gender equality perspective"; substituting, in paragraph 2(6), "as providers of health care" for "to health care"; and, in paragraph 3(5), inserting "including relevant documents presented to the Executive Board and Health Assembly"

after “publications”. The last amendment would ensure that the Secretariat was accountable to Member States.

Mr MARTIN (Switzerland) supported the draft strategy, but regretted that it did not give more attention to the support provided by women, often elderly women, to their communities in crisis situations, such as the AIDS pandemic. That unpaid burden often affected women’s health and should be studied from a gender equity perspective. He supported the draft resolution, but, bearing in mind that financing was an indicator of the priority accorded to an issue, proposed inserting “budgetary” before “planning” in paragraph 2(1). He also proposed inserting “including the corresponding budgets” between “plans” and “for integrating” in paragraph 3(4), and, in paragraph 2(4), replacing “care is” with “services are” (although amendment could be accommodated in the wording already proposed by the delegate of Sweden.)

Ms JOHRI (India) said that in India policy planning and implementation included gender budgeting as a first step towards integrating gender into health policies and programmes. A broad approach to narrowing gender gaps was being used. Sex selection and other practices that had an adverse effect on gender equality had been made illegal in order to prevent female feticide. India was not alone in requiring technical assistance for gender planning, budgeting and impact assessment. She suggested that paragraph 3(4) of the draft resolution should be amended accordingly.

Dr VIOLAKI-PARASKEVA (Greece) said that the empowerment of women was one way of combating poverty. A coherent approach to gender and health must include strategies that related to men’s and women’s health. Both sexes should be treated with dignity and interventions tailored to their respective needs. The issues of gender and women’s health were linked to sexual and reproductive health and reflected social and cultural factors, including gender-based violence.

Dr TAKAHASHI (Japan) observed that addressing gender issues would yield benefits for children as well as women. He supported the draft resolution. Ensuring that health policies and indicators were feasible always needed consideration of the cultural background and values of each country or area.

Ms MALULEKE (South Africa) supported the draft strategy and would welcome the establishment of sustainable capacity-building partnerships and technical and financial support to Member States by the Secretariat in order to integrate gender equality in all health policies, programmes and research. She supported the amendment to the draft resolution proposed by the delegate of Sweden and her remarks regarding the allocation of adequate resources for implementation of the strategy. Sufficient resources should be made available for the disaggregation of information by sex and, in that connection, the Health Metrics Network should work closely with gender focal points in Member States.

Ms YUAN (United States of America) said that her Government was deeply committed to addressing women’s health needs, and data disaggregated by sex were essential to its programmes. Empowering women and educating girls about health were critical to achieving the goal of healthy and sustainable populations. Member States should respond collectively in order to meet the health needs of women globally, particularly underserved women. Availability of data and research that translated those data into practical applications at the country level should be emphasized. She supported the original text of the draft resolution but would need to see how it had changed as a result of the amendments proposed.

Dr SOLOFONIRINA (Madagascar) said that discrimination persisted in her country, as evidenced, for example, by lower levels of education among female heads of households in comparison with their male counterparts, a factor in women’s exclusion and poverty. Her Government promoted gender equality and economic independence for women as a means of combating poverty,

hunger and diseases. Signs of progress included the election of female mayors in rural communities, traditionally the exclusive preserve of men. She supported the draft resolution, but suggested that it should be accompanied by a timetable for the nomination or recruitment of gender focal points at all three levels of the Organization.

Dr CAMPBELL FORRESTER (Jamaica), speaking on behalf of the member countries of the Caribbean Community, said that health services in the region had traditionally focused primarily on the health and well-being of mothers and children, and males had been somewhat marginalized. Many gains in health care worldwide had resulted from programmes geared towards women and children, and only recently, with the advent of HIV/AIDS, had the role of males in reproductive health been recognized. The identification of women's health as a priority was commendable, but more efforts and research should be directed towards elucidating men's health issues, their health-seeking behaviour and how they could better support women and families. The findings should be shared and used to develop policies aimed at achieving that end. She supported the draft resolution, but proposed amending paragraph 2(4) so as to incorporate the idea of gender-friendly health services for adolescents and youth, and, in paragraph 2(6), adding "and training for the health work force" after "health policy and planning".

Dr SALANIPONI (Malawi) said that Malawi used sex-disaggregated data for some of its health indicators. Of those people accessing the antiretroviral programme, 60% were women – a particularly encouraging figure, given that more young women than men contracted HIV infection, and care of AIDS patients was left to older women and young girls. He urged the Director-General to implement the draft strategy and to ensure that gender mainstreaming was universally applied. He supported the draft resolution, placing emphasis on paragraph 3(4), and called on the Director-General to allocate more funding for activities relating to women. He was pleased that the Director-General had placed the health of women at the centre of her work.

Mr MASUKU (Food and Agriculture Organization of the United Nations) welcomed the draft strategy, adding that it should highlight diseases linked to gender inequality, such as HIV/AIDS, and that national strategies should also take account of HIV/AIDS and consequent loss of livelihood. FAO had studied the link between nutrition, health and food security as well as ways of maintaining productive labour when active family members died or were incapacitated. In its gender-mainstreaming strategy, WHO should consider how men and women coped with the impact of disease and were able to sustain families without land and resources. FAO would collaborate with WHO in collecting and using sex-disaggregated data.

Mrs MAFUBELU (Assistant Director-General) acknowledged delegates' comments and strong support for the draft strategy and the draft resolution. She welcomed the progress made towards achieving gender equality, recognizing its importance, together with women's empowerment, in accelerating attainment of health-related Millennium Development Goals. WHO's mandate explicitly integrated gender analysis and actions into its work. A plan of action for implementing the draft strategy had been made available. WHO would explore collaboration with the European Institute of Gender Equality, to which the delegate of Germany had referred. The integration of a gender perspective into the mainstream of WHO's policies and programmes was a top priority of the Director-General, who had instructed that gender mainstreaming must be considered in all activities and at all levels of the Organization. Appropriate staff would be identified or recruited. The Secretariat would also ensure that sex-disaggregated data and gender analysis were included in WHO's documents. She had noted that paragraph 3(7) of the draft resolution requested the Director-General to report every two years to the Health Assembly.

Mr AITKEN (Representative of the Director General) read out the proposed amendments to the draft resolution. In paragraph 2(1), "strategic and operational" should be replaced by "strategic, operational and budget". The amendments to paragraph 2(4) suggested by Sweden and Switzerland

would be amalgamated as: “to ensure that a gender-equality perspective is incorporated in all levels of health-care services and delivery”. In paragraph 2(5), Thailand had suggested the insertion of “and conduct research on underlying factors leading to gender inequality” between “sex-disaggregated data” and “and use”. In paragraph 2(6), Sweden had proposed replacing “to health care” with “as providers of health care” after “and boys”, and adding “and training for the health workforce” at the end of the paragraph. In paragraph 3(3), Botswana had suggested inserting “as soon as possible” after “recruiting staff”. Amendments proposed by India, Kenya, Niger and Switzerland to paragraph 3(4) could be combined to read: “to provide support to Member States to build their capacity for gender analysis and actions and for formulating and sustaining strategies and action plans, including relevant budgets, for integrating gender equality in all health policies, programmes and research”. In paragraph 3(5), “including relevant documents presented to the Executive Board and World Health Assembly” should be added after “publications”. Chile had suggested an additional paragraph, which would be inserted between paragraphs 3(6) and 3(7), to read: “to identify and disseminate good practices on the impact of integrating gender in health policies, including the development of indicators and health information systems that disaggregate data by sex”.

The CHAIRMAN, in response to a request from Ms YUAN (United States of America), said that a revised version of the draft resolution, incorporating the amendments read out, would be prepared for consideration by the Committee at a later meeting.

It was so agreed.

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

Workers’ health: draft global plan of action: Item 12.13 of the Agenda (Documents A60/20 and A60/20 Add.1)

Mrs REITENBACH (Germany), speaking on behalf of the European Union and its 27 Member States, said that the candidate countries of Croatia, The former Yugoslav Republic of Macedonia and Turkey, the countries of the Stabilisation and Association Process, and potential candidates Albania, Bosnia and Herzegovina, and Serbia, as well as the Republic of Moldova and Ukraine aligned themselves with her statement. She welcomed the consultations held and the improved draft resolution. However, the draft global plan of action should better reflect the need for close collaboration between WHO and ILO; the first bullet point in paragraph 30 should therefore be amended to read: “promoting and engaging in partnerships and joint action with ILO and other organizations of the United Nations system, employers, organizations, trade unions and other stakeholders in civil society and the private sector in order to strengthen international efforts on workers’ health”. At the beginning of the second bullet point, “in coherence with the actions undertaken by ILO” should be added.

Dr HUWAIL (Iraq) said that, in order for occupational health services to become an integral part of primary health care, there needed to be: an effective information system; provision of services for workers within their catchment areas; capacity building in occupational health; a comparable standard in the quality of both public and private occupational health services, as well as intersectoral collaboration; and labour legislation covering occupational health services.

Dr TAKAHASHI (Japan) said that his Government had long recognized the importance of workers’ health, and employers were required to appoint an industrial physician in order to provide health care. Since 2001, health, labour and welfare issues had been addressed by the same ministry, enabling comprehensive measures to be taken to protect and promote the health of workers. Referring to paragraph 3(2) of the draft resolution contained in document A60/20, he emphasized collaboration between WHO and ILO. Japan would be willing to provide technical assistance to WHO.

Mr DJEDOSSOUM (Chad), speaking on behalf of the 46 Member States of the African Region, said that workers' health was of key importance for productivity and the overall health of an economy. The draft global plan of action should take into account living conditions and working environments, which, in developing countries, were being badly damaged by the migration of skilled workers. The health status of workers depended on hygiene and sanitation, levels of environmental and health protection, and investment in health and human resources. The draft global plan of action should cover both formal and informal workers and independent workers. Its implementation would require high political commitment in order to develop specific programmes and ensure funding and consistency in the treatment of human resources in both the private and public sectors. He called on the Secretariat, ILO and all partners to assist Member States in implementation, and highlighted the need for intersectoral collaboration and local and international partnerships.

The African Region was ready to adopt the global plan of action, provided the following points were taken into account: the possible need to modify legislation in line with the draft global action plan; financing of workers' health protection; legislative and management mechanisms for increasing efficiency and productivity, thereby reducing international migration and the brain drain; and reliable provision of data on health and safety at work, and a health monitoring and assessment system for sharing experiences and good practice. He called for guidelines to facilitate implementation of the global plan.

Dr GONZÁLEZ (Cuba) said that the report covered the major actions to improve health protection of workers, many of which had already been implemented in Cuba with a current focus on improving occupational health coverage, health promotion and accident prevention at the primary health-care level. Support for the strategy at the international level would improve the lives of workers and human and social development. The draft resolution rightly urged Member States to work towards full coverage of all workers. The plan of action should be implemented and results evaluated.

Professor PEREIRA MIGUEL (Portugal) said that the electronic consultations had resulted in a stronger draft global plan of action. Referring to paragraph 1 of the draft resolution, he expressed a preference for the word "endorses". Millions of migrant workers took on jobs with high risks, were often exploited, lived in unhealthy conditions and had difficult access to health services. He welcomed the reference to migrant workers in paragraph 2(2). Attention should be paid to occupational cancers, exposures to chemicals, asbestos and heavy metals, and problems arising from HIV/AIDS and tuberculosis. Portugal would support the implementation of the global plan of action.

Dr OLIVEROS (Philippines) said that her country's labour force, estimated at 34 million in 2003, represented some 42% of the population. Nearly 9% of those working in service industries were health workers and some 8 million were migrant workers. Poor working conditions and terms of employment were compounded by the increasing incidence of HIV/AIDS among migrant workers, which led to repatriation, stigmatization and poverty. The Philippine Overseas Labor Offices provided medical and psychosocial support to overseas workers; there was also a network of resource centres for the protection and promotion of workers' welfare. She supported the draft global plan of action and proposed that the draft resolution should be amended by adding a new paragraph 2(6) that would read, "to develop national and intercountry strategic approaches in providing medical care and services for sick and injured migrant workers", and a new paragraph 2(7) that would read "to encourage development of comprehensive health and non-health strategies to ensure reintegration of sick and injured workers to the mainstream of society in coordination with different government and nongovernment organizations". She further proposed that in paragraph 3(2) "the International Organization for Migration and other international organizations" should be inserted after "ILO", and that a new paragraph 3(4) should be added that would read, "to support capacity building for interstate/intercountry coordination and information management concerning health of migrant workers".

Dr SOPIDA CHAVANICHKUL (Thailand) endorsed the draft global plan of action and the draft resolution. She proposed that the words “including reproductive and family health” should be inserted in paragraph 14 of the plan of action after “health promotion”. Because evidence for action and practice, considered under Objective 4 of the plan of action, was not mentioned in the draft resolution, a new paragraph 2(5) should be added that would read: “to generate evidence on workers’ health and to translate this evidence into policy and actions”. Since the plan of action did not refer to any indicators or schedule for implementation, the words “with definite timeline and indicators for the achievement of global occupational health services” should be added at the end of paragraph 3(1). WHO should increase collaboration with ILO.

Dr SULEIMAN (Oman), speaking on behalf of the members of the Gulf Cooperation Council, Bahrain, Kuwait, Oman, Qatar, Saudi Arabia and the United Arab Emirates, as well as Jordan, Lebanon, the Syrian Arab Republic and Yemen, observed that workers’ health was vital for national socioeconomic development. There were many opportunities for work in his region and many workers from other countries were employed by contractors and subcontractors. He therefore proposed that “contract workers” should be added to paragraph 2(2) of the draft resolution after “migrant workers”.

Mrs BELLA ASSUMPTA (Cameroon) emphasized the importance of protecting health-care workers, especially in the developing countries, since they were frequently exposed to communicable diseases, infectious biological products and ionizing radiation, and were often overworked. She therefore proposed that the words “including health-care workers” should be added at the end of paragraph 2(3) of the draft resolution.

Dr AHMED (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the revised draft global plan of action. Workers in his Region represented 45% to 50% of the population and their health needs should be given priority. The workplace should be safe and healthy; it could also be a setting for coordinated health interventions. The draft global plan of action should strengthen the protection and health of workers, their families and the community.

Since the endorsement of the WHO global strategy for occupational health for all in 1996, the Member States of the Region had strengthened workers’ health programmes at regional and national levels, despite scarce resources. However, intersectoral coordination, resources, and coverage of occupational health services remained inadequate. The countries of the Region should transform obstacles into opportunities by combining an occupational approach with health promotion, reaching out to families and communities through the working population, and suggest practical occupational models for health services. Intersectoral coordination should be strengthened at all levels, making effective use of scarce human and financial resources and avoiding duplication of effort. He supported the draft global plan of action and draft resolution.

Mr DEL PICÓ (Chile) endorsed the draft global plan of action. Chile was preparing a plan of action in order to reduce occupational diseases and accidents and improve workers’ quality of life. The plan gave priority to vulnerable groups and facilitated access to occupational health services independently of social security coverage, whether public or private. Migrant workers were also covered. Chile had also incorporated in its programmes the occupational health recommendations of WHO and ILO, such as those of the ILO/WHO global programme for the elimination of silicosis as an occupational health problem by 2030.

Professor KEVAU (Papua New Guinea) welcomed the draft global plan of action and supported the draft resolution. However, neither text mentioned the health and safety of local communities that hosted industrial and commercial activities, including mining and plantations, an aspect of health that was often ignored by project planners. He therefore proposed that the matter should be reflected in the plan of action and that the draft resolution should be amended by inserting “in the local communities” after “workers” in the penultimate paragraph of the preambular section; after “workers” in paragraph 2(1); and after “workers” in paragraph 2(5). He further proposed the addition of a new paragraph 3(4)

to read: “to develop and make available to Member States specific guidelines for the establishment of appropriate health services and monitoring tools for human and environmental hazards and diseases introduced to local communities where commercial activities are established and that their needs are met”.

Mr POMOELL (Finland) endorsed the draft global plan of action, which provided a good basis for the further development of occupational health services. Drawing attention to paragraph 10 of the plan, he said that a global ban on all uses of asbestos would ensure the elimination of asbestos-related diseases. The plan’s emphasis on promotion of the working ability of older people was timely, given the demographic changes taking place in industrialized countries. He drew attention to ILO Convention 161, adopted in 1985, and to the new concept of basic occupational health services, developed by the ILO/WHO Joint Committee on Occupational Health in 2003, which provided guidance on the provision of occupational health services, especially for underserved groups and developing countries. The network of WHO collaborating centres provided support in occupational health activities at the national, regional and global levels. Finnish institutions would participate in the network and the implementation of the global plan of action.

Dr SHEVYREVA (Russian Federation) said that global campaigns to eliminate asbestos-related disease were important, but Member States should adopt a scientific approach to the elimination of harmful forms of asbestos. Paragraph 10 of the plan of action should therefore be amended by adding a sentence reading: “In conducting global campaigns to eliminate asbestos-related diseases, it is essential to take into account a differentiated approach in regulating the various forms of asbestos, such as those mentioned in the Rotterdam Convention”.

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that her Government was developing risk prevention in the workplace and promulgating health and safety legislation. The National Institute for Occupational Health and Safety had issued a technical guide and was preparing minimum health and safety standards. Surveys of work conditions were being undertaken and plans for the protection of construction workers and for the health and safety of women working in the home were also being prepared. Special medical attention was given to persons who had experienced occupational accidents, and information, education and communication activities were raising awareness of occupational health. She would submit comments on the draft global plan of action in writing.

Mrs SCHAER BOURBEAU (Switzerland) supported the draft resolution and the main thrust of the draft global action plan, as well as the amendment to paragraph 30 proposed by the delegate of Germany. Switzerland accorded high priority to the health of its population and, in particular, its workers. Good health was crucial for economic prosperity and sustainable development. Access to occupational health services should be improved, but social and individual factors, training in primary health care and proper housing were also important. The international organizations responsible for health and protection of workers, WHO and ILO, respectively, should join forces in order to implement the global plan of action. Workers’ and employers’ organizations should also be involved in the implementation of the plan at the global and national levels.

Mrs PANTAZOPOULOU (Greece) said that the draft global action plan should contribute to the expansion of occupational health services and the strengthening of health systems. Early diagnosis of occupational diseases and the collection of comparable data were important. The family and social life of workers must also be taken into consideration. She proposed that in paragraph 2(1) of the draft resolution the word “execution” should be replaced by “implementation”, and requested clarification of the term “informal economy” used in paragraph 2(2).

Dr CARBALLO QUESADA (Costa Rica) welcomed the draft global plan of action. Costa Rica’s Occupational Health Council was revising its strategic plan for the period up to 2010 for

coordination among government institutions, trade unions and employers' organizations involved in occupational health. Emphasis was placed on the follow-up and monitoring of programmes and projects. Guides had been prepared for use in schools. Physical exercise and healthy lifestyles in the workplace were being piloted in the Ministry of Labour.

She proposed that the basic training of health professionals should be included in paragraph 18 of the draft global plan of action, as "postgraduate training" was not sufficiently broad.

Ms YUAN (United States of America) observed that the issues surrounding workers' health and safety were complex and multisectoral, requiring the engagement of ministries of labour and commerce, and public and private employers. The Secretariat, in collaboration with relevant international organizations, could help Member States to implement a plan of action, including surveillance systems for workers' health, data on occupational diseases for policy-makers, and capacity for public health prevention and intervention strategies. Member States should consider the draft global plan of action within their own national contexts. The plan should provide flexibility and guidance over time.

She preferred the word "welcomes" to "endorses" in the first paragraph of the draft resolution, as Member States had yet to hold a separate review of the plan of action at country level. She could not support the amendments proposed by the delegate of Thailand to paragraph 14 of the draft plan of action, which text had been carefully negotiated in the electronic consultation between Member States, nor could she support the proposal to include reproductive and family health in paragraph 2 of the draft resolution because it would dilute the resolution and loosen its focus on workers' health.

Ms USIKU (Namibia) said that her country still needed to improve and strengthen the planning, coordination and monitoring of the implementation of occupational health services and employee assistance programmes, so as to benefit all workers in the public and private sectors. The draft global plan of action provided a useful framework and guidance in that regard. She endorsed the report and draft resolution. Namibia looked forward to technical support from WHO in preparing its strategic plan of action.

Dr NYIKAL (Kenya) observed that many aspects of workers' health, such as occupational accidents and exposure to toxic or carcinogenic compounds, had legal implications, which often led employers to limit treatment or attempt to cover up injuries or illnesses. Legal frameworks were necessary to tackle that problem. He therefore proposed inserting the words "and legal frameworks" after the word "mechanisms" in paragraph 2(1) of the draft resolution. The aspect should also be covered in the global plan of action.

Dr NDELU (South Africa) said that her country had already implemented some of the actions recommended in the draft global plan of action, while others still required the formulation of plans. Member States should develop legislation in line with ILO conventions. South Africa had promulgated legislation on occupational health and safety in 1993, and mine health and safety legislation in 1996. It had also made good efforts towards preventing asbestos-related diseases and silicosis, asbestos mining having ended in South Africa in 2003; tobacco-control legislation was already in place. She emphasized the need for more effective occupational health and safety collaborating centres in developing countries, and endorsed the draft global plan of action.

Mr KHALEEL (Maldives) endorsed the draft global plan of action. Pregnant women and lactating mothers should be specifically mentioned as a vulnerable group in paragraph 9. He emphasized the need for strong collaborating centres, and endorsed the draft resolution.

Mr ABUSAA (Libyan Arab Jamahiriya) supported the proposal by the delegate of Oman to include a reference to contract workers in the draft resolution.

Ms KAZRAGIENE (Lithuania) said that the draft global plan of action covered all aspects of workers' health. She supported the objectives of the plan, in particular Objective 3, and the diagnosis of occupational diseases which, together with standardized statistics, was important in providing evidence for action.

Official statistics on occupational diseases were often inadequate for formulation of national prevention policies, primarily because of gross under-reporting of occupational injuries. Therefore, work on the harmonization of statistics on occupational illness should be intensified by the Secretariat and Member States. She strongly advocated the regional networking of stakeholders, whose responsibilities could include generating evidence for policy-making, monitoring and evaluation. Collaboration in establishing norms and standards for the health workforce, including internationally agreed definitions, classification systems and indicators, was also important.

She endorsed the views of previous speakers on the need to tackle asbestos-related health problems. In its capacity as chair of the Northern Dimension Partnership in Public Health and Social Well-Being, Lithuania would return to the subject of occupational safety and health at a high-level conference in Vilnius in November 2007.

Dr KARAGULOVA (Kazakhstan) supported the amendment proposed by the Russian Federation to paragraph 10 of the draft global plan of action. Attention needed to be paid to the elimination of asbestos in developing countries and countries with transition economies. A differentiated approach to the regulation of different types of asbestos and materials containing asbestos would be required for a global campaign to eliminate asbestos-related diseases. WHO should conduct an additional technical study in that area, taking into account the latest scientific information. Kazakhstan would work with the Secretariat on that issue.

Ms WISEMAN (Canada) supported the draft global plan of action, but expressed concern about the plan as it related to the use of chrysotile asbestos. While supporting WHO's goal to prevent and eliminate asbestos-related diseases, she encouraged WHO to consider all the scientific evidence, including risk-management approaches such as controlled use, in minimizing risks to the health of workers. Canada remained committed to working with the Secretariat and other health experts in order to ensure that the strategies regarding chrysotile were based on the latest science. Canada would share its considerable experience of controlled-use approaches.

Mr GAUDÊNCIO (Brazil) endorsed the draft plan of action and the draft resolution.

Dr AL-TUWAIJRI (International Labour Organization) said that ILO and WHO had a common definition of occupational health and coordinated their activities efficiently, particularly in the context of the Joint ILO/WHO Committee on Occupational Health. Cooperation between ILO and WHO would lead to a multidisciplinary and intersectoral approach to occupational health and prevention in a globalized world. The core of ILO's action was the preparation of international labour conventions, which provided the legal framework for developing policies and programmes for occupational health practice on a tripartite basis. The Promotional Framework for Occupational Safety and Health Convention, 2006 (No. 187) promoted strengthening of national occupational safety and health infrastructures. ILO had also contributed to the preparation of the draft global plan of action on workers' health.

Together ILO and WHO could reach all the key stakeholders at the national level: their approaches were convergent, complementary and mutually supportive. Both were committed to the common goals of improving the working environment and providing occupational health for all. The proposed plan of action would boost prevention at all levels in Member States of both Organizations.

ILO fully supported the adoption of the draft resolution and was strongly committed to cooperation with WHO on successful implementation of the global plan of action.

Ms CALDWELL (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that her statement reflected the views of more than 25 million health professionals

worldwide. Underinvestment in the health sector, and poor employment conditions and policies, had led to a deterioration in working conditions in many countries, negatively affecting recruitment and retention of health personnel, the performance of health facilities and, ultimately, patient outcomes.

She supported measures to promote the health, safety and well-being of health workers, particularly vulnerable groups such as migrant health workers. The work environment must be made safe from occupational hazards. Management practices must support the well-being of workers as well as patient safety, ensuring manageable workloads and lower stress levels. Such issues were the responsibility of all stakeholders in the health sector. In 2007, the health professions, together with the Global Health Workforce Alliance and the International Hospital Federation, would launch a campaign for safe and healthy workplaces for health workers. She called upon WHO to join them in that effort.

Dr HATCHER (World Federation of Public Health Associations), speaking at the invitation of the CHAIRMAN, said that much of the global burden of disease was caused by poor working conditions. She supported the draft global plan of action because it set out a realistic, long-term programme to deal with occupational cancer, chemicals, asbestos and contamination with heavy metals, as well as HIV/AIDS. The plan recognized the importance of employment, sustainable development, poverty reduction and environmental protection. It made workers the focus of training and consultation in building capacity. It included representatives of both workers and employers in action to reduce inequalities in workers' health, identified responsibilities of health professionals, and promoted access to services for the working people of the world.

Her organization would participate in the implementation of the global plan of action through the network of WHO collaborating centres in occupational health.

Professor GUILLEMIN (International Commission on Occupational Health), speaking at the invitation of the CHAIRMAN, supported the draft global plan of action. There were on average one million occupational injuries and half a million cases of occupational disease every day, nearly all of which were preventable, as the zero-risk programmes introduced by some industries had shown. The industries where the coverage of occupational health services was lowest were precisely the ones where they were most needed. The needs of workers in agriculture, small-scale enterprises and the informal sector, as well as of self-employed and migrant workers were particularly great. There were 2000 million of those workers worldwide, who faced a high level of risk and had virtually no access to occupational health services. International guidance, collaboration and technical support were needed to assist them.

Developed countries needed the global plan of action in order to guide them in dealing with new occupational diseases, including stress, musculoskeletal disorders and occupational allergies, as well as potential global epidemics connected with occupations such as animal husbandry or food production. Health workers were a high-risk group in their own right. Constant changes in working life continually threw up new risks, which must be researched and assessed. WHO and its regional offices should stimulate research, compile scientific knowledge, assess the data collected and disseminate it at national level in a form in which it could be easily incorporated into everyday practice. His organization would support WHO in the implementation of the global plan.

Ms WEBER-MOSDORF (Assistant Director-General) thanked Member States for their support for the draft global plan of action. Twenty-nine Member States of all levels of development and from all regions had responded to the electronic consultations conducted during the preparation of the plan.

She had noted delegates' comments on the need to prioritize the primary prevention of occupational hazards, with integrated action to protect the most vulnerable groups, including migrants, children and pregnant women; the need to take into account the ageing of societies and links between occupational health and other public health programmes, such as nutrition, mental health, substance abuse and communicable diseases, including HIV/AIDS, malaria and severe acute respiratory syndrome; the risk to health workers of communicable diseases; the need for strong intersectoral

linkages; and concerns regarding the elimination of asbestos-related diseases, especially in the light of resolution WHA58.22 on cancer prevention and control.

With regard to the respective roles of WHO and ILO, the global plan of action would provide a framework for strengthening cooperation between the two organizations and other international agencies. The Secretariat would take into account all relevant Conventions and concert its activities with other specialized agencies of the United Nations.

WHO and its partners could achieve primary prevention in occupational health. Every year, about two million people died as a result of occupational accidents or exposure to harmful substances, but only a tiny proportion of them had access to occupational health services. Workers were more mobile, and many more worked without formal employment contracts or social security coverage. The global plan of action should encourage health protection policies and primary prevention of occupational hazards.

The CHAIRMAN suggested that the Secretariat should prepare a revised version of the draft resolution, incorporating the amendments proposed to the resolution and the draft global plan of action, for consideration at a subsequent meeting.

It was so agreed.

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

Health systems: emergency-care systems: Item 12.14 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R4, and A60/21)

Dr ANTEZANA ARANÍBAR (representative of the Executive Board), introducing the item, said that the Board had adopted resolution EB120.R4, which recommended a draft resolution to the Health Assembly. The term “emergency-care systems” had been preferred to “emergency-care services” because of the need to emphasize the scale of provision required and the need for sustainability.

Dr HUWAIL (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that accidents and injuries were particularly serious for low-income and middle-income countries, which frequently lacked prehospital and trauma-care systems. Many people used emergency services in non-urgent cases because of the shortage of primary health-care services – a situation which the countries of his Region wished to study in more depth. Clearly, those services should also be strengthened.

Many deaths and much long-term disability could be prevented by strengthening trauma services and emergency care. The challenges facing the Region included the lack of attention paid to emergency care in reform of health systems and investment.

He supported the draft resolution. An interagency committee should be set up to coordinate support for countries which suffered man-made or natural disasters and promote investment in their emergency systems and trauma care. WHO should focus on simple techniques and less costly methods for saving lives. All relevant sectors should be involved in trauma care, particularly at the prehospital stage. WHO should invest in capacity building and document experiences.

Strengthening a country’s trauma-care system would help to strengthen its health system as a whole and contribute to regular and sustainable development of the primary health-care system at all levels.

Mr PINKAS (Poland) said that an emergency-care system should be based on education of the general public, logistical support that facilitated access to emergency care, and cooperation between the medical and nonmedical emergency services. Those principles of emergency care had been introduced in his country earlier in the year. A legal base was crucial to creating an efficient

emergency-care system flexible enough to expand to meet future needs. His country would be glad to share its experiences with others. He supported the draft resolution.

Professor TLOU (Botswana) said that, following her country's urbanization, trauma had become the second greatest cause of mortality and morbidity after HIV/AIDS, with dire economic consequences. Every year, there were 18 deaths for every 10 000 vehicles on the road, including many productive members of the community. The Ministry of Health was preparing a national policy on prehospital care. The Secretariat should support Member States in establishing training centres for paramedics; in Botswana, that would improve the standard of prehospital care and release more nurses for patient care.

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

The meeting rose at 17:30.

TWELFTH MEETING

Tuesday, 22 May 2007, at 09:55

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. FOURTH REPORT OF COMMITTEE A (Document A60/59)

Mrs BU FIGUEROA (Honduras), Rapporteur, read out the draft fourth report of Committee A.

Dr ASSOGBA (Benin) observed that the amendment he had proposed for paragraph 5 of the draft resolution on tuberculosis control had not been reflected in the text. He would submit wording in writing to the Secretariat.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Health systems: emergency-care systems: Item 12.14 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R4, and A60/21) (continued from the eleventh meeting)

Dr OPART KARNKAWINPONG (Thailand) said that health systems should ensure equitable access to affordable services that responded to the needs of the population, that were sustainable through optimal use of primary care, and that were supported by referral and systems for health promotion and disease prevention.

He supported the draft resolution contained in resolution EB120.R4. Regrettably, without adequate funding for the necessary infrastructure, training in emergency care and daily operations, trauma and emergency-care services would not become a reality.

Dr VÁSCONEZ (Ecuador) emphasized collaboration between institutions and sectors in the planning of emergency-care systems that best used all the resources available in the sector. Ecuador was currently extending coverage of primary, prehospital and community health care in order to reduce the number of unnecessary hospital admissions. It was increasing the numbers of medical staff and upgrading the ambulance fleet. All basic hospitals provided emergency services and had trauma departments.

She proposed that, after paragraph 2(4) of the draft resolution, wording should be inserted to the effect that the national health authority should determine the licensing or authorization standards for trauma and emergency-care services as part of the interinstitutional and intersectoral network. In paragraph 2(4), the phrase “to provide improved pertinent information” should be inserted after the words “to ensure that a monitoring mechanism exists”. In paragraph 2(10) the word “methods” should be replaced by “aspects”.

¹ See page 311.

Ms VIELMA (Bolivarian Republic of Venezuela) said that her country had launched media campaigns and other measures to reduce the high number of road-traffic crashes and deaths on the roads particularly during holiday periods. The health service provided training in emergency care for hospital staff and post-trauma rehabilitation services which were free of charge. Moreover, the Government had concluded several international agreements in order to equip health centres with high technology. She supported the draft resolution.

Dr AYDINLI (Turkey) emphasized that analysis and planning, intersectoral cooperation, system development and sustainability were priorities for improving emergency-care systems. In Turkey, emergencies were reported on a toll-free telephone line and casualties were taken by fully equipped ambulance to one of the 1178 emergency-care centres established nationwide. He supported the draft resolution and called for support for Member States in improving their casualty-management systems and reviewing the relevant legislation.

Professor FAIZ (Bangladesh) said that, although he welcomed the draft resolution, both its title and content should refer to emergencies other than road-traffic injuries.

In Bangladesh, emergency care was provided in hospitals or in one of the five trauma centres set up to respond to road-traffic injuries. Services for other types of emergencies, including the establishment of a burns unit, training at community level and for health-care professionals in treatment for snake bites, pesticide poisoning and drowning had been implemented. Crisis centres had also been opened for female victims of violence. Despite all those measures, emergency-care systems in his country remained inadequate.

Dr FAKEYE (Nigeria) said that weak national health systems must be strengthened if adequate emergency care was to be provided. Moreover, all barriers, whether financial, related to gender, religious or cultural, must be removed in order to ensure access to emergency care for all who required it.

He supported the draft resolution, but proposed that in paragraph 2(3) the words “in locations where they would be cost-effective” should be deleted, since they could dissuade governments from establishing the relevant systems in such areas, despite a high rate of injury. In paragraph 3(2), he proposed the insertion of the words “policy and” after “techniques for reviewing”, and the addition at the end of the paragraph of the phrase: “and to use such institutional capacity to assist Member States, upon request, to review and update their policies and legislation”. A new subparagraph under paragraph 3 should also be added, that would read: “to work with Member States to design strategies for providing on a regular basis, optimal non-emergency and emergency care to all those in need; and to provide support to Member States for mobilizing adequate resources from donors and development partners to achieve this goal”.

Mr KAYITAYIRE (Rwanda), speaking on behalf of the 46 Member States of the African Region, said that, other than poverty, the main hindrance to progress towards the Millennium Development Goals in Africa was the poor functioning of many health systems. Furthermore, the effectiveness of measures taken to tackle major health issues depended on health systems, and particularly emergency care. Advocating free treatment in order to improve access to health care for the largest number of people was not necessarily a sustainable solution. In Africa, health systems depended on the State, and faced obstacles such as the presence of remnants of former systems, the lack of social security and health insurance schemes, and scarcity of resources.

The main causes of the high rates of mortality and disability in Africa were road-traffic injuries, violence, poisoning, injuries, drowning and burns. The lack of access to emergency care increased premature deaths, as few countries were able to provide emergency and prehospital care.

He called for development partners to support the plan of action on health drawn up at the fifty-third session of the Regional Committee for Africa. One strategic orientation for WHO's action in the African Region in 2005–2009 was the strengthening of policies and systems to improve health care at local levels. To that end, WHO should target its action in Africa to building capacity and

sharing experience; the revitalization of emergency health care was essential. Primary prevention remained most important in reducing the burden of trauma cases. The measures already taken by WHO had been fruitful, but further financial and technical support was necessary for the implementation of national health plans, the retention of skilled health personnel, and strengthening of prehospital and emergency-care systems.

He called for cooperation between Africa's main development partners, especially WHO and the Global Fund to Fight AIDS, Tuberculosis and Malaria, in strengthening health systems and hospital reform, incorporating emergency care into medical training, the procurement of ambulances, the upgrading of emergency communication systems, and care and rehabilitation for victims of violence.

Mr EKEKE MONONO (Cameroon) said that Cameroon was preparing a violence and injury prevention plan based on the tools proposed by the Secretariat. It had already set up a prehospital emergency-care system covering the two main cities and the major road linking them, where many fatal road crashes occurred, and intended to extend the system to the rest of the country. The Secretariat should support Member States that had improved their emergency-care systems and had established prevention programmes for violence and injury. He supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) said that emergency care should be a component of national health-care systems, with a focus on practical interventions. Primary prevention remained most important for reducing rates of death, injury and long-term disability. Health-care curricula should include training in emergency care, with provision for continuing education. The burden of injuries could only be reduced if an emergency-care system was in place. She supported the draft resolution.

Dr MIYOSHI (Japan) said that an integrated and intersectoral approach to emergency care would correspond well to the current strategy of strengthening health systems as a whole. There was a need for sustainable, low-cost systems. The increasing importance of emergency-care systems to developing countries should be matched by strengthening those systems through international cooperation, taking into account the medical level, infrastructure and socioeconomic status of the region or country concerned. Since 1977, Japan had been establishing an integrated emergency service, including transportation, and was keen to share its experience, as it had done with Bolivia and Viet Nam. He supported the draft resolution.

Ms CAMARGO (Mexico) said that in Mexico around 53 000 people died and more than 2.5 million were treated each year under the national health system as a result of road-traffic or other injuries and violent behaviour. Pursuant to resolution WHA57.10, Mexico had introduced prehospital emergency care in order to guarantee access to treatment. An emergency control centre had been set up. Work was under way in order to establish curricula and qualifications in emergency medicine, refresher courses for medical, paramedical and administrative staff, and standardized procedures. Mexico was strengthening emergency and trauma care at federal and state level. She supported the draft resolution.

Mr ZHOU Jun (China) said that emergency services in China had been integrated into the social security system. In order that county-level hospitals could make a significant contribution to providing emergency care in rural areas, those institutions had been strengthened. Emergency services could not be provided by trauma centres alone. Rather, networks of emergency service should be established, for smaller geographical areas, with short response times, and involving the health, public security, transport and insurance sectors. The general public should be educated in first aid so that assistance could be provided even more quickly in an emergency. The Secretariat should propose follow-up measures, and support for developing countries should be forthcoming from developed countries.

Professor IANCU (Romania) said that deaths from injury were on the increase and that, particularly in low-income and middle-income countries, injury was the main cause of disability. Her Government was strengthening the trauma-care system as the best way to save lives. Since 2006, specific legislation on trauma and emergency care had been in place, covering both the public and private sectors. Training and specialization of medical staff was a major concern. She supported the draft resolution as it stood.

Mr BELGHITI ALAOUI (Morocco) said that the draft resolution provided an opportunity to reorganize and strengthen national health systems. Emergency care was an element of essential care, and should allow for rapid response to incidents, wherever and whenever they took place. Emergency care should be part of an integrated system covering primary prevention and comprehensive emergency services. He re-emphasized integration as the basis of an enduring emergency-care system.

He suggested that the word “prehospital” in paragraph 2(3) should be replaced by “and integrated”. There seemed to be some discrepancy between the concept of emergency care in paragraph 4 of the report and the draft resolution, the former implying that trauma care was part of emergency care, while the draft resolution regularly referred to “trauma and emergency care”, giving the impression that the two were separate. The terminology should include trauma care within emergency care. He stressed the need for data collection systems for monitoring and evaluating emergency-care services.

Mr YOHANNES (Eritrea) said that Eritrea had strengthened its emergency-care system. With donor support and in collaboration with WHO’s country office, a management structure had been introduced at district level. At the national level, integrated supervision and monitoring and evaluation systems had been established. The strengthening of the referral system would be followed by enhanced emergency-care systems in 2007.

Health systems were only as strong as their weakest link. Emergency care was the biggest challenge in delivering health-care services. Developing robust emergency-care systems should begin with sectoral situation analyses and continue by building human resources, improving infrastructure and providing necessary equipment and supplies.

He supported the draft resolution.

Dr METAI (Kiribati) said that his country had been improving its emergency-care system but was hampered by financial limitations. Western medicine, traditional medicine and community participation had been integrated within the system, but depended on voluntary participation.

Legislation governing speed limits and blood-alcohol concentrations was in force and had more than halved the number of road crashes, while voluntary community policing had reduced the number of injuries caused by violence in the home and in the community. People disabled by traffic injuries could receive physical and psychological assistance from practitioners of Western medicine and traditional healers. However, improvements were still needed in the areas of planning, training, emergency facilities, rehabilitation centres and developing legislation, all of which would require support from WHO and development partners.

He supported the draft resolution with the amendments so far proposed.

Mrs DIOUF (Senegal) said that emergencies posed a real problem to public health. In many African countries, as well as injuries resulting from road traffic crashes, there were many obstetric and other emergencies, which combined to give a very high mortality rate.

In Senegal, emergencies had always been dealt with by the public authorities, particularly the Ministry of Health. Emergency transport was often by private means, which risked aggravating injuries, or by the national fire service, using ambulances that were not medically equipped. Emergency facilities existed in hospitals, but lacked qualified staff, maintenance, and reliable supplies. In an effort to improve the situation, Senegal had established, within the public health system, an emergency medical assistance service. It was also involved in health education, research and training, and the implementation of emergency plans.

Based on the concept of emergency care set out in the report, the Secretariat should support countries in situation analyses, mobilizing resources, and strengthening emergency-care services. She supported the draft resolution.

Ms YUAN (United States of America) said that primary prevention played a significant part in reducing the burden of injury and violence, but the strengthening of trauma and emergency care was crucial. Developing emergency-care systems, however, was complex and Member States must assess their own needs, set priorities and develop systems appropriate for their own national situation. The Secretariat could play an important role in that process. To the extent possible, the components of emergency-care and trauma-care systems should be developed simultaneously. Prehospital care, including ambulance services, could be strengthened by training community paramedics and first-aid workers.

Dr FEDOROV (Russian Federation), stressing the high social and economic burden caused by injuries, said that both prevention and proper treatment were essential. Improved emergency care would alleviate the effects of injuries, and required an approach encompassing minor treatment, hospital care and various types of rehabilitation. The principles for improving emergency-care systems had been included in WHO initiatives over the past three or four years and had already proven their effectiveness in several low-income and middle-income countries.

In the Russian Federation, where injuries, particularly from road-traffic crashes, were a leading cause of death, emergency medical transport services and specialized in situ health centres were being strengthened. Although measures to improve emergency care were complex, he supported the draft resolution, which would assist Member States to strengthen their emergency-care systems with low-cost technology and effective planning and organization.

Dr SOLOFONIRINA (Madagascar) echoed previous speakers' comments on the importance of strengthening emergency-care systems. Urgent measures were needed, including better primary prevention. Madagascar had transformed medical facilities close to major road transport routes into surgical centres in order to allow for better referral and treatment of road traffic accident victims. She supported the draft resolution.

Ms NGAUNJE (Malawi) welcomed WHO's efforts to strengthen trauma and emergency-care systems. She supported the draft resolution. Trauma and injuries were a leading cause of death in Africa. Hospitals and other institutions providing emergency care were hampered by inadequate emergency-care equipment, transport, means of communication, technical know-how and life-saving skills. The situation was exacerbated by poor socioeconomic conditions. Although Africa was prone to natural disasters, there was insufficient preparedness for mass-casualty incidents. Most African economies were based on agriculture; pesticide poisoning was common and increasing. The issues surrounding HIV/AIDS discouraged many from donating blood, and its availability for blood transfusions for the victims of road-traffic and other injuries was therefore limited.

Her country's policy for emergency-care systems was limited to certain emergency-care interventions, such as for road-traffic injuries, basic obstetric care emergencies and cholera. Communication through wireless was provided in health centres in remote communities, and families were given guidance on how to access transport in health emergencies. She urged the Secretariat to assist Member States by providing the expertise and resources that would enable them to establish prehospital trauma and emergency-care systems and training.

Dr LEAFASIA (Solomon Islands) supported the draft resolution. The health facilities in the Solomon Islands provided both clinical and emergency care. Emergency health services were hampered by insufficient resources, a shortage of skilled workers and the vast distances that isolated most of the Islands' populations. The lack of reliable transport and communications contributed to the inability to respond to all forms of emergencies, whether man-made or natural. Changing lifestyles were leading to health problems, such as HIV/AIDS and trauma resulting from road-traffic crashes,

overloading a fragile and poorly equipped health system. In recent years, a civil uprising and a tsunami had resulted in many deaths and casualties; assistance from neighbouring countries and other development partners had enabled his country to deal with those emergencies effectively.

In order to strengthen primary health-care systems, his Government was establishing a network of community health centres, whose activities would include preparedness planning and mitigation of emergencies, and improving hospital facilities at the district and regional levels. He requested WHO to provide funding for the implementation of that strategy and the draft resolution.

Professor BOUPHA (Lao People's Democratic Republic) said that her country was strengthening the management of both its formal and informal health-care systems in order to achieve the health-related Millenium Development Goals by the year 2015. She supported the draft resolution.

Dr KAZIHISE (Burundi) said that in the area of maternal and child care, access to which was partly free, Burundi had set up ambulance and referral systems in various regions, and had saved numerous lives. The ambulance service would be extended to include all people who needed emergency care as a result of road-crash and other injuries. The provision of emergency care to all would require substantial resources, for setting up facilities and for training the personnel.

He supported the draft resolution.

Dr LE GALÈS-CAMUS (Assistant Director-General), in reply to the delegate of Bangladesh, observed that, although the preambular part of the draft resolution referred to two resolutions adopted by the Health Assembly that dealt with violence and road-traffic injuries, respectively, the scope of the report and the draft resolution under discussion included all traumas. In reply to the concern of the delegate of Morocco, she suggested that "systèmes de soins traumatologiques d'urgence" might make the link more clear between emergency care and trauma.

She thanked the experts who had helped the Secretariat in its work on emergency-care systems.

Mr AITKEN (Representative of the Director-General) read out the proposed amendments. In paragraph 2(4), the delegate of Ecuador had proposed inserting "to improve knowledge of the problem and" after "monitoring mechanism exists" and, in paragraph 2(10) replacing "methods" with "aspects". In paragraph 2(3), the delegate of Nigeria had proposed the deletion of "in locations where they would be cost-effective"; in paragraph 3(2), the insertion of "policy and" between "reviewing" and "legislation" and of "and to use such institutional capacity to assist Member States, upon request, to review and update their policies and legislation" at the end of the paragraph; and the addition of a new subparagraph 3(3bis), to read: "to work with Member States to design strategies required for providing optimal, regular non-emergency and emergency care to all who need them and to assist Member States to mobilize adequate resources from donors and development partners to acheive this goal".

Ms YUAN (United States of America) suggested that "as appropriate" should be added after "mobilize adequate resources" in the new subparagraph proposed by the delegate of Nigeria.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA60.22.

Prevention and control of noncommunicable diseases: implementation of the global strategy:
Item 12.8 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R17, and A60/15) (continued from the ninth meeting, section 2)

The CHAIRMAN drew attention to a revised text of the draft resolution, which incorporated amendments proposed by the delegations of Greece, Japan, Mexico, Norway, Philippines, Poland, Russian Federation and Thailand and which read:

The Sixtieth World Health Assembly,

Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy;¹

Recalling resolutions WHA53.17 on prevention and control of noncommunicable diseases, **WHA54.18 on transparency in tobacco control process, [Thailand]** WHA56.1 on the WHO Framework Convention on Tobacco Control, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA57.16 on health promotion and healthy lifestyles, WHA58.22 on cancer prevention and control, and WHA58.26 on public-health problems caused by harmful use of alcohol, and the many related regional committee resolutions, including on mental health;

Deeply concerned that in 2005 noncommunicable diseases caused an estimated 35 million deaths (60% of all deaths globally), that 80% of these deaths occurred in low- and middle-income countries, and that about 16 million deaths occurred among people under 70 years of age;

Noting that the mortality due to noncommunicable diseases is expected to rise by a further 17% by 2015, with serious socioeconomic consequences for Member States, communities and families;

Noting the links between noncommunicable diseases, development, the environment, and human security, and their contribution to health inequalities;

Noting that multisectoral responses continue to be limited by lack of awareness of, and appropriate action to reverse, the pandemic of noncommunicable diseases;

Noting that the importance of prevention and control of noncommunicable diseases has been highlighted in the Eleventh General Programme of Work 2006–2015, which includes the target of reducing death rates from noncommunicable diseases by 2% annually during the next 10 years;

Noting the increasing evidence on the cost-effectiveness of several simple interventions for prevention and control of noncommunicable diseases;

Noting the importance of motivating, educating and supporting individuals and families to make healthy choices in their daily lives, and the important role played by governments in providing healthy public policy and environments;

Confirming the importance of tackling the major underlying risk factors for noncommunicable diseases in an integrated, comprehensive, multisectoral and step-by-step manner;

Recognizing the heavy social and economic burden of musculoskeletal disorders especially among the work force and elderly people; [Greece]

Bearing in mind that the response to the triple burden of infectious diseases, noncommunicable diseases and injuries faced by many countries, and their severe resource constraints, requires a strong primary health-care system within an integrated health system;

Recognizing that the implementation of the WHO Framework Convention on Tobacco Control is an essential measure for the prevention and control of noncommunicable diseases;

¹ Document A60/15.

Recognizing that greater efforts are required globally to promote physical activity and healthy lifestyles, and to improve the nutritional quality of food and drink products, the way in which they are marketed, and the quality of information and its availability to consumers and their families, in particular children, young people and other population groups in vulnerable circumstances;

Recognizing that more information is required on the socioeconomic and developmental impact of noncommunicable diseases and on the outcome of available interventions;

Aware that Member States spend only a small proportion of their health-care budget on prevention of noncommunicable diseases and on public health, and that even a minor increase in that percentage would yield tremendous health and socioeconomic benefits;

1. URGES Member States:

(1) to strengthen national and local political will to prevent and control noncommunicable diseases as part of a commitment to achieving the target of reducing death rates from noncommunicable diseases by 2% annually for the next 10 years, as contained in the Eleventh General Programme of Work, 2006–2015;¹

(2) to establish ~~or to~~ **and [Philippines]** strengthen a national coordinating mechanism **and local coalitions [Philippines]** for prevention **and control [Philippines]** of noncommunicable diseases where appropriate to national circumstances, with a broad multisectoral mandate including mobilization of political will and financial resources, and involving all relevant stakeholders;

(3) to develop and implement a national multisectoral evidence-based action plan for prevention and control of noncommunicable diseases that sets out priorities, a time frame and performance indicators, provides the basis for coordinating the work of all stakeholders, and actively engages civil society, while ensuring avoidance of potential conflict of interest;

(4) to increase, as appropriate, resources for programmes for the prevention and control of noncommunicable diseases;

(5) to implement and increase support for existing global initiatives and the Framework Convention on Tobacco Control that contribute to achieving the target of reducing death rates from noncommunicable diseases by 2% annually for the next 10 years;

(6) to **strengthen the capacity of health systems for prevention [Greece]** and make prevention and control of noncommunicable diseases an integral part of programmes aimed at strengthening primary health-care systems, and to strengthen primary health care institutions so that they respond to the challenges raised by noncommunicable diseases;

OR (with also the deletion of paragraph 8)

(6) to make prevention and control of noncommunicable diseases an integral part of primary health-care programmes and to ensure that health institutions are adequately organized in order to meet the serious challenges raised by noncommunicable diseases, thereby implicitly focusing in particular on primary health care; [Japan]

(7) to strengthen monitoring and evaluation systems, including country-level epidemiological surveillance mechanisms, in order to compile evidence for informing policy decisions;

(8) to ensure that health institutions are adequately organized in order to address the serious challenges raised by noncommunicable diseases, which implies a particular focus on primary health care;

¹ Document A59/25, Appendix 6.

- (9) to emphasize the key role of governmental functions, including regulatory functions, when combating noncommunicable diseases;
- (10) to increase access to **appropriate health care including [Japan] low-price, high-quality [Philippines] medicines** for high-risk populations in low- and middle-income countries;
- (11) to incorporate into their national health programmes strategies for public health interventions designed to reduce the incidence of obesity in children and adults, together with measures to prevent and control diabetes mellitus; [Mexico]**

2. REQUESTS the Director-General:

- (1) on the basis of an outline contained in the report on prevention and control of noncommunicable diseases: implementation of the global strategy,¹ to prepare an action plan to be submitted to the Sixty-first World Health Assembly, through the Executive Board, that sets out priorities, actions, a time frame and performance indicators for prevention and control of noncommunicable diseases between 2008 and 2013 at global and regional levels, and to provide support where needed for elaboration, intensified implementation and monitoring of national plans for prevention and control of noncommunicable diseases, including the further development of an intervention to manage the conditions of people at high risk of such diseases;
- (2) to raise further awareness among Member States of the importance of drawing up, promoting and funding supportive national multisectoral coordination and surveillance mechanisms, **health promotion programmes [Poland]** and plans for prevention and control of noncommunicable diseases;
- (3) to provide support to Member States, on request, and to foster partnership, collaboration, cooperation and sharing of best practices among Member States for incorporating comprehensive noncommunicable disease interventions into national policies and programmes, including health systems policies and programmes, and for expanding interventions, including strategies to educate and support individuals and families;
- (4) to disseminate to Member States, in a timely and consistent manner, information on cost-effective, core interventions aimed at preventing and controlling noncommunicable diseases;
- (5) to encourage dialogue with international, regional and national nongovernmental organizations, donors and technical-agency partners and the private sector, while ensuring the avoidance of potential conflict of interest, in order to increase support, resources and partnerships for prevention and control of noncommunicable diseases, including health and wellness programmes at the workplace as appropriate;
- (6) to promote initiatives aimed at implementing the global strategy ~~in order to~~ **with the purpose of increase increasing availability of [Japan] healthy feeds food, [Japan] and encouraging promoting healthy diets and healthy eating habits, [Japan]** and to promote responsible marketing **including the development of a set of recommendations on marketing of foods and non-alcoholic beverages to children, [Norway]** in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties, while ensuring avoidance of potential conflict of interest;
- (7) to build and sustain contact with the mass media in order to ensure continued prominence in the media of issues related to the prevention and control of noncommunicable diseases;

¹ Document A60/15.

(8) to improve understanding of the socioeconomic impact of noncommunicable diseases at national and household levels, especially in low- and middle-income countries;

(9) to ensure that the work on prevention and control of noncommunicable diseases is given suitably high priority and support where appropriate;

(10) to develop mechanisms for Member States to coordinate activities on the prevention and control of noncommunicable diseases, in particular to recognize global and regional networking programmes on the prevention and control of noncommunicable diseases as an effective means of cooperation and implementing the global strategy, and to provide funding and support for the organization and coordination of these programmes at global and regional levels; [Russian Federation]

(11) to strongly promote dialogue between Member States with a view to implementation of concrete actions to prevent obesity and diabetes mellitus within the framework of resolution WHA53.17 on prevention and control of noncommunicable diseases and the Global Strategy on Diet, Physical Activity and Health; [Mexico]

(12) to report to the Sixty-third World Health Assembly, and subsequently every two years to the Health Assembly, through the Executive Board, on progress in implementing the global strategy on prevention and control of noncommunicable diseases, including progress on the action plan.

Mr AITKEN (Representative of the Director-General) suggested merging the amendments proposed by the delegates of Greece and Japan to paragraph 1(6), so that it would begin with the wording suggested by Greece and continue with that suggested by Japan; that option would involve the deletion of paragraph 1(8).

Ms YUAN (United States of America) endorsed that suggestion. She proposed that the words “low-price” should be deleted in paragraph 1(10) since the most important factor was the provision of high-quality medicines rather than their cost.

Dr OLIVEROS (Philippines) said that it was important to retain the qualifying term, “low-price”, because for low-income countries high-quality medicines at low prices were essential.

Ms YUAN (United States of America) suggested the alternative word “affordable”, but was prepared to discuss appropriate wording with the delegate of the Philippines if that suggestion was not acceptable.

Mr AITKEN (Representative of the Director-General) said that, if the proposal by the delegate of the United States of America were accepted, the beginning of paragraph 1(10) would read: “to increase access to appropriate health care including affordable, high-quality medicines”.

Dr OLIVEROS (Philippines) agreed with the proposal.

The draft resolution, as amended, was approved.¹

Health promotion in a globalized world: Item 12.11 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R14, and A60/18) (continued from the tenth meeting, section 2)

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA60.23.

The CHAIRMAN drew attention to a revised text of the draft resolution contained in resolution EB120.R14, which incorporated amendments proposed by the delegates of Cuba, Germany, Ghana, Greece, Kenya, Kuwait, Mexico, Sweden, Thailand and the Bolivarian Republic of Venezuela and which read:

The Sixtieth World Health Assembly,

Recalling resolutions WHA42.44 on health promotion, public information and education for health, WHA51.12 on health promotion, WHA57.16 on health promotion and healthy lifestyles, and the outcomes of the six international conferences on health promotion (Ottawa, 1986; Adelaide, Australia, 1988; Sundsvall, Sweden, 1991; Jakarta, 1997; Mexico City, 2000; Bangkok, 2005);

Having considered the report on follow-up to the 6th Global Conference on Health Promotion (Bangkok in 2005),¹ which confirms the need to focus on health promotion actions to address the determinants of health;

Drawing on the Declaration of Alma-Ata, the Ottawa Charter for Health Promotion, and the Bangkok Charter for Health Promotion in a Globalized World which sets out strategic directions for equitable health improvement in the first decades of the twenty-first century;

Considering the actions and recommendations set out in the Bangkok Charter for Health Promotion in a Globalized World to make the promotion of health central to the global development agenda, a core responsibility for all governments and a key focus of communities, civil society, and the private sector;

Noting that health promotion is essential for meeting the targets of the internationally agreed health-related development goals, including those contained in the Millennium Declaration, is intimately related to the work of WHO's Commission on Social Determinants of Health, and makes an important contribution to realizing the objectives of the Eleventh General Programme of Work;

Recognizing that the dramatic changes of the global burden of disease, **notably due to noncommunicable diseases, [Sweden]** require greater attention, and call for adjustments in society at large and in resource allocation in order to tackle the immediate and underlying determinants of health;

Recognizing that health promotion contributes to the achievement of health for all; [Greece]

Confirming the importance of addressing also the wider determinants of health, and of implementing recommendations on, and undertaking action for, health for all,

1. URGES all Member States:
 - (1) to increase, as appropriate, investments in, and to frame sound policies for, health promotion as an essential component of equitable social and economic development;
 - (2) to establish, as appropriate, effective mechanisms for a multisectoral, **including interministerial, [Germany]** approach in order to address effectively the social, economic, political and environmental determinants of health throughout the life-course;
 - (3) to support and foster the active engagement in health promotion of communities, civil society, **especially people or groups making positive contributions, [Kuwait]** the public **including and private sectors and nongovernmental organizations, including associations of public health, [Venezuela]** **professional and labour unions, businesses and associations, bodies, especially those involved in public health and health promotion, [Venezuela]** while avoiding any possible conflict of interest **and promoting constructive engagement for mutual benefit; [Thailand]**

¹ Document A60/18.

(4) systematically to monitor, evaluate **and improve [Kuwait]** health-promotion policies, programmes, infrastructure and investment, on a regular basis, including consideration of the use of health-impact assessments, **to report results in solving problems related to health promotion and to publicize and use those results in the planning process; [Thailand]**

(4bis) to reorient national public health systems towards the promotion and adoption of healthier lifestyles by individuals, families and communities; [Ghana]

(5) ~~to close the gap between~~ **to introduce into** current practices ~~and those functions based on the evidence of effective, health promotion by the full use of evidence-based health promotion interventions; [Cuba]~~

(6) that have successfully implemented a national public health policy, within which health promotion is the key to modifying the determinants of health, effectively to transfer their expertise to those countries that are still in the implementation phase; [Mexico]

2. REQUESTS the Director-General:

(1) to strengthen the capacity for health promotion across the Organization in order to provide better support to Member States by advancing knowledge and the active engagement of other appropriate organizations of the United Nations system and international organizations;

(2) to provide support to Member States in their continuous efforts to strengthen national health systems with a special focus on the primary health sector, in order to enhance the ability to tackle serious threats to health, ~~including those caused by noncommunicable diseases; [Cuba]~~

(3) to optimize use of existing forums of Member States for multisectoral, **including interministerial** stakeholders, interested organizations and other bodies, while avoiding any possible conflict of interest, in order to support the development and implementation of health promotion; **[Germany]**

(4) to encourage the convening of national, subregional, regional and global **multisectoral** conferences on health promotion on a regular basis; **[Cuba]**

(5) to monitor and evaluate progress, to identify major shortcomings in health promotion globally, and to report on a regular basis **and make the reports accessible to the public; [Thailand]**

(6) to facilitate exchange of information with international nonhealth forums on key aspects of health promotion;

(6bis) to advocate political and socioeconomic policies that impact positively on health; [Kenya]

(7) to report to the Sixty-first World Health Assembly, through the Executive Board, on progress in implementing this resolution.

Ms YUAN (United States of America) said that the Director-General should be requested to advocate all policies that impacted positively on health. She therefore proposed that in the new paragraph 2(6bis) proposed by Kenya, the words “political and socioeconomic” should be deleted.

Dr OKEYO (Kenya) agreed with that proposal.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA60.24.

Integrating gender analysis and actions into the work of WHO: draft strategy: Item 12.12 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R6, and A60/19) (continued from the eleventh meeting)

The CHAIRMAN drew attention to a revised text of the draft resolution contained in EB120.R6, which incorporated amendments proposed by the delegations of Botswana, Chile, India, Jamaica, Kenya, Nigeria, Sweden, Switzerland and Thailand and which read:

The Sixtieth World Health Assembly,

Having considered the draft strategy for ~~incorporating a~~ **integrating** gender perspective **analysis and actions** into the ~~mainstream work~~ of WHO's policies and programmes;¹

Recalling the Programme of Action of the International Conference on Population and Development (Cairo, 1994), the Beijing Declaration and Platform for Action (Beijing, 1995), the recommendations of Beijing plus 10 Conference (2005) and their reports, the Economic and Social Council's agreed conclusions 1997/2, the United Nations Millennium Declaration 2000, the 2005 World Summit Outcome² and resolution WHA58.30 on accelerating achievement of the internationally agreed health-related development goals, including those contained in the Millennium Declaration,

1. NOTES WITH APPRECIATION the strategy for ~~incorporating a~~ **integrating** gender **analysis and actions** perspective into the ~~mainstream work~~ of WHO's work;
2. URGES Member States:
 - (1) to include gender analysis and planning in joint strategic, ~~and~~ operational **and budget [Switzerland]** planning, including country cooperation strategies;
 - (2) to formulate national strategies for addressing gender issues in health policies, programmes and research, including in the area of reproductive and sexual health;
 - (3) to lay emphasis on training and sensitization on, and promotion of, gender, women and health;
 - (4) to ensure that a gender-equality perspective ~~gender-friendly health care~~ [Sweden] is incorporated in all levels of health-care delivery and services, [Sweden and Switzerland] ~~delivery~~, including those for adolescents and youth; [Jamaica]
 - (5) to collect and analyse sex-disaggregated data, **conduct research on the underlying factors of gender inequality [Thailand]** and use the results to inform policies and programmes;
 - (6) to make progress towards gender equality in the health sector, in order to ensure that the contribution of women, men, girls and boys ~~to~~ **as providers of [Sweden] health care** is considered in health policy and planning **and training for the health workforce; [Jamaica]**
3. REQUESTS the Director-General:
 - (1) to assess and address gender differences and inequalities in the planning, implementation, monitoring and evaluation of WHO's work, and to include this requirement in post descriptions and criterion in performance evaluation;
 - (2) to define indicators and to monitor, and assure accountability for, implementation of the strategy by the Secretariat at headquarters and in regional and country offices;

¹ Document A60/19.

² United Nations General Assembly resolution 60/1.

- (3) to support and sustain incorporation of a gender perspective into the mainstream of WHO's policies and programmes, including through recruiting staff **as soon as possible [Botswana]** with specific responsibility and experience on gender and women's health;
- (4) to provide support to Member States **to build their capacity for gender analysis and action, and [Kenya and India]** for formulating and sustaining strategies and action plans **(and relevant budgets) [Switzerland]** for integrating gender equality in all health policies, programmes, and research;
- (5) to give priority to the use of sex-disaggregated data and gender analysis in WHO's publications, **including relevant documents submitted to the Executive Board and the Health Assembly, [Sweden]** and in efforts to strengthen health-information systems, in order to ensure that they reflect awareness of gender equality as a determinant of health;
- (6) to ensure that programmatic and thematic evaluations indicate the extent to which gender issues have been incorporated in the Organization's work;
- (7) **to identify, and divulgate information about, good practices on measuring the impact of integrating gender into health policies, including the development of indicators and health-information systems that disaggregate data by sex; [Chile]**
- (7 8) to ensure full implementation of the strategy, and to report every two years on progress to the Health Assembly, through the Executive Board.

Ms YUAN (United States of America) proposed the insertion of "as appropriate" in paragraph 2(1) between "strategic, operational and" and "budget planning". In paragraph 2(5), in order to promote research into all the factors that influenced gender disparities, she proposed replacing "on the underlying factors of gender inequality" by "on the factors of gender disparities".

Mr AITKEN (Representative of the Director-General) suggested that it might be better to insert "as appropriate" after "budget planning".

Dr SOPIDA CHAVANICHKUL (Thailand) agreed with the amendment proposed to paragraph 2(5).

Mr MARTIN (Switzerland) said that he had understood the words "as appropriate" in paragraph 2(1) to refer only to budget planning. The text must make it clear that they did not refer to strategic and operational planning as well.

Mr AITKEN (Representative of the Director-General) suggested the following wording to resolve the problem: "strategic and operational planning, and budget planning as appropriate,".

Mr KAZIHISE (Burundi) said that in the French version, the words "health workforce" in paragraph 2(6) would be better rendered in French by "personnel sanitaire" than by "main d'oeuvre sanitaire".

The draft resolution, as amended, was approved.¹

Workers' health: draft global plan of action: Item 12.13 of the Agenda (Documents A60/20 and A60/20/Add.1) (continued from the eleventh meeting)

The CHAIRMAN drew attention to a revised text of the draft resolution on workers' health: draft global plan of action, which incorporated amendments proposed by the delegations of Cameroon, Costa Rica, Germany, Greece, Kenya, Oman, Papua New Guinea, Philippines, Russian Federation,

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA60.25.

Switzerland, Thailand, United States of America and Bolivarian Republic of Venezuela and which read:

The Sixtieth World Health Assembly,

Having considered the draft global plan of action on workers' health;¹

Recalling resolution WHA49.12 which endorsed the global strategy for occupational health for all;

Recalling and recognizing the recommendations of the World Summit on Sustainable Development (Johannesburg, South Africa, 2002) on strengthening WHO action on occupational health and linking it to public health;²

Recalling the Promotional Framework for Occupational Safety and Health Convention, 2006, and the other international instruments in the area of occupational safety and health adopted by the General Conference of the ILO;³

Considering that the health of workers is determined not only by occupational hazards, but also by social and individual factors, and access to health services;

Mindful that interventions exist for primary prevention of occupational hazards and for developing healthy workplaces;

Concerned that there are major gaps between and within countries in the exposure of workers **and local communities [Papua New Guinea]** to occupational hazards and in their access to occupational health services;

Stressing that the health of workers is an essential prerequisite for productivity and economic development,

1. **ENDORSES [OR] WELCOMES** the global plan of action on workers' health 2008–2017;
2. **URGES** Member States:
 - (1) to devise, in collaboration with workers, employers and their organizations, national policies and plans for implementation of the global plan of action on workers' **and the local communities, [Papua New Guinea]** health as appropriate, and to establish appropriate mechanisms **and legal frameworks [Kenya]** for their ~~execution~~ **implementation [Greece]**, monitoring and evaluation;
 - (2) to work towards full coverage of all workers, including those in the informal economy, small- and medium-sized enterprises, agriculture, and migrant ~~workers~~ **and contractual workers, [Oman]** with essential interventions and basic occupational health services for primary prevention of occupational and work-related diseases and injuries;
 - (3) to take measures to establish and strengthen core institutional capacities and human resource capabilities for dealing with the special health needs of working populations;
 - (3bis) to generate evidence on workers' health and translate that evidence into policy and actions [Thailand];**
 - (4) to develop and make available specific guidelines for the establishment of appropriate health services and monitoring tools for human and environmental hazards and diseases introduced into local communities where commercial activities have been set up to meet the associated needs of those communities [Papua New Guinea];**
 - (4) to ensure collaboration and concerted action by all national health programmes relevant to workers' health, such as those dealing with prevention of occupational

¹ As contained in document A60/20, Annex.

² Plan of Implementation of the World Summit on Sustainable Development. Document A/Conf.199/20, Annex.

³ International Labour Conference, Ninety-fifth Session, Geneva 2006. Provisional Record 20A.

diseases and injuries, communicable and chronic diseases, health promotion, mental health, environmental health, and health systems development;

(5) to encourage incorporation of workers, **and the local communities, [Papua New Guinea]** health in national and sectoral policies for sustainable development, poverty reduction, employment, trade, environmental protection, and education;

(6) to formulate national and intercountry strategic approaches to providing medical care and services for sick and injured migrant workers [Philippines];

(6) to encourage the development of effective mechanisms for collaboration and cooperation between developed and developing countries at regional, subregional and country levels in implementing the global plan of action on workers' health;

(7) to encourage development of comprehensive health and nonhealth strategies to ensure reintegration of sick and injured workers into the mainstream of the society, in coordination with the different government and in nongovernmental organizations [Philippines];

3. REQUESTS the Director-General:

(1) to promote implementation of the global plan of action on workers' health 2008–2017 at national and international levels **with a definite timeline and indicators for the establishment of occupational health services at the global level [Thailand];**

(2) to strengthen collaboration with ILO, **the International Organization for Migration and other related international organizations [Philippines]** and to stimulate joint regional and country efforts on workers' health;

(3) to maintain and strengthen the network of WHO collaborating centres for occupational health as an important mechanism for implementation of the global plan of action;

(4) to support capacity building for coordination within and between countries and for management of information concerning the health of migrant workers [Philippines];

(4) to report to the Health Assembly through the Executive Board at its 132nd (2013) and its 142nd (2018) sessions on progress made in the implementation of the global plan of action.

The revised paragraphs from the draft global plan of action were as follows:

10. WHO will work with Member States to strengthen the capacities of the ministries of health to provide leadership for activities related to workers' health, to formulate and implement policies and action plans, and to stimulate intersectoral collaboration. Its activities will include global campaigns for elimination of asbestos-related diseases **in line with international legal instruments and the latest evidence for effective interventions** and immunization of health-care workers against hepatitis B, and other actions addressing priority work-related health outcomes. **In implementing the global campaign for elimination of asbestos and related diseases, allowance should be made for a differentiated approach to regulating the various forms of asbestos, as laid down in the Rotterdam Convention, on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (1998).**

...

14. Health promotion and prevention of noncommunicable diseases should be further stimulated in the workplace, in particular by advocating healthy diet and physical activity among workers, and promoting mental health, **maternal, child and newborn health** at work. Global health threats, such as tuberculosis, HIV/AIDS, **and** malaria and avian influenza, can also be prevented and controlled at the workplace.

...

18. Development of human resources for workers' health should be further strengthened by: further postgraduate training in relevant disciplines; building capacity for basic occupational health services; incorporating workers' health in the training of primary health care practitioners and other professionals needed for occupational health services; creating incentives for attracting and retaining human resources for workers' health, and encouraging the establishment of networks of services and professional associations. **Attention should be given not only to postgraduate but also to basic training for health professionals in various fields such as a promotion of workers' health and the prevention and treatment of workers' health problems. This should be a particular priority in primary health care.**

...

30. WHO, supported by its network of Collaborating Centres for Occupational Health and in partnership with other intergovernmental and international organizations, will work with the Member States to implement this plan of action by:

- ~~providing leadership to international efforts on workers' health, engaging in partnership and joint action where necessary with ILO and other organizations of the United Nations system, organizations of employers, trade unions and other stakeholders in civil society and the private sector;~~
- **promoting and engaging in partnership and joint action with ILO and other organizations of the United Nations system, organizations of employers, trade unions and other stakeholders in civil society and the private sector in order to strengthen international efforts on workers' health;**
- **in coherence with the actions undertaken by ILO**, setting standards for protection of workers' health, providing guidelines, promoting and monitoring their use, and contributing to the adoption and implementation of international labour conventions;
- articulating policy options for framing national agendas for workers' health based on best practices and evidence;
- providing technical support for tackling the specific health needs of working populations and building core institutional capacities for action on workers' health;
- monitoring and addressing trends in workers' health;
- establishing appropriate scientific and advisory mechanisms to facilitate action on workers' health at global and regional levels.

Professor PEREIRA MIGUEL (Portugal) said that, because the Executive Board would be discussing health and migration at its 122nd session, and having consulted the delegates of Papua New Guinea and Philippines, consideration of new paragraphs 2(6) and 3(4) might be deferred to that session. He proposed deleting "local communities" in paragraph 2(1); replacing "contractual workers" by "subcontracting" in paragraph 2(2), and merging paragraphs 2(3bis) and 2(3). He further proposed, in new paragraph 2(4), replacing the wording as far as "activities" by "to establish appropriate health services and tools for prevention of occupational and environmental hazards and diseases in local communities where industrial and agricultural"; in paragraph 2(5), deleting "and the local communities", at the end of original paragraph 2(6); deleting new paragraph 2(6) and inserting "including the health needs of migrant workers" and, in paragraph 3(2), deleting "the International

Organization for Migration”. In the annex containing the draft global plan of action, the third sentence of paragraph 10, referring to the Rotterdam Convention, should be deleted since it was covered by the second sentence and there were, besides, other international agreements that referred to asbestos, such as the Basel Convention and the ILO Convention.

Ms YUAN (United States of America) proposed that in paragraph 2(4), “monitoring tools” should be replaced by “surveillance mechanisms”.

Dr SOPIDA CHAVANICHKUL (Thailand), referring to paragraph 14 of the annex, said that her delegation had proposed a reference to reproductive health, not just maternal, child and newborn health. Reproductive health was the main cause of sick leave and absenteeism among health workers and was closely linked to maternity leave and to the prevention of HIV/AIDS and other sexually transmitted infections. She wanted her concerns to be reflected in a revised version of the draft global action plan.

Dr Ali Jaffer SULEIMAN (Oman) said that his delegation had requested the reference to “contractual workers” in paragraph 2(2). In the Gulf Cooperation Council countries, contracting differed considerably from subcontracting and the resolution must distinguish between them. Contractual workers worked on individual contracts of at least a year’s duration, whereas that was not the case with subcontracting. He also requested that the other Council countries should be listed as sponsors namely, Bahrain, Kuwait, Qatar, Saudi Arabia, United Arab Emirates and Yemen.

Dr BIN SHAKAR (United Arab Emirates) confirmed that contractual workers were employed under individual contracts, whereas subcontracting took place at the company level. Contractual workers were migrant workers rather than immigrants.

Dr AL-SALEH (Kuwait) said that, since subcontracting was different from contracting, changing the wording of paragraph 2(2) could result in contractual workers losing their rights.

Ms KAZRAGIENE (Lithuania) said that Lithuania wished to sponsor the resolution.

Dr LEVENTHAL (Israel) noted that the original text of paragraph 2(2) said “migrant and contractual workers”. Since the difference between contractual and subcontracted workers was that the former were documented and the latter might be undocumented, in the interests of clarity, “documented” might be added before “migrant”.

Mr AITKEN (Representative of the Director-General) asked whether the sponsors who had drafted the references to migration agreed with the proposal to delete new paragraphs 2(6) and 3(4) since their subject matter would be taken up by the Executive Board at its 122nd session.

Dr OLIVEROS (Philippines) agreed to the deferral of consideration of the matters in those paragraphs, as the discussion of health and migration at the next session of the Executive Board should meet her concerns.

Mr AITKEN (Representative of the Director-General) summarized the amendments proposed to the revised draft resolution. In paragraph 2(1), “and the local communities” would be deleted; in paragraph 2(2), “contractual workers” would be retained; and paragraphs 2(3) and 2(3bis) would be merged. With regard to the amendment proposed to new paragraph 2(4), it might be preferable to retain most of the original wording while maintaining the focus of the amendment, which involved replacing “commercial activities” by “mining and other industrial and agricultural activities”. It had also been proposed to replace the words “monitoring tools” with “surveillance mechanisms”. In the annex containing the draft global plan of action, the third sentence of paragraph 10 should be deleted

since the new wording in the second sentence was sufficient to cover it. In paragraph 14, the words “and reproductive health” should be inserted after “newborn health”.

Dr SOPIDA CHAVANICHKUL (Thailand) said that, in a spirit of compromise, she agreed to “family health” rather than “reproductive health”.

Dr SHEVYREVA (Russian Federation) insisted on retention of the third sentence of paragraph 10 in the annex. Her Government was working actively on the ratification of the Rotterdam Convention and the adoption of provisions that contradicted the Convention would be inappropriate. Her amendment simply proposed a differentiated approach to regulating asbestos and did not conflict with other countries’ interests.

Professor PEREIRA MIGUEL (Portugal) said that he had proposed the change in paragraph 10 after consulting experts. Could the Russian amendment be incorporated in the preceding sentence?

Mrs WEBER-MOSDORF (Assistant Director-General) said that the reference in the second sentence to “international legal instruments” was broader; the third sentence would be repetitive and make the paragraph less clear. She asked whether the delegate of the Russian Federation could propose a revised formulation for the second sentence.

Dr SHEVYREVA (Russian Federation) said that it was important to reflect the need for a differentiated approach to regulating the various forms of asbestos.

Mr AITKEN (Representative of the Director-General) suggested that the words “bearing in mind a differentiated approach to regulating the various forms of asbestos” could be inserted before the new text in the second sentence.

Mrs WEBER-MOSDORF (Assistant Director-General) said that that wording was still too specific for a global plan aimed at tackling all the risks caused by hazardous chemicals. She would prefer to retain a broader formulation, but the decision rested with the Member States.

Dr SHEVYREVA (Russian Federation) said that there was no need to mention asbestos again. The wording could be: “bearing in mind a differentiated approach to regulating its various forms”.

Mr AITKEN (Representative of the Director-General) said that there appeared to be a slight majority in favour of the use of “endorses” in preference to “welcomes” in paragraph 1 of the draft resolution.

Ms YUAN (United States of America) said that she could accept the term “endorses”.

Ms BELLO DE KEMPER (Dominican Republic), referring to paragraph 10 of the annexed draft global plan of action and, having understood that the reference to the Rotterdam Convention would be removed, suggested that it be replaced by the phrase “relevant international legal instruments”.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA60.26.

Strengthening of health information systems: Item 12.15 of the Agenda (Documents EBSS–EB118/2006/REC/1, resolution EB118.R4, and A60/22)

Mr ROSALES (Argentina) shared the views in the report regarding strengthening health information systems. Argentina's health statistics system had been updated in line with health policies, international regulations and user demand. The updated health statistics had helped in devising more precise indicators in order to assess both federal health plans and achievement of the Millennium Development Goals. Progress had been made in health monitoring and surveillance systems and in transplant databases. He supported the adoption of a technical framework as the global standard for producing, reproducing and using health information.

Dr AYDINLI (Turkey), in considering options for standardized terminology, recalled that even developed countries had incompatible terminology systems. He appreciated WHO's efforts to collaborate with international organizations and to represent the interests of Member States, particularly in developing countries. Collaboration between Member States was crucial in standardizing terminology. WHO should participate more in the management boards of international standardization organizations. Harmonization efforts, mapping studies and agreeing rules in a spirit of consensus would assist countries in successfully adopting terminologies whatever their infrastructure capacity. The Secretariat should also help Member States to introduce the necessary structures for managing and sustaining e-health services and applications.

Mr DANKOKO (Senegal) said that his Government's Ministry of Health continued to strengthen its health information system with the involvement of all stakeholders. A national health information service established in 2004 aimed to improve statistics management, communication and the consistency of health data. However, an integrated system able to take into account international data had yet to be set up. Centralized systems lacked institutional support, and functional and communication links, with the result that collection, dissemination and processing of data were dysfunctional. There were many information subsystems in various departments, with no master plan for development of health information. Qualified staff were lacking. At the decentralized level, data collected were often incomplete and of insufficient quality and staff lacked the necessary information, motivation or training to complete the forms.

Data management tools and systems were being evaluated in order to improve recording and dissemination of data. A spreadsheet for data collection had been designed and distributed. A strategy to upgrade training in software applications and data management had been implemented for the past year. Senegal was committed to improving its health information system and supported the draft resolution contained in resolution EB118.R4.

Dr ADDAI (Ghana) said that health information systems were vital for functioning and sustainable health systems, equitable allocation, efficient use of resources and accountability. Yet they were weak in the poorer settings where they were most needed. Efforts to strengthen them were often fragmented and led by disease control programmes. Ghana had begun to work with the Health Metrics Network, strengthening key areas in which it was difficult to attract donor support. Ghana was investing in information and communication technology that would facilitate the dissemination of information. However, such efforts to harmonize and strengthen national health systems were challenged by information needs, and investments in health information systems were sometimes directed by vertically-funded and donor-led disease control programmes, including some of WHO's activities. He asked whether there was consensus within the Secretariat on using the technical framework proposed by the Health Metrics Network. Building consensus on information systems within the Secretariat would ensure that harmonized support was given to Member States. He proposed that subparagraph 3.2 of the draft resolution should be amended by inserting the word "harmonized" before "support to Member States".

Dr METAI (Kiribati) acknowledged the extensive help provided by WHO to improve his country's health information systems in the past 15 years: computers had been installed and staff had been trained in standardized reporting, analysis and dissemination of data. Yet data reporting from clinics was still poor; timely communication, although vital, was hampered by the large area over which the Kiribati islands were scattered. He requested further technological support to improve reporting from isolated islands and clinics; the technology should be user-friendly and easy to maintain, and powered by local sources of energy. He supported the draft resolution with the addition in the fourth preambular paragraph of the words "have scattered, isolated and hard-to-reach primary sources of information" before "understaffed and inadequately resourced". Solving communication problems should be part of the strengthening of health information systems, a need Kiribati shared with other developing countries.

Dr CHAKIROU (Congo), speaking on behalf of the 46 Member States of WHO's African Region, said that producing indicators posed complex technical problems and required specific competence in public health, biomedicine and statistics. The reliability and validity of health statistics in African countries varied enormously, as did the accuracy of the measurement tools. Data requests were often linked to donor requirements or to international initiatives, further weakening national health information systems. Information was not often used for decision-making in African countries because it was seldom analysed or disseminated in time. Since health statistics were unreliable, owing to limited resources, they posed a threat to public health, made planning difficult and left decision-makers unable to identify problems and needs or to monitor progress and assess the impact of interventions. Given the need for a high-quality, standardized, health information system, he fully supported the proposal for all to work within the same global framework. Many countries in the African Region had benefited from the Health Metrics Network tool, which adapted well to existing systems. The Region's Member States were committed to meeting the challenges through a standardized national, regional and global framework; strengthening health information systems through development plans; improving processes for producing, analysing, disseminating and using information for decision-making; and establishing monitoring mechanisms. The Network and its partners should support the "pathfinder countries" in completing the exercise, and produce a development plan for health information services. The Region's Member States supported the strategic approach but would need the assistance of the Secretariat. He supported the draft resolution.

The meeting rose at 12:30.

THIRTEENTH MEETING

Tuesday, 22 May 2007, at 14:45

Chairman: Professor ENG HUOT (Cambodia)

later: Dr R.R. JEAN LOUIS (Madagascar)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Strengthening of health information systems: Item 12.15 of the Agenda (Documents EBSS-EB118/2006/REC/1, resolution EB118.R4, and A60/22) (continued)

Ms VIELMA (Bolivarian Republic of Venezuela) observed that building an accurate and up-to-date health information system was important for the formulation of health policies. Good health information required collaboration between the health and statistics sectors. Venezuela was strengthening its health information system through training of the personnel producing vital statistics and epidemiological bulletins, and through programmes aimed at upgrading research. A draft law on the national health system would create a system for collecting, analysing and evaluating the most recent health data, consolidated in accordance with the requirements of institutions comprising the national health system and organized on the basis of age, sex, social stratum and ethnic group. The draft law provided for a national strategic plan on information and communication technologies, aimed at safeguarding available health information. She supported the draft resolution.

Dr HUWAIL (Iraq) said that an effective health information system required: an elaborated health information system that took into account all epidemiological and demographic variables; intergovernmental coordination and cooperation with the support of WHO; updated technologies; a health information system in all primary health-care programmes; institutional and individual capacity-building on all aspects of the system; maintaining an efficient health system; intersectoral collaboration; and communication at all levels. Information should be shared for creating such a system.

Ms WARANYA TEOKUL (Thailand) said that evidence-based decision-making could help parliaments, civil society and the international development community to minimize the gaps in public health delivery and raise commitment levels. Health information systems could be used for prioritizing programmes, guiding resource allocation, and identify targets; they could also serve as monitoring and evaluation tools. They must be strengthened in order to provide a baseline indicator of health status and of health-care delivery. Limited financial and human resources had been made available for health information systems nationally and internationally. In WHO, for example, only 3.8% of appropriations for the 2008–2009 financial period had been allocated to the strategic objective relating to health systems. She welcomed the contributions from the Bill & Melinda Gates Foundation and other partners in WHO's Health Metrics Network for strengthening health information systems. She sought more information on the relationship between that Network and the Health Metrics Institute at the University of Washington. She endorsed the views of the delegate of Ghana regarding the collection of information based on the Network's technical framework. She supported the draft resolution as amended by Ghana.

Dr Jean Louis took the Chair.

Mr MABUZA (Swaziland) said that health information systems were crucial for decision-making. Implementing the Health Metrics Network programme had begun in Swaziland the previous year. Following a comprehensive assessment of the health information system, a health information systems policy would be framed. With the help of the Network, the Ministry of Health was applying a new patient management system in antiretroviral treatment clinics. It was also connecting all health information systems to a national computer network, and linking hospitals, health centres, public health units and antiretroviral sites. A data validation exercise had been conducted. Swaziland's comprehensive Human Resource Information System covered all staff in the health sector and provided analyses of variables including staff levels and vacancy rates. He thanked WHO and other development partners for their continued support.

Mr HU Jianping (China) commended the Secretariat's work on strengthening health information systems in Member States. The report should have given more attention to two difficulties in the sharing and use of the information collected: poor coordination and division of labour in some countries, and even within a health system itself; and differences in the standard of information collected by the various health sectors in a country.

In the draft resolution, he proposed the addition of "and through effective coordination and reasonable division of labour within the health sector" at the end of paragraph 1(1), and a new paragraph 1(6), reading: "to increase human resources and financial input and strengthen health information standards research in order to improve standardization of health information systems".

Mrs EL-HALABI (Botswana) said that many developing countries, including Botswana, had fragmented, understaffed and underfunded health information systems, which hindered progress in monitoring the attainment of national and international goals. Botswana was concerned about the duplication and fragmentation of data and the existence of obsolete data. In order to ensure that the data collected were accurate and relevant, nurses, doctors and other health-care workers at the central and district levels were receiving training on the use of the International Classification of Diseases (10th edition) and of software applications. A new Department of Policy, Planning, Monitoring and Evaluation had been entrusted with developing a focal point for the integration, coordination and strengthening of the country's health information systems.

Botswana welcomed the Health Metrics Network and the target set for 2011. The Secretariat should support countries in the preparation of grant proposals; the criteria for providing financial support to countries for implementing the Network should be reviewed in order to confer eligibility on countries like Botswana, which were above the low-income to middle-income bracket yet in need of assistance. The participation of WHO and other development partners was crucial for the strengthening of health information systems, and she supported the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece) said that health information was essential in order to provide basic health care for all and agreed that relevant and good-quality information was necessary to support health action. If health information systems were to be improved, the information generated through research must be taken into account, and activities in health statistics should be increased in each country. Observing that health information went beyond the responsibility of any single government entity, she drew attention to WHO's role (paragraph 6 of the report). In future, when the Health Assembly was invited to consider a resolution recommended in a resolution of the Executive Board, the relevant text should be appended to the Health Assembly document for ease of reference.

Dr LEAFASIA (Solomon Islands) noted the importance of accurate and up-to-date health information for making decisions, including those on WHO's budgetary allocations. Some development partners working in the Solomon Islands cited different statistics, depending on whether they were reporting on progress or requesting more funds for their work, a situation that showed the importance of a good and accurate information system. His Government needed support from WHO to strengthen its health information system and so ensure that decisions on resource allocation and planning reflected actual needs.

Dr MTONGA (Zambia) said that the Health Metrics Network would increase the availability, quality, value and use of timely and accurate health information, enhance coordination, and reduce fragmentation and duplication of efforts. Zambia had continued to develop a strong health information system through its national statistics system. The health management information system was being extensively revised to make it more responsive to reporting needs at all levels of health service delivery and to generate statistics on Zambia's progress towards the Millennium Development Goals. It was designed around the framework set out in the Health Metrics Network in order to ascertain quality in reporting and data flow.

The joint annual review in the Zambian health sector had confirmed its contribution to poverty reduction within the fifth national development plan. It also identified opportunities for investment for development partners. Other surveys, such as those on sexual behaviour and on the food, health and nutrition information system, conducted by the Central Statistics Office, were important in identifying needs in the Zambian health sector. Noting the importance of political leadership, he recalled that his President had launched an information, communication and technology policy that would foster environments conducive to investment, thus enhancing health information systems at all levels. He appreciated WHO's continued support and endorsed the draft resolution.

Dr AL GHAFIRI (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the work on strengthening health information systems. The report did not place enough emphasis on WHO's normative role as the only organization capable of setting standards for health information systems. Member States expected the Secretariat to lend its expertise and technical assistance in order to ensure that countries had the capacity to collect data and, more importantly, to transform them into useful knowledge. He was concerned that the report treated improved capacity to produce estimates (paragraph 20) as an end in itself. As far as possible, estimates should be avoided. Sound evidence should be generated by strengthening capacity for routine data collection from health-care facilities.

However, constraints had to be recognized. Many countries in the Region had not developed national information policies or the necessary infrastructure for collecting, storing, managing, disseminating and using information; sustainable funding and serious commitment from governments and donors were lacking. Additional human resources were needed at managerial level, and a culture had to be promoted in which planning was based on evidence; that would require intervention in the early stages of medical and health sciences education. The organizational culture of ministries of health and other health-care institutions also needed to change. Health information systems should also aim to support health systems. Funding agencies should cease promoting information systems for specific health programmes or diseases.

Dr FAKEYE (Nigeria) said that improving health information systems was a core strategy for strengthening health systems. In 1999, Nigeria had introduced a health management information system with specified minimum capacities at the federal, state and local government levels. During 2004–2006, formats and minimum data sets for the various levels had been reviewed. Nigeria was also involved in the Health Metrics Network, and was mapping the availability of services. Data should be collected, analysed and used to inform decision-making at all levels. Those activities, in a country the size of Nigeria, demanded enormous resources. Health information systems for specific programmes could distort national systems. Countries should organize such systems as subsets of their national systems, and to harmonize the procedures followed.

In the draft resolution, he proposed the addition of two new subparagraphs in paragraph 1, the first reading: "to recognize, establish and operationalize health information systems as one of the core strategies for strengthening their national health systems", and the second: "to regard programme-based information systems as subsets of national health information systems and to organize the harmonization of the various programme information subsystems in this context".

Mrs CHERQAOU (Morocco) supported the draft resolution. The target date for achieving the Millennium Development Goals was approaching, yet many countries were still without adequate or

any health information systems. To achieve the Goals, priority must be given to strengthening those systems and ensuring their appropriate use. Member States would need support for that purpose. She therefore proposed an additional subparagraph in paragraph 3 of the draft resolution, requesting the Director-General to give priority to country programmes and to increase WHO's support for the strengthening of national health information systems. Only a few countries had so far benefited from the Health Metrics Network, possibly because of a lack of information on how to take part. Paragraph 3 of the draft resolution should therefore be further amended by requesting the Director-General to keep Member States informed about the Network, in order to enable them to cooperate more closely with it.

Dr TSESHKOVSKIY (Russian Federation) said that the standardized collection and analysis of reliable data through a health information system were essential for making decisions about resources and priorities. The functioning of a health information system depended on funding, the setting of standards, staffing, organization, programming and techniques. Data should also be comparable, nationally and internationally.

In the Russian Federation, it was difficult to compare data from different ministries. His country would continue to cooperate with WHO in strengthening its national health information system and in using the Health Metrics Network. That might involve monitoring the introduction of international standards for primary statistical data, especially mortality statistics; the translation into Russian and adaptation of methods of data collection; and technical support for the training of various target groups, ranging from the doctors who supplied the data to the statisticians analysing them for decision-makers. He supported the draft resolution.

Dr SUGIURA (Japan) said that reliable and timely information was needed for monitoring and evaluation, achievement of the Millennium Development Goals and other health targets, and effective policy-making. He supported the draft resolution. WHO should continue to play a leading role in the area, working with other relevant international organizations and donors.

Ms YUAN (United States of America) supported the use of health information technology to improve the quality and efficacy of health care and provide statistics and epidemiological data. Accurate information was vital in working towards the Millennium Development Goals. It was clear that many developing countries faced difficulties in gathering the necessary data. The United States supported the role played by WHO at headquarters and regional levels in exploring ways of using health information technology to improve the delivery of primary health care, especially in resource-poor settings. WHO should foster and support collaboration among stakeholders in the Health Metrics Network. It must, however, remain the prerogative of Member States to establish national systems and to negotiate and develop international systems. Supporting the draft resolution, she suggested that, since Member States were urged in paragraph 1 to mobilize the necessary scientific, technical, social, political, human and financial resources, the words "to strengthen" in the amendment proposed by the delegate of China should be replaced by "to increase".

Mr BENKACI (Algeria) said that several reports to the Health Assembly had pointed to weaknesses in the health information systems of Member States. The burden of responding to demands from external organizations was distracting country information systems from fulfilling their role in health planning, especially where donor support depended on statistical and other information. Nevertheless, countries should collect, analyse and use data, initially for their own purposes and then to inform others. If treated as a vertical function and part of national health programmes, the gathering of data would permit the formulation of sound policies and their subsequent adjustment as necessary.

Algeria had established a health information system and an epidemiological surveillance system underpinned by telecommunication technology. The national health intranet provided health professionals with access to databases and up-to-date information, enabling them to intervene immediately in the event of disease outbreaks or other crises. However, the financing of the

infrastructure was a burden to the health sector. WHO should assist in standardizing methods of establishing integrated and reliable information systems in Member States.

The report should not have included the reference in paragraph 1 to the attainment of international development goals by public health policy-makers. The last sentence of paragraph 18 should have included a mention of health information system professionals and specialists in the collection and compilation of data, those being the people responsible for preparing information for analysts and decision-makers.

Dr EVANS (Assistant Director-General) assured the delegate of Turkey that WHO would continue to work with organizations that were developing standards for health terminologies. In reply to the comment by the delegate of Kiribati about the need to develop appropriate technology for the reporting of information from locations such as small island States, he said that implementation of the measures set out in resolution WHA58.28 on eHealth would provide affordable and accessible solutions. Discussions on the matter were currently under way at the tenth session of the UNCTAD Commission on Science and Technology for Development. In reply to the delegate of Thailand, he said that the Secretariat would take steps to learn more about the Health Metrics Institute to be funded by the Bill & Melinda Gates Foundation and its relation to the Health Metrics Network, and would keep Member States informed. In reply to the delegate of Botswana, he said that as a member of the Health Metrics Network board, WHO would draw attention to the concerns of Member States about the criteria for obtaining support from the Network. In response to the delegate of Oman, he said that WHO's normative role had not been supplanted by the Health Metrics Network; in fact, the Network was looking to WHO to extend its role so as to bring in other partners. In reply to the additional comment by the delegate of Oman, he said that all the instruments used for conducting surveys and aggregating data on the basis of clinical records carried a degree of bias, and that the process of correcting for bias involved estimation. It was therefore important to strengthen capacity in order to produce the best possible estimates. However, better data would also improve the estimates. In reply to the delegate of Morocco, he said that the progress of the Health Metrics Network had been discussed in Committee B, and that WHO would continue to report on the Network's activities; so far 65 Member States were involved. The Network's web site provided further information.

The meeting was suspended from 15:40 to 16:50.

Mr AITKEN (Representative of the Director-General) read out the proposed amendments. The delegate of Kiribati had proposed the insertion, in the fourth preambular paragraph, after "fragmented", of the words "and have on occasions scattered, isolated and hard-to-reach primary sources of information, and are ...". The delegate of Nigeria had proposed a new subparagraph 1(1), to read: "to recognize, establish and operationalize health information systems as one of the core strategies for strengthening their national health systems". The delegate of China had suggested adding to paragraph 1(1) the words: "and through effective coordination within health departments as well as a rational division of responsibilities". The delegate of Nigeria had suggested the addition of a new paragraph 1(1), to read: "to regard programme-based information systems as subsets of national health information systems and to organize the harmonization of the various programme information subsystems in this context". A new subparagraph 1(6), proposed by the delegate of China, had been amended by the delegate of the United States of America because paragraph 1 already contained a reference to human and financial resources. The amended proposal, supported by the delegate of China, read: "to strengthen research on health information standards, as well as to promote the standardization and harmonization of health information systems". The delegate of Ghana had proposed inserting "harmonized" before "support" in paragraph 3(2). The delegate of Morocco had proposed adding to paragraph 3(4) the words "and to give priority to programmes that support health information systems"; and, inserting in paragraph 3(5), after "evolving methodologies" the words

“ to keep countries informed about the Health Metrics Network and support countries’ capabilities to become involved in the Network.”

The draft resolution, as amended, was approved.¹

Avian and pandemic influenza: Item 12.1 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R7, A60/7, A60/8 and A60/INF.DOC./1) (continued from the second meeting, section 2)

- **Developments, response and follow-up** (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R7, and A60/7) (continued from the second meeting, section 2)
- **Application of the International Health Regulations (2005)** (Document A60/8) (continued from the second meeting, section 2)
- **Best practice for sharing influenza viruses and sequence data** (Document A60/INF.DOC./1) (continued from the second meeting, section 2)

The CHAIRMAN said that he would suspend the meeting to allow time for delegations to consider a draft resolution on pandemic influenza preparedness.

The meeting was suspended from 17:00 to 17:35.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking as the chairman of the drafting group, reported that the group had met 12 times, because of the technical and political complexities involved, with the active participation of between 30 and 40 delegations. It had been convinced that a resolution on avian influenza was needed in order to authorize the Director-General to take immediate action in the event of an influenza pandemic. Despite major differences of view, a consensus had been achieved on the following draft resolution:

The Sixtieth World Health Assembly,

Having considered the report on avian and pandemic influenza: developments, response and follow-up;²

Reaffirming obligations of States Parties under the International Health Regulations (2005);

Recalling resolutions WHA58.5 and WHA59.2, which expressed concern about the potential of the H5N1 strain of *Influenzavirus A* to cause a pandemic and urged Member States to disseminate to WHO collaborating centres information and relevant biological materials, including clinical specimens and viruses;

Recognizing the sovereign right of States over their biological resources, and the importance of collective action to mitigate public health risks;

Recognizing that intellectual property rights do not and should not prevent Member States from taking measures to protect public health;

Recalling the Jakarta Declaration on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits and the recommendations of the High-Level Meeting on Responsible Practices for Sharing Avian Influenza Viruses and Resulting Benefits (Jakarta, 26–28 March 2007);

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA60.27.

² Documents A60/7, A60/8 and A60/INF.DOC./1.

Recognizing, in particular, the importance of international sharing, with WHO collaborating centres, of clinical specimens and viruses as a contribution to assessment of the pandemic risk, development of pandemic vaccines, updating of diagnostic reagents and test kits, and surveillance for resistance to antiviral medicines;

Stressing the need for effective and transparent international mechanisms aimed at ensuring fair and equitable sharing of benefits, including access to, and distribution of, affordable diagnostics and treatments, including vaccines, to those in need, especially in developing countries, in a timely manner;

Noting WHO's global pandemic influenza action plan to increase vaccine supply and its goal of reducing the gap between the potential vaccine demand and supply expected during an influenza pandemic by expanding over the medium- and long-term the supply of pandemic vaccine,¹

1. URGES Member States:

(1) to continue to support, strengthen and improve the WHO Global Influenza Surveillance Network and its procedures through the timely sharing of viruses and specimens with WHO collaborating centres, as a foundation of public health, to ensure critical risk assessment and response, and to aim to ensure and promote transparent, fair and equitable sharing of benefits arising from the generation of information, diagnostics, medicines, vaccines and other technologies;

(2) to support and promote research to improve the prevention, detection, diagnosis and management of influenza viral infection, with the goal of developing better tools for public health;

(3) to support WHO as appropriate in order to identify and implement mechanisms referred to in paragraph 2, subparagraph (1);

(4) to formulate as appropriate and to strengthen existing policies on influenza vaccines as an integral part of their national influenza-pandemic preparedness plans;

(5) to strengthen where appropriate the capacity of national and regional regulatory authorities to efficiently and effectively carry out necessary measures for the rapid approval of safe and effective candidate influenza vaccines, especially those derived from new subtypes of influenza viruses, and in this respect to encourage international collaboration among regulatory authorities;

2. REQUESTS the Director-General:

(1) to identify and propose, in close consultation with Member States, frameworks and mechanisms that aim to ensure fair and equitable sharing of benefits, in support of public health, among all Member States, taking strongly into consideration the specific needs of developing countries, such as, but not limited to:

(a) innovative financing mechanisms to facilitate timely and affordable procurement of pandemic vaccines for and by Member States in need;

(b) facilitation of acquisition by developing countries of capacity for manufacturing in-country influenza vaccine;

(c) access to influenza-vaccine viruses developed by WHO for the production of vaccines by all influenza-vaccine manufacturers, particularly in developing countries;

(d) in times of public health emergencies of international concern, full access of all influenza-vaccine manufacturers to pandemic influenza-vaccine viruses developed by WHO for the production of pandemic influenza vaccines;

¹ Document WHO/IVB/06.13 – WHO/CDS/EPR/GIP/2006.1.

- (e) technical assistance to developing countries to enhance local research and surveillance capacity, including staff training, with the objective of assuring work on influenza viruses at national and regional levels;
 - (f) upon request, provision of support to Member States, especially developing and affected countries, to improve their capacity to establish and strengthen testing capacity for H5 and other viruses, including identification and characterization, and to establish and strengthen their capacity to meet WHO requirements for becoming a reference laboratory or collaborating centre, if desired;
- (2) to establish, in close consultation with Member States, an international stockpile of vaccines for H5N1 or other influenza viruses of pandemic potential as appropriate, for use in countries in need in a timely manner and according to sound public-health principles, with transparent rules and procedures, informed by expert guidance and evidence, for operation, prioritization, release of stocks, management and oversight;
 - (3) to formulate mechanisms and guidelines, in close consultation with Member States, aimed at ensuring fair and equitable distribution of pandemic-influenza vaccines at affordable prices in the event of a pandemic in order to ensure timely availability of such vaccines to Member States in need;
 - (4) to mobilize financial, technical and other appropriate support from Member States, vaccine manufacturers, development banks, charitable organizations, private donors and others, in order to implement mechanisms that increase the equitable sharing of benefits as described in paragraph 2, subparagraphs (1), (2) and (3);
 - (5) to convene an interdisciplinary working group to revise the terms of reference of WHO collaborating centres, H5 Reference Laboratories, and national influenza centres, devise oversight mechanisms, formulate draft standard terms and conditions for sharing viruses between originating countries and WHO collaborating centres, between the latter and third parties, and to review all relevant documents for sharing influenza viruses and sequencing data, based on mutual trust, transparency, and such overriding principles:
 - (a) timely sharing of viruses within the Global Influenza Surveillance Network;
 - (b) application of the same standard terms and conditions to all transactions, as appropriate;
 - (c) timely consultation and sharing of information with originating countries, especially on use outside the Network;
 - (d) for any use of influenza viruses outside the scope of the terms of reference of WHO collaborating centres, H5 Reference Laboratories, and national influenza centres, submission of a request directly to the relevant national influenza centre or other originating laboratory of the country where the virus was collected and require appropriate response from the centre; such requests would be bilateral activities not requiring the intervention of WHO;
 - (e) recognition and respect of the crucial and fundamental role and contribution of countries in providing viruses for the Global Influenza Surveillance Network;
 - (f) increased involvement, participation and recognition of contribution of scientists from originating country in research related to viruses and specimens;
 - (g) attribution of the work and increased co-authorship of scientists from originating countries in scientific publications;
 - (h) due consideration of relevant national and international laws;
 - (6) to assure a membership of the interdisciplinary working group consisting of four Member States from each of the six WHO regions, taking into account balanced representation between developed and developing countries and including both experts and policy-makers;
 - (7) to convene an intergovernmental meeting to consider the reports by the Director-General on paragraph 2, subparagraphs (1), (2), (3) and (8), and by the interdisciplinary working group on paragraph 2, subparagraph (5), that shall be open to all Member States and regional economic integration organizations;

- (8) to commission an expert report on the patent issues related to influenza viruses and its genes, and report to the intergovernmental meeting;
- (9) to continue to work with Member States on the potential for the conversion of existing biological facilities, such as those for the production of veterinary vaccines, so as to meet the standards for development and production of human vaccines, thereby increasing the availability of pandemic vaccines, and to enable them to receive vaccine seed strains;
- (10) to report on progress on implementation of this resolution, including the work of the intergovernmental meeting, to the Sixty-first World Health Assembly, through Executive Board.

The financial and administrative implications for the Secretariat were as follows:

1. Resolution Avian and pandemic influenza: vaccine production capacity, vaccine stockpile and best practices for sharing influenza viruses and sequence data	
2. Linkage to programme budget	
Area of work:	Expected result
Epidemic alert and response	Support provided to Member States for strengthening national communicable disease surveillance and response systems, including the capability for early detection, investigation of, and response to, epidemics, pandemics and emerging infectious disease threats.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution is consistent with the expected results for the area of work, strategic objective 1 of the Medium-term strategic plan 2008–2013, namely: to reduce the health, social and economic burden of communicable diseases. The resolution supports immediate action to supplement medium- and longer-term objectives of WHO's global pandemic influenza action plan to increase vaccine supply.	
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\$ 6 343 820. This covers management of the process, not the actual stockpile costs.	
(b) Estimated cost for the biennium 2006-2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 2 200 000	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? US\$ 300 000	
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) All levels of the Organization, with specific emphasis at regional and country offices in the South-East Asia and Western Pacific regions, and with international coordination at headquarters.	

- (b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)** The equivalent of four full-time staff in the professional category would be required for the period 2007–2009. These staff will ensure the implementation of the second phase of technology transfer, and the organization and management of the processes undertaken through meetings of an interdisciplinary working group and an intergovernmental working group, which will result in updated mechanisms for the functioning of the WHO Global Influenza Surveillance Network, with regard to the sharing of influenza viruses and the development of a stockpile of H5N1 vaccines
- (c) Time frames (indicate broad time frames for implementation and evaluation)** Projects already under way in this biennium for laboratory strengthening, research coordination and facilitation of specimen shipment will be continued and accelerated through the biennium 2008–2009. The establishment of an interdisciplinary working group and an intergovernmental working group and the creation of a mechanism for stockpiling vaccines and sharing influenza viruses will take place over the next two years. Longer-term implementation will be linked to WHO's global pandemic influenza action plan to increase vaccine supply.

The CHAIRMAN recorded some editorial changes to the text. In paragraph 1(1), the phrase “sharing of viruses and specimens” should be replaced by “sharing of viruses or specimens”. In paragraphs 2(1)(c) and (d), the phrase “developed by WHO” should be replaced by “developed by WHO Collaborating Centres”. In paragraph 2(1)(f), the phrase “other viruses” should be replaced by “other influenza viruses”. Paragraph 2(5)(d), “... the National Influenza Centre” should be amended to “the national influenza centre”.

The draft resolution, as amended, was approved.¹

Dr FAKEYE (Nigeria) noted that millions of dollars had been pledged for the fight against influenza at the International Pledging Conference on Avian and Human Influenza (Beijing, 17–18 January 2006), but those resources had not been equitably distributed among the regions. In order to prevent similar occurrences, paragraph 2 of the resolution should be amended to read: “... equitable sharing of benefits, including funds, in support of ...”.

Mr HOHMAN (United States of America), speaking on a point of order, said that since the draft resolution had been approved, it could not be further amended.

Ms MAZUR (Office of the Legal Counsel) confirmed that any decision to reopen consideration of the draft resolution would require a two-thirds majority.

The DIRECTOR-GENERAL said that she had taken due note of the concerns expressed by the delegate of Nigeria. The Beijing conference had not been organized by WHO, which played no part in deciding how the pledged resources would be used.

She expressed her gratitude to all the delegations that had taken part in the work of the drafting group, especially its chairman. The approved draft resolution gave a clear and reassuring message to the world. Despite the real threat of an influenza pandemic and the complexities of protecting people, WHO had proved its unwavering commitment to the fight against influenza.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA60.28.

Dr LUKITO (Indonesia), speaking on behalf of the sponsors of one of the original draft resolutions, welcomed the spirit of compromise displayed during the negotiations, and commended the work of the Chairman of the drafting group and the President of the Sixtieth World Health Assembly.

The meeting rose at 18:00.

FOURTEENTH MEETING

Wednesday, 23 May 2007, at 09:35

Chairman: Dr R.R. JEAN LOUIS (Madagascar)

1. FIFTH REPORT OF COMMITTEE A (Document A60/61)

Mrs BU FIGUEROA (Honduras), Rapporteur, read out the draft fifth report of Committee A.

The report was adopted.¹

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Evidence-based strategies and interventions to reduce alcohol-related harm: Item 12.7 of the Agenda (Documents A60/14 and A60/14 Add.1) (continued from the eighth meeting)

The CHAIRMAN drew attention to a revised draft resolution on strategies to reduce the harmful use of alcohol, proposed by an informal working group, together with its financial and administrative implications, which read:

The Sixtieth World Health Assembly,

Having considered the report on evidence-based strategies and interventions to reduce alcohol-related harm, including the addendum on a global assessment of public-health problems caused by harmful use of alcohol;²

Reaffirming **Recalling** resolutions **WHA32.40 and WHA36.12, reaffirming resolution WHA58.26** on **Public-health problems caused by harmful use of alcohol**, and recalling its request to the Director-General to draw up recommendations for effective policies and interventions to reduce alcohol-related harm, and to develop technical tools that would support Member States in implementing and evaluating recommended strategies and programmes;

Stressing that the strategies and programmes developed pursuant to resolution WHA58.26 should be implemented in accordance with different national health-related needs, priorities and levels of development, and in a balanced, gender-responsive and appropriate way according to national circumstances, such as existing institutional, socioeconomic, religious, cultural and traditional contexts;

1. URGES Member States to continue developing and implementing effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol,

¹ See page 311.

² Documents A60/14 and A60/14 Add.1.

2. REQUESTS the Director-General:
- (1) to strengthen and intensify, ~~the work of the Secretariat,~~ **in consultation with Member States, work on developing and formulating, recommending and, where appropriate, implementing, in accordance with resolution WHA58.26, evidenced-based strategies and interventions on reducing the global burden of public-health problems caused by harmful use of alcohol, [according to] [which can be adapted to] the different national health-related needs and priorities and the diverse cultural and social circumstances and levels of economic and social development, in order to provide guidance for development and implementation of policies on alcohol; and to develop uniform concepts, indicators and methods for measuring the health and social consequences of the harmful use of alcohol;** (1bis) to provide technical support to Member States, on request, for reducing public-health problems caused by harmful use of alcohol, taking into account the full range of its health, social and economic consequences;
- (2bis) to continue to collaborate with all stakeholders in accordance with resolution WHA58.26;
- (2ter) to [submit a] report through the Executive Board to the Sixty-[first] [second] World Health Assembly on progress made in implementation of this resolution [and strategic directions, [Sweden] meeting human, financial and technical assistance needs of Member States, and international cooperation for these purposes, and on shortcomings and strengths of primary health-care systems to address these issues]. [Cuba]

1. Resolution Strategies to reduce the harmful use of alcohol	
2. Linkage to programme budget	
Biennium 2006–2007	Expected results
Area of work	
Mental health and substance abuse	5. Guidance and support provided to countries for development of evidence-based strategies, programmes and interventions for prevention and management of disorders related to substance use and reducing the adverse health and social consequences of use of alcohol and other psychoactive substances.
Biennium 2008–2009	4. Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed, and technical support provided to Member States with a high or increasing burden of disease or death associated with alcohol, drugs and other psychoactive substance use, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution will strengthen and intensify the Secretariat's work, in consultation with Member States, on developing, recommending and - where appropriate - implementing evidence-based strategies and interventions on reducing the global burden of public-health problems caused by the harmful use of alcohol; on providing technical support, when requested, to Member States; and on developing uniform concepts, indicators and methods for measuring the health and social consequences of the harmful use of alcohol.	
3. Financial implications The financial implications will depend on the decision taken by the Health Assembly with regard to operational paragraph 2.1 of the draft resolution. Option (i) refers to “[according to]” and implies a broader range of strategies and interventions to be developed according to country needs mentioned in para 2.1; it also involves a more extensive consultation process. Option (ii) refers to “[which can be adapted to]” and implies a more general set of strategies and interventions that can be adapted to the different country needs.	

(a) Total estimated cost for implementation over the “life-cycle” of the resolution (estimated to the nearest US\$ 10 000, including staff and activities)

Option (i): US\$ 22 460 000

Option (ii): US\$ 19 780 000

(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities)

Option (i) US\$ 3 290 000 (US\$ 13 170 000, estimated cost for the biennium 2008–2009)

Option (ii) US\$ 2 756 000 (US\$ 11 024 000, estimated cost for the biennium 2008–2009)

(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? Nil for the biennium 2006–2007 for options (i) and (ii); US\$ 10 400 000 for the biennium 2008–2009 for options (i) and (ii)

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 mainly take place at the global level, but consultations with Member States will be organized as follows: for option (i), according to the criteria implied by “[according to]” in paragraph 2.1; for option (ii), in the six regions.

(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile)

Option (i): Beginning in 2007 and continuing during the biennium 2008–2009, four additional staff in the professional category, and two additional staff in the general service category will be required at headquarters. No additional staff will be required at regional level.

Option (ii): Beginning in 2007 and continuing during the biennium 2008–2009, two additional staff in the professional category, and one additional general staff member will be required at headquarters. No additional staff will be required at regional level.

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

The activities have to be initiated in 2007 so that the main tasks can be accomplished before the Sixty-second World Health Assembly. The work will be concentrated on: developing strategies and interventions in the context of intensive consultation with Member States, and with the appropriate engagement of all stakeholders; and on developing uniform concepts, indicators and methods for measuring the health and social consequences of harmful use of alcohol.

Option (i) envisages a more extensive consultation process with Member States.

Dr BLOOMFIELD (New Zealand), speaking in his capacity as chairman of the informal working group, emphasized that, although there had been substantial support for the work to reduce alcohol-related harm, the many views on how best to deal with the issue were reflected in the fact that there had been five versions of the draft resolution. The working group had failed to reach consensus, but the draft resolution before the Committee represented the progress made.

The following corrections should be made to the draft text: in the third preambular paragraph “the” should be replaced with “these” between “that” and “strategies”; in paragraph 2(1), “the work of the Secretariat” and “developing” should be reinstated, “formulating” deleted, and “provide guidance” replaced with “serve as a guide”; in paragraph 2(1bis), “on request” should be changed to “when requested”; in paragraph 2(2bis) “collaborate” should be replaced by “engage”, and “in their ongoing work” added after and “WHA58.26”; and in paragraph 2(2ter) a left square bracket should be inserted before “meeting”.

The CHAIRMAN proposed that the draft resolution and its financial implications should be referred to the Executive Board for consideration.

Mr LEÓN GONZÁLEZ (Cuba) drew attention to two elements agreed in the drafting group that appeared to have been overlooked. In the third preambular paragraph, the phrase “developed pursuant to resolution WHA58.26” should not have been included. In paragraph 2(2ter), the word “on” should have been inserted before “strategic” and the word “meeting” after “[Sweden]” should have been deleted.

Dr VIOLAKI-PARASKEVA (Greece) said that there had been much discussion about the violence that resulted from the harmful use of alcohol, yet paragraph 1 referred simply to the “negative health and social consequences”. It was important that there should be specific reference to violence in that paragraph.

Mr GAUDÊNCIO (Brazil) noted that the harmful use of alcohol accounted for around 3.2% of global mortality and 4% of disability-adjusted life-years lost. In Latin America, the figures were four times the global average. Alcohol consumption was implicated in a large proportion of road traffic crashes, violence in general and domestic violence in particular, and the public cost was rising steadily. Given that situation, it was high time for WHO to move forward by providing countries with general guidelines for tackling the consequences of harmful use of alcohol. Consultations with all interested parties must continue, the advertising of alcoholic beverages must be regulated and public campaigns must provide information, raise awareness and mobilize public opinion. The revised text was intended to spur WHO into action, but if no consensus could be reached, it would be better to go back to the draft resolution proposed by New Zealand and Sweden and try to move forward on that basis.

Mr PETTERSSON (Sweden) said that his delegation had proposed the draft resolution out of concern about the need to make progress. With some other delegations, it had also sponsored a second draft resolution. Unfortunately, by the time the drafting group had completed its work the previous day, numerous new amendments had been proposed and the revised version no longer reflected the intentions of the original, and his delegation could not support it. If the issue was to be referred to the Executive Board, he proposed forwarding the draft resolution as originally submitted by New Zealand and Sweden after consultation in an informal working group, as it provided a better basis for discussion. He requested the Director-General to continue to work on implementing resolution WHA58.26 and to present evidence-based strategies and interventions for reducing the harmful use of alcohol. He deeply regretted that one Member State had been unable to cooperate constructively on the issue, which was of fundamental importance to people’s health.

Dr HIGUCHI (Japan) said that the harmful use of alcohol was having serious consequences for health worldwide. It was therefore regrettable that agreement had not been reached on the text of the draft resolution. He requested the Director-General to prioritize and scale up work on resolution WHA58.26.

Mr LEÓN GONZÁLEZ (Cuba) supported the statement made by the chairman of the working group and endorsed the proposal to refer the latest version of the draft resolution, together with all earlier versions, to the Executive Board.

Decision: The Sixtieth World Health Assembly decided to request that an item entitled “Strategies to reduce the harmful use of alcohol” and related documents discussed at the Health Assembly be included in the agenda of the 122nd session of the Executive Board, to be held in January 2008, and asked the Director-General, in the interim, to continue her work on that question.

The decision was adopted.¹

¹ Decision WHA60(10).

3. CLOSURE

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

The meeting rose at 10:15.