

COMMITTEE B

FIRST MEETING

Wednesday, 16 May 2007, scheduled at 16:35

Chairman: Mr T. ZELTNER (Switzerland)

1. OPENING OF THE COMMITTEE: Item 13 of the Agenda (Document A60/52)

The CHAIRMAN welcomed participants and reminded the Committee that representatives of the Executive Board, namely Dr Sadasivan and Dr Suwit Wibulpolprasert, would express the Board's views and explain the rationale behind recommendations made by the Board for the Health Assembly's consideration.

He drew the Committee's attention to document A60/52,¹ in which Mr Francis (Trinidad and Tobago) and Dr Yoosuf (Maldives) were nominated for the offices of Vice-Chairmen of Committee B, and Mr bin M. Al-Fakheri (Saudi Arabia) was nominated for the office of Rapporteur.

Decision: Committee B elected Mr D. Francis (Trinidad and Tobago) and Dr A.A. Yoosuf (Maldives) as Vice-Chairmen, and Mr H. bin M. Al-Fakheri (Saudi Arabia) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit their statements to a maximum of three minutes. Document EB119/2006–EB120/2007/REC/1, to which frequent reference would be made, contained the resolutions and decisions adopted by the Executive Board at its previous two sessions.

He reminded the Committee that at its meeting on 14 May 2005 the General Committee had agreed that items would be taken in the order in which they appeared in the agenda, with the exception of item 15.7 (Appointment of the External Auditor), which would be considered on 17 May. Items 12.16 to 12.21, which had been transferred from Committee A, would be considered after the items initially assigned to the Committee.

Mrs SIEFKER-EBERLE (Germany), speaking on behalf of the European Union, formally requested the Committee to invite the European Commission to participate without vote, in accordance with Rule 48 of the Rules of Procedure of the World Health Assembly, in the deliberations on items 12.16 to 12.21, which had been transferred from Committee A. The reason was that the European Community shared competence with European Union Member States in the areas covered by those items.

¹ See page 309.

² Decision WHA60(4).

The CHAIRMAN took it that the suggested working arrangements were acceptable to the Committee.

It was so agreed.

3. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:
Item 14 of the Agenda (Documents A60/29, A60/29 Add.1, A60/INF.DOC./4, A60/INF.DOC./5 and A60/INF.DOC./7)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegations of Algeria, Bahrain, Cuba, Egypt, Indonesia, Iraq, Jordan, Kuwait, Libyan Arab Jamahiriya, Madagascar, Malaysia, Morocco, Oman, Pakistan, Palestine, Qatar, Saudi Arabia, Senegal, Sudan, Syrian Arab Republic, Tunisia and United Arab Emirates, which read:

The Sixtieth World Health Assembly,

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

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

Expressing appreciation for the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;¹

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

Expressing its concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory due to Israel's withholding of Palestinian customs revenues;

Affirming the need for guaranteeing universal coverage of health services and for preserving the functions of the public health services in the occupied Palestinian territory;

Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

Deploring the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which led to casualties among Palestinian medical personnel, as well as the restrictions on movement imposed on them by Israel, the occupying power, in violation of international humanitarian law;

Expressing deep concern at the grave implication of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

Expressing deep concern also at the serious implications on pregnant women and patients of Israeli restriction of movement imposed on Palestinian ambulances and medical personnel;

1. DEMANDS that Israel, the occupying power:

(1) lift the closure in the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of drugs

¹ Document A60/29.

- and medical supplies therein and comply in this regard with the provisions of the Israeli-Palestinian Agreement on Movement and Access of November 2005;
- (2) comply with the advisory opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
 - (3) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem;
 - (4) pay the Palestinian Authority regularly and without delay its customs and health insurance revenues in order to enable it to fulfil its responsibilities with respect to basic human needs, including health services;
 - (5) ensure unhindered and safe passage for Palestinian ambulances as well as respect and protection of medical personnel, in compliance with international humanitarian law;
 - (6) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients;
 - (7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (8) shoulder its responsibility towards the humanitarian needs of the Palestinian people and their daily access to humanitarian aid, including food and medicine, in compliance with international humanitarian law;
 - (9) halt immediately all its practices, policies and plans, including its policy of closure, that seriously affect the health conditions of civilians under occupation;
2. URGES Member States and intergovernmental and nongovernmental organizations:
- (1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
 - (2) to provide financial and technical support to public health and veterinary services in order to implement the Palestinian national plan for fighting the potential spread of avian influenza in the occupied Palestinian territory;
 - (3) to help lift the financial sanctions imposed on the Palestinian people in the occupied Palestinian territory;
 - (4) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
 - (5) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949;
3. EXPRESSES its deep appreciation to the Director-General for:
- (1) the efforts to provide necessary assistance to the Palestinian people in the occupied Palestinian territory, including east Jerusalem, and to the Syrian population in the occupied Syrian Golan;
 - (2) organizing a one-day emergency meeting on the health crisis in the occupied Palestinian territory and for the assistance provided as a result thereof;
4. REQUESTS the Director-General:
- (1) to provide support to the Palestinian health and veterinary services in establishing a modern public health laboratory capable to diagnose avian influenza in humans and animals;
 - (2) to submit a fact-finding report on the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;
 - (3) to provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;
 - (4) to continue providing necessary technical assistance to meet the health needs of the Palestinian people, including the handicapped and injured;

- (5) to support the development of the health system in Palestine, including development of human resources;
- (6) to assist in determining the so far inexplicable causes of fatal injuries and suffering afflicting Palestinian victims of Israeli attacks;
- (7) to report on implementation of this resolution to the Sixty-first World Health Assembly.

Mr SHOUKRY (Egypt), introducing the draft resolution, said that it reflected the situation of the Palestinian people after long years of Israeli occupation in flagrant violation of basic human rights. The Israeli occupation had imposed sanctions and a separation wall, denying humanitarian and medical assistance and thus causing a severe humanitarian crisis. The international community could not turn a blind eye to the situation. The draft resolution sought to focus world attention on the plight of the Palestinian people and the need for appropriate measures to prevent further deterioration of the situation. Its sponsors called on Israel to lift the sanctions and halt the construction of the separation wall, which was harmful to the Palestinian people and contrary to a 2004 decision of the International Court of Justice. The text also urged the international community to take all possible steps to help the Palestinian people to improve their health conditions. WHO, as the leading specialized agency dealing with health throughout the world, should ensure that the Palestinian people received technical assistance, and should do more to improve the health situation and health infrastructure in Palestine.

The fact that such a draft resolution was repeatedly presented to the Health Assembly was largely a consequence of Israeli practices day after day. Israel, as an occupying power, should meet its international obligations and responsibilities. The draft resolution sought to uphold the right of the Palestinian people to decent health conditions, to force Israel to accept its responsibilities and to ensure that a people under occupation was not denied its basic rights. As the issues covered were of a purely medical nature, the Health Assembly should assume its responsibilities without hesitation.

He proposed amending paragraph 2(3) to read: "to help lift the restrictions and obstacles imposed on the Palestinian people in the occupied Palestinian territories". The amendment reflected the sponsors' desire to show flexibility with a view to meeting the concerns of all Member States.

Dr AL-HOUSAMI (Syrian Arab Republic) described the Israeli occupation of Palestinian and Syrian territory as a dangerous epidemic that had had a serious impact on the lives of the people living there. He did not wish to politicize the debate. The current discussions were aimed not at liberating the territory but at preventing the population from suffering as a result of the conditions prevailing under the occupation. It was wrong to distinguish between good occupation and bad occupation. The practices of the Israeli occupation force were extremely detrimental to all Palestinians in the Gaza Strip, which had become one big prison, and were denying the Arab population in the occupied Syrian Golan their basic human rights to health care, housing and living on their own land. Attempts were even being made to compel Arabs in the occupied Golan to assume Israeli nationality, and the health authorities were struggling to provide basic services, which had become prohibitively expensive to anyone not carrying Israeli identity papers. Arab villages were suffering from a lack of clinics and ambulances, and specialist treatment, especially in the fields of radiology and maternal and child health care, was practically non-existent. Doctors and medical staff were being denied permits to work in the occupied Golan, and young people were prevented from enrolling in medical schools unless they applied for Israeli nationality. In the meantime, every attempt on the part of the Syrian Arab Republic to alleviate the plight of the local population by setting up health centres and a specialized hospital, with the support of humanitarian organizations and the specialized agencies of the United Nations, had been obstructed. Treatment was being denied to Syrian detainees suffering from various ailments caused by physical and mental torture in Israeli prisons, with some even having died as a result. The disposal of radioactive uranium and other toxic waste, some of which had a lifespan of 30 to 50 years, would create a public health emergency once the containers began to disintegrate.

He requested the sending of a fact-finding mission to the region and the preparation of a report for submission to the next Health Assembly. The previous mission assigned to implement resolution

WHA59.3 had been unable to visit the occupied Golan because the Israeli authorities had refused to allow it to enter the area.

He supported the draft resolution as presented by the delegate of Egypt.

Mr LEVANON (Israel) declined to reply to the comments of the previous speaker whose description of the situation in the occupied Syrian Golan had been wholly inaccurate. He acknowledged the existence of health concerns in the Palestinian territories and that the local population was entitled to the best health care available. But instead of devoting a separate agenda item to those matters at every single session, the Health Assembly could discuss them under any of the broader items relating to universal health concerns, including the other 45 crisis situations identified by WHO. Furthermore, the provision and quality of medical care for Palestinians had been the responsibility of the Palestinian authorities since 1995. A first step towards improving the situation and restoring good relations would be Palestinian acceptance of the three benchmarks established by the Middle East Quartet, namely a commitment to renounce violence, recognition of Israel and acceptance of previous agreements and obligations, including the Road Map. The chances of political progress had been hampered by the fact that all ties with Israel had been severed, and the Hamas-led government of national unity, with whom even the international community was reluctant to engage, had not improved the situation.

Nevertheless, Israel had continued to assist the Palestinian people. Over the previous year, increasing numbers of patients, an average of 200 a day, had been treated in Israeli hospitals, even though the Palestinian Authority had halted payments for the services. Increasing numbers of ambulances were being admitted into the country without delays in emergencies, on humanitarian grounds, despite well-documented cases of Palestinian factions using them to transport terrorists and explosives. On average, 47 truckloads of medical supplies were entering the Gaza Strip each day. Selected Palestinian health professionals had enrolled in training programmes at Israeli hospitals; WHO representatives and experts had supported and overseen projects to encourage joint Israeli-Palestinian efforts to tackle the previous year's influenza pandemic: Palestinian and Israeli health experts had met in Jerusalem on 20 April 2007 to discuss a joint response to any future outbreak of avian influenza in the region.

The draft resolution was groundless, biased and highly political in its intentions. It would encourage the extremist Palestinian factions responsible for not only the daily rocket attacks on Israel – praised by the leaders of Hamas – that just the previous day had wounded more than 20 people in the southern city of Sderot, but also the intra-Palestinian violence in the territories, which, according to a Palestinian human rights group, had claimed over 147 lives, including 10 children, in the first three months of 2007. The health of the Palestinian people might have been markedly different had the resolution's sponsors refrained from spreading unfounded allegations and diverting the world's attention away from genuine emergencies, and instead sought to work with Israel in a spirit of cooperation in order to overcome the difficulties and to provide a better health system.

Mr TICHENOR (United States of America) strongly regretted that the draft resolution was interjecting political considerations into the deliberations of the global health body. It would neither further the search for peace in the Middle East nor improve the health of those living in the West Bank and the Gaza Strip. The United States cared deeply about the health of the Palestinian people and in order to help to meet their humanitarian needs it had invested US\$ 24.2 million in maternal and child health and nutrition activities and contributed US\$ 30 million to an emergency medical assistance project providing pharmaceuticals, medical supplies and equipment to the Palestinian health sector, US\$ 27.4 million to WFP's food assistance activities in the West Bank and the Gaza Strip, and US\$ 12 million to support emergency intervention in small-scale water and sanitary projects. It had given US\$ 50 million to the 2006 UNRWA emergency appeal, which had helped Palestinian refugees in the West Bank and the Gaza Strip whose livelihoods and health needs had been badly affected by the Hamas-led Palestinian Authority Government's policy choices, and enabled UNRWA to support five fixed health stations and five mobile units providing health services to West Bank Palestinians who could no longer travel to their former health clinics. His country would continue to seek ways to

meet the basic needs of the Palestinian people and would encourage others to join it in that effort. Nevertheless, the members of the Middle East Quartet continued to maintain that any Palestinian government must renounce violence, recognize Israel and respect previous agreements and obligations between the parties.

Much of the draft resolution was biased and political. It ignored the obligation of the Palestinian Authority to govern responsibly, to end terror and to commit itself to the path of a peaceful resolution in search of a two-state solution called for in the Road Map, with a Palestinian State and Israel living side by side in peace and security thus allowing the Palestinian people's rightful health needs and other aspirations to be realized. He opposed the draft resolution and requested a roll-call vote.

Dr BURAYZAT (Jordan) said that the difficulties and complexities of the health situation in the occupied Palestinian territory and the occupied Syrian Golan were evident from international reports submitted to the Health Assembly and because people from Jordan could see the situation with their own eyes. Jordan was supporting two hospitals in Palestine, to which it sent medicines on a regular basis. Over the past two years, programmes run by the Ministry of Health had been jeopardized, primary health care services had ceased to operate, accident and emergency departments in hospitals had been closed down, and the distribution of medicines for treatment of chronic illnesses had become almost impossible. International aid did sometimes reach those who needed it, but it was insufficient, not covering even 10% of the health and medical needs of the Palestinian people in the occupied territory.

The delegate of Israel had referred to the political aspects of the situation, but sick people should not have to pay the price of a difficult political situation. Inevitably there were political issues, such as the recognition of Israel and adherence to international agreements, but they were not appropriate topics for debate within an international health forum. The core issue in the current debate was the fundamental right of the Palestinian people to appropriate health care, and the task of the Committee was to find a solution to the existing problems on the ground.

Arab countries had been seeking to hold out an olive branch to Israel, but to no avail. If Israel wanted to improve the political situation, it should respond to those various initiatives. Assistance would be needed from Israel if the humanitarian situation was to be resolved. Jordan was doing all that it could to help, but the situation demanded more aid, from neighbouring countries and the rest of the world. He thanked all the international organizations and bodies, including UNWRA and WHO, that had provided assistance and support to the Palestinian people. Several Arab countries provided medical equipment to hospitals and clinics, but the Palestinians needed to be able to move around freely in order to benefit from such aid.

He supported the draft resolution.

Dr AMMAR (Lebanon) said that, beyond the dire economic situation, the occupation was putting barriers in the way of movement of the Palestinian people, making access to medical care difficult. The building of the wall, the sealing-off of territories, the establishment of crossing points which were sometimes closed, the levying of customs dues and difficulties relating to medical insurance were all examples of such barriers.

He urged WHO to apply extraordinary measures to avert a humanitarian and health-related disaster in the occupied Palestinian territory, east Jerusalem and the Syrian Golan. He supported the draft resolution, as amended by the delegate of Egypt; it was the minimum that could be undertaken to halt the deterioration of the health situation.

It was regrettable that the delegate of Israel should have used the current forum to say that passage of the resolution would not result in a change in Israeli policy or any positive outcome, thereby demonstrating Israel's lack of respect for decisions and resolutions adopted by the Health Assembly and the United Nations General Assembly.

Mr MOKHTARI (Islamic Republic of Iran) observed that the Committee was once again hearing facts about the grave health situation of the Palestinian people under occupation, and the hardships and difficulties that they had to face in their daily life. The impact of the brutal occupation

on the physical, mental and social health of the Palestinians was beyond imagination. Fortunately WHO still offered a beacon of hope, by maintaining its presence in Palestine and by continuing its engagement with the Palestinian authorities. At the same time, it was regrettable that all WHO's efforts, which under normal circumstances should have helped to build Palestinian medical infrastructures for the next generation, instead had to be largely expended on undoing harm and wrongs perpetrated by the forces of occupation. He was especially concerned about the health of the Palestinians after the brutal war waged by Israel in 2006, particularly those inside the occupied territories and those living in Lebanon, and about the consequences for the health of ordinary people in Palestine of the Israeli policy of collective punishment.

He strongly supported the draft resolution and urged all Member States to strive for the well-being of the Palestinians and Syrians under occupation, and to ensure that occupation, oppression and injustice did not cast a shadow over the noble goal of health for human beings.

Dr AL-AKHRAS (Palestine) said that the number of barriers and checkpoints had increased in the occupied Palestinian territory – to 547 in 2006, 40% more than in 2005. The Israeli forces also hampered the work of medical institutions and teams, and restricted ambulances' access to health centres and hospitals, leading to the death of a great many sick people. Up to 7 April 2007, there had been 142 deaths at the military posts. In addition, women had given birth at the barriers, with Israeli soldiers often completely ignoring their appeals for help.

Palestinians receiving medical treatment in Israel were forced to pay. A request for transfer to a Palestinian hospital in east Jerusalem could be processed only in an Israeli hospital, and that process too was subject to a fee. In addition, Israeli hospitals placed restrictions on medical insurance. Israel was also hampering the entry of medicines and medical equipment from abroad. Much of the equipment, when finally received, was no longer usable. The Palestinian Authority had tried to send personnel to receive medical training in Israel, but many obstacles had been placed in their way. Israeli forces paid no attention to environmental problems if they affected only the Palestinians, taking remedial action only if there was an ecological threat to Israel. The Israeli authorities represented a threat to the state of health of the Palestinian people, and Israel should abide by all international agreements and apply them to everyone equally.

Mr M.N. KHAN (Pakistan) said that the report on the situation in the occupied Palestinian territory and the occupied Syrian Golan made sad and shameful reading. What was happening in Palestine was ethically, religiously, morally, politically and medically wrong. It was time for the human race to pull together and go forward. Unlike the Dark Ages, nowadays everyone could become instantly aware of the wrongs being done, of Palestinian boys being brutally kicked and humiliated, of young Palestinian girls being humiliatingly searched at Israeli checkpoints. The humiliation and the insanity had to be stopped. The killings of civilians should be condemned. If the Israelis and the Palestinians could change places, then Israel would rapidly understand the suffering that it was inflicting.

The fact-finding mission called for in the draft resolution was important, and the major countries of the world should participate. The United States of America should play a historical role. Who understood freedom better than the people of that nation? Indeed, who better than the Israelis understood oppression? With their history, they should be the most compassionate people in the world.

He supported the draft resolution purely for humanitarian reasons, not political ones.

The meeting rose at 17:40.

SECOND MEETING

Thursday, 17 May 2007, at 09:15

Chairman: Mr T. ZELTNER (Switzerland)
later: Mr D. FRANCIS (Trinidad and Tobago)

1. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:
Item 14 of the Agenda (Documents A60/29, A60/29 Add.1, A60/INF.DOC./4, A60/INF.DOC./5 and A60/INF.DOC./7) (continued)

Mr LY (Senegal) said that, despite WHO's action in the occupied Palestinian territory,¹ the Palestinian Authority's health ministry was finding it difficult, as a result of suspension of the principal donors' contributions, to ensure health service delivery, implement health action programmes and even to pay staff salaries. Imperfect compromises were no solution to the problem and failed to meet WHO's constitutional goal of "enjoyment of the highest attainable standard of health".

Senegal continued to uphold the right of the peoples of the occupied territories to complete physical, mental and social well-being. The political situation could not serve as an alibi for ongoing tragedies with intolerable humanitarian and health consequences. He supported the draft resolution.

Dr BIN RAHMAT (Malaysia) welcomed the continued consideration of the current agenda item. The health of all peoples was fundamental to peace and security, but, over the years, health conditions in the occupied Arab territories, especially occupied Palestine, had not improved. A crisis had been created by the occupying power's intransigent policies. WHO should convince the international community to react urgently to the problems highlighted in the Secretariat's reports; and the international community should revive the national health system in the occupied territories by providing funding.

As a sponsor of the draft resolution, he urged the Committee to support it.

Dr GONZÁLEZ (Cuba) said that the Secretariat's reports sadly confirmed the worsening situation in the occupied territories caused by Israel's aggressive actions. Restrictions on freedom of movement had damaged the economy and increased unemployment. Food insecurity was widespread, and chronic malnutrition was rising. Israel's aggressive acts in 2006 had brought the health system to the brink of collapse. The Health Assembly had repeatedly called on Israel to end its restrictive measures.

The cause of the Palestinian people had aroused worldwide solidarity and sympathy. Israel's illegal occupation, and its flagrant violations of human rights and international humanitarian law, had been condemned. The so-called Palestinian question had led to wars, prolonged occupation and fruitless attempts at a settlement. The Palestinian people remained subject to injustice and were denied self-determination. Cuba upheld their inalienable right to establish an independent, sovereign state; it called for the unconditional return of all Arab territories occupied by Israel, and it reiterated the illegal nature of all Israeli settlements established in the occupied Arab territories since 1967. For more than

¹ Documents A60/29 and A60/29 Add.1.

half a century, the United Nations General Assembly and the Health Assembly had been approving many reports and resolutions condemning the violations of the Palestinian people's rights, but Israel had accepted none of them. He called upon all Member States to support the draft resolution.

Mr FU Cong (China) said that the question of the occupied territories had been debated for half a century, but the peoples concerned continued to suffer. During the past year their isolation and economic hardship had worsened; food and fuel were in short supply, the infrastructure had deteriorated, and the medical and health services had been paralysed. Medical and other aid could not be delivered. China opposed such isolation and the consequent decline in health conditions; it called on the international community to take measures in order to alleviate the Palestinian people's suffering.

China advocated a definite solution to the problems of the occupied territories, without which there could be no peace in the Middle East. It called for a political settlement on the basis of United Nations resolutions, and remained ready to work to that end. For those reasons, he supported the draft resolution.

Mrs AL QASSIMI (United Arab Emirates) observed that the situation in the occupied territories was rapidly worsening, with many people living below the poverty line. Sanctions by the occupying power had adversely affected programmes in the health sector and many others; the impending humanitarian crisis must be dealt with rapidly. Security measures were creating great difficulties, for example, for the movement of ambulances and the treatment of injuries arising from conflicts.

She regretted that the fact-finding report did not deal with the situation in the occupied Syrian Golan. Nevertheless, it cited many examples of the gravity of the situation, which called for appropriate action by the international community.

Mr ELBEY (Algeria) supported the previous speakers' observations on the health conditions in the occupied territories and the need for action by the international community. Israeli practices were making it impossible to maintain minimum health standards. Likewise, sanctions and the blockade against an elected government were a serious obstacle to the provision of health services. He supported the Human Rights Council's proposal to send a fact-finding mission and called on the Health Assembly to do likewise, putting pressure on Israel to cease its oppression. The Health Assembly must take seriously its objective of health for all. He called on the whole international community to ensure that the situation in the occupied territories did not deteriorate further.

Mrs VIELMA (Bolivarian Republic of Venezuela) said that she had noted the Secretariat's reports and appreciated the Organization's efforts to help to alleviate the serious health situation of the Palestinian people. She firmly supported the draft resolution as an important step towards a solution. However, there should also be an accompanying call to the international community for an effort to make Israel lift the blockade on the occupied Palestinian territories and respect their citizens' right to health. The grave situation there had led to a shortage of medical, surgical and basic health services. She called on the Israeli Government to halt the building of the security wall and the restrictions on personal movement, which were a clear violation of the Palestinian people's human rights.

Mr RADEBE (South Africa) said that the Health Assembly had to give special attention to the humanitarian crisis in the occupied territories, especially the Gaza Strip. The Palestinian people needed WHO's help more than ever, and he was concerned at the lack of health-care services, the logistical and professional constraints on care providers, and the declining nutritional status of women and of children under five.

The reports were balanced, calling for reasonable action to ensure that the Palestinian people could exercise their basic human rights, including that of access to health care. South Africa was finalizing proposals in order to contribute to WHO's work through the consolidated appeals process being proposed by the United Nations. South Africa was committed to upholding the dignity of the Israeli and Palestinian peoples, to the right of both to live in peace and security, and to achieving a

solution. In the meantime, every effort should be made to meet the Palestinian people's health needs. For those reasons he supported the draft resolution.

Dr BUDIARDJA (Indonesia) expressed deep concern at the dire health situation which persisted in the occupied territories as a result of the occupying power's restrictions, closures and aggression. It would degenerate into a major disaster unless urgent remedial action was taken. Indonesia supported providing humanitarian assistance, and maintaining and improving the presence of WHO for the essential relief and basic medical care so desperately needed. He supported the draft resolution.

Dr AL-MUBARAK (Kuwait) said that it was high time to move away from political issues and concentrate on the humanitarian disaster in the occupied territories which was worsening rapidly, because of the occupying forces' actions and inhumane measures. She supported the draft resolution, and called for all to uphold the initiative of health for all. Urgent measures were needed to prevent any further deterioration of the situation, and she called on Israel to withdraw from the occupied territories, in accordance with international resolutions. Kuwait wanted the Director-General to visit the territories in order to see conditions for herself.

Mr LANDOULSI (Tunisia) said that the Israeli forces had seriously affected the provision of health services in the occupied territories. The situation was deteriorating rapidly and exacerbated by the international boycott. Israel's practice of targeting health services violated basic human rights and breached international law. He supported the draft resolution.

Dr AL-HOUSAMI (Syrian Arab Republic) refuted the claim by the delegate of Israel that the draft resolution was an attempt to politicize the work of the Health Assembly and that its adoption would not lead to an improvement of the health situation in the occupied territories but would hamper any humanitarian attempts on the part of the international community. The report on health conditions in the territories was based on sources including Israeli ones. For example, attempts to test medicines on Arab detainees in Israeli prisons had been reported by Israeli political figures and the disposal of toxic waste in the occupied territories had been reported in the Israeli press. Israeli landmines also remained a constant threat to the inhabitants of the Syrian Golan. He urged the Committee to support the draft resolution, contribute to improved health conditions and distance themselves from the criminal attempt to undermine the quality of life of those in the occupied territories. He called on the delegation of the United States of America to accept its responsibility as a neutral partner in the process, and for the world to show compassion for the situation of the Syrian people.

Ms FURMAN (Israel) said that, although her delegation was always prepared to enter into meaningful discussion, the groundless comments made by the delegate of the Syrian Arab Republic did not merit a response.

The CHAIRMAN recalled the proposal to proceed to a roll-call vote.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the modalities for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly and would therefore be unable to participate in the vote were: Antigua and Barbuda, Argentina, Central African Republic, Comoros, Democratic Republic of the Congo, Dominica, Fiji, Guinea-Bissau, Guyana, Kyrgyzstan, Niue, Saint Lucia, Somalia.

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

The result of the vote was as follows:

In favour: Afghanistan, Algeria, Andorra, Angola, Armenia, Austria, Azerbaijan, Bahrain, Bangladesh, Barbados, Belgium, Belize, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brunei Darussalam, Bulgaria, Burkina Faso, Cameroon, Chile, China, Congo, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Denmark, Djibouti, Ecuador, Egypt, Estonia, Finland, France, Germany, Ghana, Greece, Hungary, Iceland, India, Indonesia, Islamic Republic of Iran, Iraq, Ireland, Italy, Jamaica, Japan, Jordan, Kuwait, Latvia, Lebanon, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Monaco, Morocco, Mozambique, Namibia, Nepal, Netherlands, Nicaragua, Norway, Oman, Pakistan, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, San Marino, Saudi Arabia, Senegal, Serbia, Slovakia, Slovenia, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, The former Yugoslav Republic of Macedonia, Tunisia, Turkey, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, Bolivarian Republic of Venezuela, Viet Nam, Yemen, Zimbabwe.

Against: Australia, Canada, Israel, Palau, Papua New Guinea, Solomon Islands, United States of America.

Abstaining: Cambodia, Cook Islands, El Salvador, Guatemala, Kiribati, Liberia, Malawi, New Zealand, Singapore, Thailand, Tonga, Trinidad and Tobago.

Absent: Albania, Bahamas, Belarus, Benin, Brazil, Burundi, Cape Verde, Chad, Colombia, Côte d'Ivoire, Dominican Republic, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Gambia, Georgia, Grenada, Guinea, Haiti, Honduras, Kazakhstan, Kenya, Lao People's Democratic Republic, Madagascar, Marshall Islands, Mauritius, Federated States of Micronesia, Mongolia, Montenegro, Myanmar, Nauru, Niger, Nigeria, Panama, Paraguay, Peru, Rwanda, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Suriname, Swaziland, Tajikistan, Timor-Leste, Togo, Turkmenistan, Tuvalu, Uruguay, Uzbekistan, Vanuatu, Zambia.

The draft resolution, as amended, was therefore approved by 106 votes to 7, with 12 abstentions.¹

Mr ESTRELA DE CARVALHO (Brazil) explained that Latin American and Caribbean Group Member States and other Latin American countries had been unable to be present for the vote because of their participation in discussions on other draft documents.

Mr OLDHAM (Canada), speaking in explanation of vote, said that his country remained deeply concerned by the humanitarian situation in the West Bank, the Gaza Strip and the Syrian Golan and was therefore providing assistance to the Palestinian people through nongovernmental and multilateral organizations. The resolution represented a one-sided view of the health-care needs of the Palestinian people, by focusing exclusively on the actions of Israel. While his country recognized that Israel had an important role to play in facilitating the humanitarian well-being of the Palestinian people, the text approved remained the only resolution at the Health Assembly which explicitly singled out one conflict. His country had therefore decided to vote against the resolution.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as a resolution WHA60.2.

Ms SIEFKER-EBERLE (Germany), speaking on behalf of the Member States of the European Union and in explanation of vote, expressed deep concern about deteriorating health in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan. Primarily for that reason the European Union Members had voted in favour of the resolution. The resolution ought to have reflected a more balanced approach to the relevant issues and a more balanced reading of the situation; issues included the responsibilities of the Palestinian authorities, such as good governance, improving security in the area, ending intra-Palestinian violence and consolidating the ceasefire. The European Union remained ready to work with, and resume direct assistance to, a Palestinian government whose policy and actions reflected the Quartet principles, in accordance with the European Union Council Conclusions of 23 April 2007.

The European Union and its Member States remained the largest contributor of assistance to the Palestinian people, having pledged some €650 million in 2006, a figure that demonstrated the importance they attached to the needs of the Palestinian people, including health care, and their concern about the health impact of the conflict on all peoples in the region.

Dr SADASIVAN (Singapore), speaking in explanation of vote, recalled that his country had consistently supported all efforts to bring a just and lasting peace to the Middle East and had taken a principled stand on the right of the Palestinian people to a homeland and the two-State solution. The Health Assembly was not an appropriate forum for the discussion of political issues.

Mr MORARU (Republic of Moldova), speaking in explanation of vote, said that his delegation aligned itself with the position of the European Union.

2. FINANCIAL MATTERS: Item 15 of the Agenda

Unaudited interim financial report on the accounts of WHO for 2006 and comments thereon made by the Programme, Budget and Administration Committee of the Executive Board: Item 15.1 of the Agenda (Documents A60/30, A60/30 Add.1 and A60/41)

The CHAIRMAN invited the Committee to consider the draft resolution recommended in paragraph 6 of document A60/41.

The draft resolution was approved.¹

Interim report of the External Auditor: Item 15.2 of the Agenda (Documents A60/31 and A60/45)

Mr RAO (Representative of the External Auditor) presented the interim results of the external audit of WHO for the financial period 2006–2007 on behalf of the Comptroller and Auditor General of India, the External Auditor. The practice of submitting an interim report had been continued, and that report² contained the results of an audit carried out in the first year of the current financial period. The opinion on the financial statements of WHO for the financial period 2006–2007 would be presented to the Health Assembly in 2008.

A detailed audit plan had been drawn up, based on the experience gained from previous audits and risk analyses. The audits detailed in the report (Annex, paragraph 6) were conducted in accordance with the common auditing standards of the Panel of External Auditors of the United Nations, and covered key areas of WHO's activity. The results and related recommendations were contained in the interim report. In the remaining part of the financial period, the other regional offices

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.3.

² Document A60/31.

and some additional country offices would be audited, and management reviews on specific aspects of the functioning of the Organization and a detailed examination of the financial statements of the financial period 2006–2007 would also be undertaken.

In addition, certain trust funds had also been audited: at IARC, the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, the International Computing Centre and UNAIDS, and the findings had been communicated to the bodies concerned through Management Letters.

Interaction with the Secretariat had been constructive and marked by good cooperation and dialogue. There had been regular interaction with the Internal Auditor and, where necessary, the internal audit had been relied upon. The interim report and the recommendations contained therein had been accepted by the Director-General, and assurances had been given that the necessary action would be taken.

He supported WHO's plans to adopt the International Public Sector Accounting Standards. Implementation of the global management system would fully integrate programme management and the Organization's administration and financial system. Work on the framework of delegation of responsibility and authority and the environmental policy should be completed. There were shortcomings in the management of cash and bank accounts in some of the offices audited. Regular cash counts and separate cash checks had not been done in some cases. Bank reconciliation and adjustment of transactions remained outstanding for long periods, and there was a need to close long-dormant bank accounts. Contrary to existing rules, regular payments had also been made from petty cash. Travel claims should be submitted within 30 days of completion of travel. In many cases advances had remained outstanding for long periods of time; it would be necessary to implement an action plan to clear those cases. The Secretariat was aware of the issue and had initiated steps in that regard.

In the area of personnel, it was essential to complete stipulated formalities of employment contracts before commencement of a contract. To that end, closer coordination between country and regional offices was required. In a significant number of cases the appraisal of staff performance, sometimes dating back to 2004, had not been completed. In that regard, he supported the implementation of the performance management and development system software.

Cases of non-adherence to the provisions in WHO's Manual on procurement had been noted. Purchase orders had been split and competitive rates had not been obtained. The vendor database in the country offices should be broadened to enhance the transparency of the procurement process. He further noted instances of incomplete and inaccurately maintained inventory records. Regular physical verification of the inventory should be insisted upon.

The review of WHO's operations under the United Nations Development Group Iraq Trust Fund had assessed internal controls and tested transactions in key areas of financial and project management. In the area of finance it had been seen that, in addition to the stipulated programme support costs and direct and miscellaneous costs, the concerned cluster at WHO headquarters had been retaining additional funds; that needed to be reviewed. There had been obligations where disbursements had far exceeded the obligated amounts. Furthermore, all obligations had to be linked to Activity Management System codes. A significant number of high-value obligations without those codes had been seen. Despite ground-level difficulties in project implementation and procurement activities, several specific areas required attention and had been identified in the report.

The tracking mechanism for external and internal audit recommendations, developed by the Secretariat, had entered into force, strengthening the accountability framework. The implementation of significant recommendations would be noted in the final report on the current financial period. The External Auditor would continue to work towards bringing value to WHO and its stakeholders through the external audit process.

Mr MACPHEE (Canada) endorsed the interim report which clearly identified discrepancies or other problems and offered recommendations for consideration by Member States and the Director-General. He welcomed the inclusion of recommendations made by the Internal Auditor and encouraged development for the final report of a matrix that would summarize the major

recommendations and progress of action taken. He also welcomed the thorough discussion of the interim report at the Programme, Budget and Administration Committee's meeting the previous week,¹ and, in particular, the strong assurances provided by the Director-General at that meeting.

Dr SUWIT WIBULPOLPRASERT (representative of the Executive Board), acknowledging the interim report, drew attention to the long-standing problem of management of the travel claims backlog, which had worsened over the previous 10 years despite having repeatedly featured in the External Auditor's reports. Thousands of travel claims were still waiting to be settled. International foundations, nongovernmental organizations and private industries all reimbursed travel within one month. WHO was encouraging countries to improve their health system performance and increase value for money, but in the case of travel claims the backlog prevented economies. He expected changes under the new Director-General.

Ms BLACKWOOD (United States of America) said that the Programme, Budget and Administration Committee had fully discussed the reports of the External Auditor and Internal Auditor. The latter's report contained several worrying findings that affected WHO at all levels, including cash management and management of contracts. She appreciated the Director-General's commitment to follow up those findings and establish a tracking system. WHO, as an accountable and transparent organization, needed to show that action was being taken.

Mrs PRADHAN (Assistant Director-General) acknowledged the comments. The Secretariat took the External Auditor's recommendations very seriously. A tracking system was in place to ensure that those recommendations were met and that improvements were made. Constant efforts were being undertaken to improve accountability, transparency and effectiveness.

The DIRECTOR-GENERAL commended the open discussion at the previous week's meeting of the Programme, Budget and Administration Committee, which she had attended. She had subsequently met regional directors in order to share the comments made. She reassured Member States that she took audit functions very seriously; they were extremely important management tools and helped WHO to meet its commitments to accountability and transparency. She would continue to work to ensure a satisfactory report on the implementation of the auditors' recommendations.

The Committee noted the report.

Mr Francis took the chair.

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 15.3 of the Agenda (Documents A60/42 and A60/INF.DOC./6)

Mr JEFFREYS (Comptroller) said that, since the meeting of the Programme, Budget and Administration Committee the previous week, a total of US\$ 14.5 million in outstanding assessed contributions had been received. The Dominican Republic, Nauru and Niger had made sufficient payments to have their voting privileges restored. Palau had paid its outstanding assessments in full and therefore was no longer concerned by the draft resolution to be discussed. He asked the Chairman to amend the draft resolution contained in paragraph 9 of document A60/42 by removing the names of those four Member States.

¹ Document A60/45.

Mr MACPHEE (Canada) welcomed the report and supported the emphasis on timely payment of assessed contributions. Canada had always paid in full and on time, and he urged all Member States to honour their obligations in that regard. The sustained improvement in the annual collection rate was gratifying, but he remained concerned about the continuing high level of total outstanding contributions. Late payment or non-payment of assessed contributions denied the Organization the income required to meet the programme objectives of Member States. The Director-General was seeking a 4% increase in the assessed regular budget for 2008–2009, which was about US\$ 36 million, less even than the shortfall in contributions in 2006 alone of US\$ 51 million, which had forced the Director-General to borrow US\$ 22 million from the Working Capital Fund. That illustrated the seriousness of the situation.

Dr SHANGULA (Namibia) expressed concern at the large number of Member States that had not yet paid any part of their assessed contributions, and the fact that more than half the total amount due had not been collected. The Secretariat should actively encourage Member States to pay their contributions. He welcomed the advance payments made by some Member States, but asked how WHO was managing those advance payments. If the amounts were being used earlier than the intended financial year in order to meet an existing shortfall, that would have an impact in later years. He urged Member States to meet their financial obligations so that the mandated activities, requested by Member States, could be carried out. He encouraged improved presentation of the financial data in document A60/INF.DOC./6.

Mr JEFFREYS (Comptroller) said that payments made in time or in advance were welcomed, as that helped the cash flow of the Organization. Efforts were being made to resolve the long-standing arrears of some Members, but those States had been unable to make proposals in time for the current Health Assembly. With regard to the management of advance payments, as reported in the financial statements those totalled US\$ 47 million as at the end of December 2006. Those funds had been invested in accordance with WHO policies and represented part of the cash and investment balances held by the Organization. WHO had a conservative investment policy which was overseen by an investment committee, advised by banking and investment professionals. Interest was earned from those investments, which appeared as miscellaneous income within the Regular Budget.

The CHAIRMAN invited the Committee to consider the draft resolution, amended in light of the additional information provided by the Comptroller by the removal of the Dominican Republic, Nauru and Niger from the list in the second preambular paragraph and the words “and Palau” from paragraphs 1 and 2.

Mr VAN DER HOEVEN (Netherlands) said that the words “and Palau” should also be removed from the third preambular paragraph.

The draft resolution as amended was approved.¹

Scale of assessments 2008–2009: Item 15.5 of the Agenda (Document EB119/2006–EB120/2007/REC/1, resolution EB120.R18)

The CHAIRMAN drew attention to the draft resolution recommended by the Executive Board in resolution EB120.R18.

Dr SUWIT WIBULPOLPRASERT (representative of the Executive Board) said that at its 120th session in January 2007 the Board had considered the proposed scale of assessments for the

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA60.4.

period 2008–2009 and had agreed to recommend a new scale of assessments based on the latest United Nations scale of assessments approved by the General Assembly on 21 December 2006 by resolution 61/237.

The draft resolution was approved.¹

Assessment of new Members and Associate Members: Item 15.6 of the Agenda (Document A60/44)

The CHAIRMAN drew attention to the draft resolution on the assessment of the Republic of Montenegro contained in the report.

The draft resolution was approved.²

Financial period 2006–2007: implementation of resolution WHA58.4: Item 15.8 of the Agenda (Documents A60/43, A60/43 Add.1, A60/46 and A60/46 Add.1)

The CHAIRMAN reported that the item had been discussed the previous week by the Programme, Budget and Administration Committee, whose report was contained in document A60/46 along with a draft resolution.

Ms BLACKWOOD (United States of America) said that document containing the proposal had been received only shortly before the convening of the Programme, Budget and Administration Committee, at which the United States had expressed a concern, relating not to the global management system, which the United States supported as an important endeavour, but to the lack of information provided, the lateness of the submission, and the fact that the impact of the proposal would be to set a level of appropriation higher than that which had been approved for the period 2006–2007. Consequently, the United States of America had dissociated itself from the draft resolution contained in the Committee's report.

The CHAIRMAN said that her comments would be noted.

The draft resolution was approved.³

Amendments to the Financial Regulations and Financial Rules: Item 15.9 of the Agenda

- **Introduction of International Public Sector Accounting Standards:** (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R9, and A60/33)

The CHAIRMAN drew attention to the draft resolution recommended by the Executive Board in resolution EB120.R9.

Dr SUWIT WIBULPOLPRASERT (representative of the Executive Board) said that the Board had considered the proposed amendments to the Financial Regulations and Financial Rules at its 120th session in January 2007. It had noted that the International Public Sector Accounting Standards

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.5.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.6.

³ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.8.

would be introduced progressively, starting in 2008. Their main advantage would be to match the recording of expenditures better with the recording of the corresponding results achieved.

Mr MACPHEE (Canada) fully supported the introduction of the International Public Sector Accounting Standards at WHO, and across the United Nations system. Canada was pleased that the new electronic tracking systems being put in place would enable WHO to meet the requisite reporting standard well ahead of the deadline of 2010. It was regrettable that the financial incentive scheme had not had the intended effect of increasing the prompt payment of assessed contributions by Member States, and he agreed with the proposal that the scheme should be discontinued.

The draft resolution was approved.¹

3. REPORT OF THE INTERNAL AUDITOR: Item 16 of the Agenda (Documents A60/34 and A60/47)

The CHAIRMAN said that the report had been reviewed the previous week by the Programme, Budget and Administration Committee, whose report to the Health Assembly was contained in document A60/47.

Mr MACPHEE (Canada) welcomed the Internal Auditor's report and its thorough discussion by the Programme, Budget and Administration Committee. In future reports the tracking chart should contain more detail on progress in shortening the list of outstanding items reported by the Internal Auditor. A short summary of such progress should be given, and he welcomed the assurances given by the Director-General in that regard at the meeting the previous week.

Mr VAN DER HOEVEN (Netherlands) welcomed the scope of the clear and informative report and appreciated the prompt access provided to all relevant sources of information. WHO's management should make use of the findings of the Internal Auditor, but he noted that of the eight audits conducted in 2006 only one had received an initial response.

The Regional Office for Africa had received critical audit reports in 2003, 2004 and 2005. The appointment of a new Regional Director had raised hopes for improvement, but the latest report concluded that "the situation in the budget and finance unit will continue to be weak in terms of the capability to monitor and address effectively significant risks". As the African Region received a high share of WHO's budget and Africa was a major focus of Dutch voluntary contributions the critical situation described should be reflected in the distribution of the budget to and through the Regional Office for Africa.

Mr KOCHETKOV (Russian Federation) echoed the concerns of the previous speaker about the Regional Office for Africa. In particular, he was disturbed that staffing levels in the budget and finance area were only at 55% of requirements.

Mr LANGFORD (Office of Internal Oversight Services) said that efforts would be made in future reports to provide more detail as requested by the delegate of Canada. With regard to the Regional Office for Africa, his Office continued to work with the Regional Director and other staff both in the Regional Office and at headquarters to resolve the problems identified. Given the size and importance of the African Region, that focus would continue until acceptable solutions had been found.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.9.

Dr SAMBO (Regional Director for Africa) acknowledged the concerns expressed. Internal and external audits were important in improving management of WHO in general. The Regional Office was fully committed to improving the management of resources and had been working with the Director-General and senior management at headquarters and in country offices.

The Regional Office's first major internal difficulty had resulted from operating in Harare and Brazzaville until the end of 2006. Civil strife in Congo in 1997 had originally obliged the Office to move to Zimbabwe. Even when the Office had returned, a portion of it had had to remain behind, mainly because of a lack of office space in Brazzaville. With the entire Office back in Brazzaville, there was still a need for reorganization, taking into account both the recommendations from audit reports and the Office's own needs. The second internal problem concerned a shortage of skilled staff in financial management, both accountants and others. Improvements were already in hand, and thus in that area the report was not up to date. Recruitment of international professional staff had been concluded, and the budget and financial area had been reorganized.

Difficult banking conditions in some areas or countries hampered operations. The Regional Office had to adjust to an environment that was sometimes beyond its control. At the same time, all necessary measures to prevent problems, particularly fraud, were being taken. The Office was actively monitoring for possible fraud. Suspicious practices were reported to headquarters and an audit was undertaken. The Office should not be penalized for being proactive and thereby detecting a greater number of cases of fraud. There was no cause for alarm, as the monetary amounts involved were minor. The Office was committed to reporting an improved situation the following year.

In terms of governance, as of the current year the Regional Office was benefiting from the oversight role of the Regional Committee for Africa, within which ministers of health also gave consideration to financial and audit matters.

At present all audit matters had to be referred to headquarters. There might be advantages in decentralizing some audit functions to the regional level.

Mrs PRADHAN (Assistant Director-General) confirmed that WHO headquarters was working closely with the Regional Director and his staff on improving internal controls, systems and human resources. The administration took internal audit recommendations as seriously as external ones. The tracking mechanisms in place were being monitored closely.

Dr AL-MUBARAK (Kuwait) said that the meeting had not heard anything that suggested that any correction was taking place. The situation at the Regional Office for Africa was an emergency, out of control, and she called on the Director-General to take all necessary strict measures to close the gaps in its financial control.

The CHAIRMAN said that the comments of the delegate of Kuwait would be noted.

Dr SHANGULA (Namibia) considered that the relevant paragraph in the report of the Internal Auditor was written in such a way as to cast suspicion on the financial operations at the Regional Office. In the absence of the Regional Director's oral explanation that the situation was not alarming, a reader would have concluded that all was not well. Reports of that nature should not be couched in generalized terms likely to cast aspersions on an office's whole operation, but rather should make specific and accurate statements that did not leave scope for erroneous conclusions. Future audit reports should improve in that regard.

The Committee noted the report of the Internal Auditor.

The meeting rose at 12:10.

THIRD MEETING

Thursday, 17 May 2007, at 14:30

Chairman: Mr T. ZELTNER (Switzerland)

later: Dr A.A.YOOSUF (Maldives)

1. FINANCIAL MATTERS: Item 15 of the Agenda (continued)

Appointment of the External Auditor: Item 15.7 of the Agenda (Documents A60/32 and A60/32 Corr.1)

The CHAIRMAN said that the Health Assembly would consider candidates nominated by India, Indonesia and the Philippines for the position of External Auditor and invited the candidates to make their personal presentations to the Committee.

Mr KAUL (External Auditor), recalling that he had been appointed for the financial periods 2004–2005 and 2006–2007 pursuant to resolution WHA56.8, said that his organization, the office of the Comptroller and Auditor General of India, had gained considerable insight into the functioning of WHO during the course of work carried out in accordance with the Common Auditing Standards of the Panel of External Auditors of the United Nations, and the auditing standards of the International Organization of Supreme Audit Institutions. He had served on the United Nations Board of Auditors from 1993 to 1999 and he was currently external auditor of other specialized agencies of the United Nations besides WHO, Chairman of the International Organization of Supreme Audit Institutions' Standing Committee on IT Audit and Secretary-General of the Asian Organization of Supreme Audit Institutions. His team had experience in auditing large and complex health and social sector programmes. Should he be re-elected, his team would remain in place at headquarters and in the field, undertake 85 auditor work months per biennium, and assist WHO in its impending transition to the International Public Sector Accounting Standards.

Dr NASUTION (Indonesia), Chairman, Audit Board of the Republic of Indonesia, briefly outlined his personal career from 1996, when he had spent a year as Distinguished Sasakawa Chair in Development Economics at United Nations University/World Institute for Development Economics Research in Helsinki, through his time as economic adviser to the Asian Development Bank, the World Bank and IMF, his Deputy Governorship of the Central Bank of Indonesia, where he had supervised the auditing of commercial banks in his country, to his current posts, including Vice-Chairman of the International Organization of Supreme Audit Institutions' Task Force on Accountability and Audit of Disaster-related Aid.

The main reasons in favour of his candidature were an in-depth grasp of WHO's programmes; cooperation with other supreme audit institutions on the financial implementation of avian influenza assistance programmes; a staff of nearly 4000 auditors, with world-class experience in auditing international organizations, especially in conflict areas such as the Democratic Republic of the Congo, Eritrea and Kosovo; and a mandate to audit central, provincial and city levels of government in Indonesia as well as the central bank and more than 200 state-owned enterprises.

Mr ESPINO (Philippines) said that the Commission on Audit of the Philippines, of which he was Commissioner, was an independent body, the supreme audit institution of the Philippines, which undertook an annual audit of all government agencies and audits of government-wide and sectoral

performance, value-for-money and fraud. From 1984 to 1993 and from 1999 to the present, it had contributed as a United Nations External Auditor. It had been auditing the nationally executed UNDP projects in the Philippines for 14 years. It was active on the Panel of External Auditors of the United Nations, specialized agencies of the United Nations system and IAEA, the international and Asian organizations of supreme audit institutions, and the International Consortium on Governmental Financial Management. It provided training to auditors from other supreme audit institutions and was recognized as a major audit learning centre in Asia. Auditors assigned to the United Nations agencies, funds and programmes were drawn from a pool of about 200 highly qualified and experienced auditors. Because of its long experience auditing United Nations financial programmes, the Commission offered the shortest work-hours and the lowest-cost audit.

In the absence of any further comment, the CHAIRMAN took it that the Committee wished to conduct a vote in order to elect the External Auditor.

It was so agreed.

The CHAIRMAN suggested that, in order to save time, the Committee should use ballot papers on which the names of the countries presenting candidates were already printed in alphabetical order; two ushers, accompanied by members of the Secretariat, could pass in front of each delegation for them to deposit their ballot in the ballot box; and, rather than lots being drawn to decide the name of the first Member State to vote, the ballot box should simply be passed back from row to row, starting at the front.

It was so agreed.

Mrs Knutsdottir (Iceland) and Dr Shangula (Namibia) were appointed as tellers.

Mr BURCI (Legal Counsel) said that those Member States whose voting rights had been suspended or that were not represented at the current Health Assembly were Antigua and Barbuda, Argentina, Central African Republic, Comoros, Democratic Republic of the Congo, Dominica, Fiji, Guinea-Bissau, Guyana, Kyrgyzstan, Niue, Saint Lucia and Somalia.

A vote was taken by secret ballot.

The meeting was suspended at 15:45 and resumed at 16:10.

The result of the secret ballot was as follows:

Members entitled to vote	180
Members absent	55
Abstentions	1
Papers null and void	0
Members present and voting	124
India	80
Indonesia	26
Philippines	18
Number required for a simple majority	63

Having obtained the required majority, the Indian candidate for the position of External Auditor was elected.

The draft resolution contained in paragraph 5 of document A60/32, completed in accordance with the result of the secret ballot, was approved.¹

2. STAFFING MATTERS: Item 17 of the Agenda

Human resources: annual report: Item 17.1 of the Agenda (Document A60/35)

Mr MACPHEE (Canada) welcomed the eighth annual report and the constructive efforts to recruit qualified staff from underrepresented or unrepresented Member States, pursuant to resolution WHA56.35. Member States themselves, particularly those that were not underrepresented or unrepresented, should actively assist WHO's recruitment efforts.

Dr SOMBIE (Burkina Faso) commended progress towards gender parity, although much remained to be done. He requested the Secretariat, in its next report, to indicate whether priority was being given to temporary or to long-term contracts, and whether the main beneficiaries of long-term contracts would continue to be temporary staff, as had been the case in 2006.

Mr KOCHETKOV (Russian Federation) asked about progress on the mobility policy. He was also concerned about the apparent lack of human resources in the Regional Office for Europe, resulting in some plans not being implemented. Furthermore, what was the implementation status of Minimum Operating Security Standards, with respect to staff training and preparation to work in difficult or hazardous conditions?

Ms USIKU (Namibia) commended the progress made by WHO in the appointment of women in the professional and higher categories, to 36.4%, and asked whether the target was 50% or 70%.

Ms BLACKWOOD (United States of America) expressed concern about the decrease in the overall appointments of women, from 43.5% to 39.7%. She stressed the need to resolve the issue of unrepresented, underrepresented and overrepresented countries and asked what steps were being taken by the Secretariat in view of the high percentage of projected retirements in the next 10 years.

Mr HENNING (Human Resources Management) took note of the request for details of trends in the different types of contracts, particularly since the new contract reform process would be initiated on 1 July 2007. Regarding the questions raised by the delegate of the Russian Federation, a pilot project on mobility in the general management occupational group was scheduled to start in 2008. Concerning the Regional Office for Europe, the new human resource planning processes had been reviewed and the resulting plan would be implemented in 2008, in accordance also with the new standards of contract reform. Staff assigned to difficult duty stations worldwide usually received induction, at headquarters and in the regional office concerned, with safety and security training. The recruitment strategy targeted 50% representation of women in the professional and higher categories, though no specific date had been set for achieving that goal. Although the number of women recruited in 2006 had decreased, the percentage of women employed had increased. Recruitment targets specified in the document submitted to the Executive Board had been endorsed. Projected retirements would be dealt with under plans for the forthcoming biennium. The global management system would require a detailed action plan, as part of the normal human resource planning process at WHO.

The Committee noted the report.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA60.7.

Amendments to the Staff Regulations and Staff Rules: Item 17.2 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R11, A60/36 and A60/36 Corr.1)

The CHAIRMAN drew attention to a correction to the draft resolution contained in resolution EB120.R11. As a result of a change in the applicable salary scale, the salary of the Deputy Director-General for 2006 should read: “US\$ 176 877 per annum before staff assessment, resulting in a net salary of US\$ 127 970 (dependency rate) or US\$ 115 166 (single rate)”.

The draft resolution, as amended, was approved.¹

Report of the United Nations Joint Staff Pension Board: Item 17.3 of the Agenda (Document A60/37)

The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 17.4 of the Agenda (Document A60/38 Rev.1)

The CHAIRMAN invited the Committee to appoint one member and one alternate member to the WHO Staff Pension Committee, in accordance with the rotational schedule explained in the report.

Decision: The Sixtieth World Health Assembly nominated Dr J. Larivière of the delegation of Canada as a member and Dr A.A. Yoosuf of the delegation of the Maldives as an alternate member of the WHO Staff Pension Committee for a three-year term until May 2010.²

Dr Yoosuf took the Chair.

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (transferred from Committee A)³

WHO’s role and responsibilities in health research: Item 12.16 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R15, and A60/23)

Dr SADASIVAN (representative of the Executive Board) explained that the Fifty-ninth World Health Assembly had highlighted the fundamental importance of health research and had urged WHO to allocate more funds to that area; but it referred the matter to the Executive Board for consideration at its session in January 2007. At that session, the Board had adopted an amended resolution requesting the Director-General to promote and strengthen research advocacy, capacity, technical support and partnerships at all levels and through action by key stakeholders.

Ms YOUBA (Mali), speaking on behalf of the Member States of the African Region, said that the 2008 Global Ministerial Forum on Research for Health would be held in Bamako from 17 to 20 November 2008. The African Member States had drawn up a strategic framework for research activities and aimed to encourage a culture of health research. WHO’s primary responsibility was to lead by example; in collaboration with stakeholders, it should build capacity for health research.

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA60.10.

² Decision WHA60(9).

³ See summary record of the first meeting of the General Committee, section 3.

At least 5% of development aid to health should be devoted to research and strengthening research capacity. Member States in the African Region needed to allocate 2% of the health budget to research, implement national health research policies, including health systems research, use research results in political decision-making and integrate them into national health plans and programmes, and strengthen national committees and ethics bodies reviewing health research projects.

She supported the draft resolution as amended; a new final preambular paragraph should be added recognizing the need to assess progress since 2004 in health research and to discuss the future requirements of all Member States with regard to strengthening health research and health policies from an evidence-based perspective; and in paragraph 3 a new subparagraph (18) should be added requesting the Director-General to convene a ministerial-level conference on research for health, open to all Member States, to be held in Bamako, in November 2008.

Dr UGRID MILINTANGKUL (Thailand) welcomed the draft resolution. Health research was crucial to improving the health of populations and improving equity, efficiency and sustainability of national and international health systems. Health research should also bring social justice.

Thailand would establish through legislation an institute to support and promote health at the national level. A knowledge management institute already fostered independent exchange of knowledge among parties involved in the field.

He supported the draft resolution and asked the Director-General to introduce management and sharing of information from research activities within WHO and from research at the country level.

Dr MAZHANI (Botswana) said that, given the challenges to health systems of African Member States in the form of emerging and re-emerging diseases, the brain drain and financial constraints, research was essential in order to develop and evaluate interventions, guide policies and strengthen health systems.

WHO's commitment to building sustainable capacity for health research in Member States was crucial, especially as some health systems were still young and in need of support. Some requests to Member States contained in the draft resolution were already being implemented in Botswana. The recent first round of national health accounts had made it possible to monitor health expenditure, including spending on health research. In order for research findings to be disseminated and used in decision-making, Member States should strengthen communication for stakeholders, especially communities.

Health research was needed, but countries must possess sufficient infrastructure to allow proposed health research to be scientifically and ethically appraised. He endorsed the emphasis on strengthening national and institutional ethics committees, health research policies and legislative documents. It was also essential to make communities aware of their rights and responsibilities as study participants in order to protect people from unethical research. He welcomed the role assigned in the draft resolution to the Director-General, who should also provide support for the drawing up of communication strategies and to sensitize communities to those rights and responsibilities. Noting that the comments made by Member States at the Fifty-ninth World Health Assembly had been taken into account in the text, he supported the draft resolution.

Ms BLACKWOOD (United States of America) said that the generation of knowledge must be carefully protected and nurtured. High-quality health research required transparency, independent peer review, sustainable investment, and a strategy able to translate that knowledge into policy, minimize health inequalities and improve health, well-being and quality of life.

She supported investigator-initiated research. Basic, clinical and translational health research and investigation of the causes, prevention, and treatment of disease relied on the initiative of scientists, in partnership with sponsors and policy-makers. Increased investment by research institutions was opening new fields and accelerating advances across the spectrum of the biomedical and behavioural sciences. Her Government was the world's largest investor in biomedical, public health and behavioural research and development. Much biomedical and behavioural research was driven by the private sector. Research in the United States was built on public-private partnerships.

Partnerships with all relevant stakeholders were crucial to expanding scientific infrastructure and facing the growing scope and complexity of scientific challenges.

In the context of developing nations, she recognized the need for greater investment in research in order to scale up proven interventions. WHO should lead by example through programmes and recommendations based on the best research available.

WHO should support innovative research and stimulate transforming strategies that could benefit the entire scientific community. She supported the draft resolution.

Mr WU Peixin (China) said that WHO had played an important role in pharmaceutical and health research and in enhancing the research capabilities of developing countries. WHO should shoulder greater responsibilities in health research, which was crucial in improving health systems and in the prevention and control of diseases. Its outcomes served as the scientific basis for health policy-making. The health research capabilities of developing countries lagged far behind those of developed countries. He agreed in principle with the draft resolution. The Secretariat should strengthen coordination of its research activities and establish information networks for research outcomes to be more widely applied. The Secretariat should support collaborating centres in developing countries and provide more technical support to Member States, especially developing countries, in the training of research managers. It should also build those countries' capabilities to assess applied health technologies so as to facilitate research and policy-making. An appropriate mechanism should be set up and funding provided within WHO's research activities.

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

The meeting rose at 16:55.

FOURTH MEETING

Friday, 18 May 2007, at 09:50

Chairman: Mr T. ZELTNER (Switzerland)

later: Dr A.A. YOOSUF (Maldives)

later: Mr T. ZELTNER (Switzerland)

1. **FIRST REPORT OF COMMITTEE B** (Document A60/55)

Mr AL-FAKHERI (Saudi Arabia), Rapporteur, read out the draft first report of Committee B.

Ms BLACKWOOD (United States of America) asked that it be placed on record that the resolution relating to agenda item 14 contained in that report had been approved by a vote.

Dr SUWIT WIBULPOLPRASERT (Thailand), supporting that proposal, said that the voting numbers and the adoption without a vote of all the other resolutions mentioned in the report should also be recorded.

The report, as amended, was adopted on the understanding that it would be transmitted to the Health Assembly in plenary with the voting information requested.¹

2. **COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS:** Item 18 of the Agenda (Documents A60/39 and A60/39 Add.1)

Dr SUWIT WIBULPOLPRASERT (representative of the Executive Board) said that WHO and reform of the United Nations system had been discussed by the Board at its 120th session.² Board members had welcomed the Secretariat's report. The Director-General had reaffirmed that WHO would be an active partner in the reform process and that the Secretariat would submit regular reports to the governing bodies on the issue.

Mr STRØMMEN (Norway) strongly supported the report of the High-level Panel on UN System-wide Coherence in the areas of development, humanitarian assistance and the environment, "Delivering as One", and looked forward to a process for timely follow-up to its recommendations. Their implementation would strengthen the United Nations and make it more effective in supporting country needs. He welcomed the Director-General's assurance that WHO would participate fully in all eight pilot schemes under the One UN Country Programme. WHO should contribute actively to coordination in the United Nations system at regional and headquarters levels. All United Nations entities needed to be reconfigured to provide common regional hubs that could

¹ See page 312.

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

service the United Nations country teams. The United Nations had to modernize and achieve full compatibility in resource planning, human resources, common services and evaluation in order to promote coherence and efficiency within the system. The performance and the accountability of the United Nations needed to be improved. His Government therefore pledged US\$ 25 million in resources to fund the pilot schemes in 2007, in addition to the funds it had already committed to the United Nations and the countries involved in the Programme.

Mr GREEN (United Kingdom of Great Britain and Northern Ireland) commended WHO's efforts since January 2007 to engage in the United Nations reform process, particularly the eight pilot schemes, and to provide effective support at headquarters for the WHO teams working in the countries concerned. Reform should make the United Nations system more effective and efficient, thus improving support for countries to achieve the Millennium Development Goals; it should also raise the confidence of the system's largest contributors of funding.

Further information should be provided on the recent engagement between WHO and the World Bank, and on other elements of United Nations harmonization. The forthcoming Global Task Team's review must guide WHO's participation in, and work on, United Nations reform in the pilot countries. Action was also required to meet the targets for 2010 set in the Paris Declaration on Aid Effectiveness. The proposals of the High-level Panel on System-wide Coherence represented an opportunity for the United Nations to improve its performance. He recognized the importance of the Resident Coordinator's role and the value of sufficient separation by UNDP of the management of the Resident Coordinator system from that of other activities. Effective monitoring and evaluation of the pilot process were important.

Mr BIELER (Switzerland) underlined the importance of WHO's work to improve and consolidate its collaboration with its partners at country level. The high-level leadership and understanding of the challenges shown by the Director-General and the Executive Director of UNFPA needed to be translated into concrete action. Vertical initiatives in the health field were on the increase and the commitment to change the scale of health investment in countries with limited resources was producing results. In order to implement its Medium-term strategic plan 2008–2013 and fulfil the role entrusted to it, WHO must provide global leadership in health; it could only do so by collaborating closely with all the other partners at country level. WHO should take full advantage of the opportunity presented by the "Delivering as One" approach in the chosen pilot countries.

Despite the difficulties for WHO and other specialized agencies of integration into the United Nations Development Assistance Framework, the latter's revised guidelines would facilitate that process. The challenge lay in making the system more flexible while maintaining the strategic link between the United Nations country teams and governments. The Framework would result in joint programmes and so maximize the comparative advantages of each partner. WHO should encourage all those working for the Organization to engage in the pilot process, thereby enabling WHO country representatives, their partners and country teams to be fully integrated. The integration of WHO activities in the Framework's activities would not hinder initiatives and partnerships outside the United Nations system. WHO should identify any obstacles to its engagement at country level, modify its procedures and the approach of its staff and seize the opportunity to strengthen its role in health at country level. He requested information on the progress of engagement in countries piloting the programme and the outlook for future Frameworks in those countries.

Mr FU Cong (China) supported United Nations reform but wished to see a gradual process, based on careful study. He therefore supported the pilot schemes. While promoting better coordination of country programmes with other public health programmes, WHO should maintain its independence vis-à-vis other United Nations entities and avoid political considerations when drawing up its programmes. The reform process aimed to enhance the efficiency of the United Nations system, but it needed to avoid creating additional bureaucracy within the United Nations, particularly within country programmes.

Mr VAN DER HOEVEN (Netherlands) welcomed WHO's positive response to the pilot programmes but sought clarification of WHO's role in the programme in Viet Nam, as he had learnt that the Organization was involved in only one aspect of it.

Mr MACPHEE (Canada) also appreciated WHO's major role in the areas covered by the report. He had noted the reforms introduced in the field of humanitarian assistance, but agreed with the focus on activities that added most value for Member States, and welcomed WHO's collaboration within the United Nations system in increasing cost-effectiveness. The harmonization of business practices and the introduction of common accounting systems and cost sharing were particularly noteworthy. Canada supported WHO's efforts to facilitate the collection of data on gender mainstreaming and to make improvements in procurement. He also welcomed WHO's continued leadership in areas where it could add value in the field of health.

Ms BLACKWOOD (United States of America) said that reform was essential if the United Nations was to live up to its ideals and core purposes and remain relevant. WHO had taken a leading role in promoting a better system-wide understanding of the need for results-based management. Its participation in improving system-wide coherence was also important to its own internal operations. The "Delivering as One" report contained useful recommendations on the restructuring of United Nations operations, and the country pilot programmes had provided information of broader application. She urged WHO to participate fully in the One UN Country Programme and engage with partners in the United Nations system and beyond in order to eliminate duplication and competition and to identify reforms that would improve service delivery.

Dr ALA (Philippines) fully supported WHO's participation in the United Nations harmonization process. Although the Philippines was not one of the pilot countries, it had drawn up a health sector programme and a clear implementation strategy, using them to map out areas where support was needed and avoid duplication of development partners' efforts.

Mr A.P. SINGH (India) said that his country was closely watching the One United Nations approach at country level. He appreciated the need for greater harmonization of the work of the United Nations, but had concerns about the process. No country from the South-East Asia Region had been chosen as a pilot country; the situation in that Region would not be tested. There was a danger that health would lose its primacy as a result of the proposed One United Nations initiative. Care also needed to be taken to ensure that the specialized nature of WHO was preserved. In addition, the organizational structure of the proposed system at regional level had to be defined since the pilot schemes were restricted to country level.

Mr DE PRETER (Belgium) agreed with the comments of previous speakers and supported the "Delivering as One" project. He highlighted the importance for the Organization and the system as a whole of thoroughly analysing the situation on the ground, covering both negative and positive aspects, and the harmonization of management practices. Alignment of information, communication technology and other systems, such as the International Public Sector Accounting Standards, would also improve the One United Nations approach.

Dr MANSOOR (Iraq) welcomed WHO efforts, but emphasized coordination with the other United Nations entities about the thrust of the programmes in order to avoid duplication and improve response. Decentralization and greater decision-making power for country offices were also needed for cost-effective programme implementation. However, the support of other United Nations entities was required.

Mr DELVALLEE (France) endorsed system-wide collaboration as essential to improving efficiency. Many speakers had emphasized reforms at national and global levels, but regional reform was also important for some health issues. He regretted that the regional level had been neglected in

the report of the High-level Panel, and discussions during the meetings in October 2006 of the United Nations Economic and Social Council had confirmed the confusion surrounding that issue. Given the importance of programme and financial decentralization being implemented by WHO, he requested more information about WHO's policy on regional reforms, which had not been covered in detail in the report.

Dr MOOSA (Maldives) welcomed WHO's efforts to harmonize management and administration with the United Nations system. However, she shared the concern that the pilot projects did not cover all geographical regions, and emphasized that WHO should continue to focus on health-related issues. She asked the Secretariat to share both the positive and the negative experience gained from the pilot projects with all Member States.

Mr VAN DER HOEVEN (Netherlands) explained that he had not suggested that WHO should participate in all the pilot projects, but had merely requested clarification on WHO's participation in the Viet Nam project.

Mr HERNÁNDEZ FLEITAS (Cuba), observing that the report of the High-level Panel on System-wide Coherence had yet to be debated at the United Nations General Assembly, urged WHO to await the results of that debate and draw the necessary conclusions.

Ms MAZZANTI (International Atomic Energy Agency) said that through the Programme of Action for Cancer Therapy the Agency had contributed to the implementation of resolution WHA58.22 on cancer prevention and control, and looked forward to further supporting WHO's efforts to promote global action against noncommunicable diseases. The Programme encouraged Member States and policy-makers to pay more attention to the emerging cancer epidemic, in order to raise awareness and funding for capacity building and technical assistance. It was working with the Secretariat, including IARC, and other stakeholders. Its goal was to produce a global strategy for the prevention and control of cancer, and to contribute to WHO's fight against noncommunicable diseases. IAEA was also actively supporting programmes against communicable diseases. During 2006, rising concerns over avian influenza had led a joint FAO/IAEA programme to coordinate support for Member States in dealing with that virus. The IAEA Nobel Peace Prize Fund schools for nutrition had been held in Bangladesh, Guatemala, Uganda and other countries in Africa and Latin America, and special events on human resources development in radiation oncology in the context of cancer control programmes had been held in Cape Town (South Africa), Bangkok and Buenos Aires.

Mr AITKEN (Representative of the Director-General) reconfirmed WHO's commitment to United Nations reform and the eight pilot projects, as well as to ensuring that health remained the primary concern of WHO's daily work. In response to the delegate of the United Kingdom, he said that the focus of the engagement with the World Bank had recently been on health systems and that cooperation in advising governments on health systems had been reviewed at the first high-level joint meeting earlier that month.

In response to the question from the delegate of Switzerland, he said that WHO was working on the health dimension within the United Nations Development Assistance Framework, by incorporating WHO's country cooperation strategies into that Framework along with other United Nations system health programmes in countries.

With regard to the question raised by the delegate of the Netherlands, he said that coordination between UNDP, UNICEF, WFP and UNFPA in Viet Nam had begun before the start of the pilot scheme. Other agencies were preparing to join the system of coordination, and in the context of the pilot scheme WHO was working on joint office and business practices, and on fostering a sectoral approach to health.

With reference to the concerns raised by the delegates of India and Maldives, he said that although none of the eight pilot programmes was being carried out in the South-East Asia Region, the

regional and country offices in that Region were being kept informed of developments as a subsequent phase would undoubtedly include some countries in that Region.

He agreed with the delegate of France that the regional dimension of the reform process had been neglected. WHO was participating in new mechanisms, such as regional directors' meetings and interregional cooperation, to ensure that country-led development would also involve regional coordination.

He also agreed with the delegate of Cuba that some intergovernmental processes had not yet been completed, including the triennial comprehensive policy review and other forums.

WHO would share information on progress in the pilot programmes and the United Nations reform in general with all Member States, as requested by Maldives.

The CHAIRMAN said that he took it that the Committee wished to take note of the reports in documents A60/39 and A60/39 Add.1.

The Committee noted the reports.

- **Joint report of the Director-General and the President of the International Narcotics Control Board** (Document A60/INF.DOC./2)

The Committee noted the report.

Dr Yoosuf took the Chair.

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

WHO's role and responsibilities in health research: Item 12.16 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R15 and A60/23) (continued from the third meeting, section 3)

Dr ALA (Philippines) supported the draft resolution contained in resolution EB120.R15 but proposed amending the operative part to provide for the establishment of systems and mechanisms for greater interaction and convergence among researchers and research users in order to improve the use of research results and enhance the development of health policies. The Philippine National Health Research System was one such mechanism: a network of institutions conducting health research and government agencies involved in policy and programme development. The interaction and convergence of Member States' efforts had made the use of resources for research more efficient and had led to improvements in the use of research in policy development and health programme implementation.

Ms BINLER (Turkey), supporting the draft resolution, recognized that health research was important for achieving internationally agreed health-related development goals, improving health systems and attaining equality in health. One of WHO's primary responsibilities was to provide more efficient support to developing countries to maximize health research, and thereby to develop health systems. WHO's research should be relevant to the needs of health-service users, especially neglected populations. WHO addressed potentially controversial and neglected research issues, in disseminating results to policy-makers, civil society institutions and the general public, and in building public support for health research. WHO should also strengthen its own policies for the integration of research into national programmes, as well as encouraging networks for research, particularly on health systems, disease burden and emerging health-related issues.

Mr DEL PICÓ (Chile) supported WHO's efforts to encourage health policies based on the best available scientific information, which helped to establish local legal priorities for the generation of information and for investment in essential research. He supported the draft resolution, assuming that the 2% goal mentioned in paragraph 1(1) was to be achieved gradually, taking into account the situation in each Member State.

Dr LEE Kang-hee (Republic of Korea) recognized the key role of health research in promoting public health. He supported the draft resolution and agreed that one of WHO's major responsibilities was to encourage ethically sound research. WHO should use the results of such research for disease prevention and control, better health-care systems and equality in the health-care sector. It should broaden the scope of its activities in such areas as the application of research results, including the dissemination of research guidelines, encouraging access to harmonized information and establishing standard methodologies in various research fields, such as ethics, peer review, prioritization and relevance assessment. He urged the Director-General and Member States to continue to strive for high-quality health care and improved public health. His Government had increased its investment in research and in strengthening international cooperation.

Ms IMAI (Japan), noting the importance both of health research for strengthening health systems and of establishing and implementing health policies based on appropriate scientific evidence, supported the draft resolution. She appreciated WHO's activities for research, particularly in the area of tropical diseases. The important work of IARC and the WHO Centre for Health Development should be strengthened. Networks of WHO collaborating centres should be used. WHO should continue to take the lead in health research, including providing support for capacity building.

Mr ONGOLO ZOGO (Cameroon) supported the draft resolution, which was an improvement on the text submitted to the previous Health Assembly. He commended the activities carried out in the African Region. Many African countries had been involved in the Health Metrics and Evidence-informed Policy networks, which had improved awareness and pioneered solutions for evidence-related needs. The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the Regional Office for Africa had supported high-level ministerial meetings in Abuja and Accra, which had articulated an African position on health research relating to diseases of poverty. Some of the priorities outlined in the final communiqué of those meetings had been incorporated in the Special Programme's recently adopted strategy. More countries should support their implementation.

Africa needed to increase awareness of and investment in health research in order to sustain health and development in the region. Despite the recommendations of the Commission on Health Research for Development, few African countries would be able to allocate 2% of their national budgets to research and even fewer countries had persuaded donors to invest 5% of their existing assistance contributions in research. Countries should be encouraged to integrate national health research into national health systems. He called on the Secretariat to increase its efforts to support sub-Saharan countries in upgrading national health research systems.

Ms HALÉN (Sweden), supporting the draft resolution, said that research was essential to better health and health systems. National research provided the tools for analysing and solving problems; incorporating results into health services; participating in global research; and setting health and research priorities. Building research capacity in developing countries improved national and regional health, but it required support for individual researchers, a strong academic environment, functioning research management and a research system. The Secretariat should advise Member States on building health research systems where required, and devise resource-tracking tools. Member States should do the monitoring, and the Secretariat should coordinate and compile the data.

In 2006, the Nordic countries had requested the Director-General to submit to the Sixty-first World Health Assembly a strategy on the management and organization of health research within

WHO. The strategy should focus on organizational aspects such as mechanisms for managing and prioritizing research activities, and should clarify WHO's role in global health research.

Mr DELVALLEE (France) fully supported the draft resolution and emphasized that its title included both the role and the responsibilities of WHO in research. France would continue to support WHO in facilitating the health research needed for the best possible health care. Paragraph 3(7) seemed to require the Director-General to review all research proposals worldwide, which was both ambiguous and impossible. He therefore proposed that the second line of that paragraph should be amended to read: "including registration of its research proposals".

He welcomed the focus of the draft resolution on ethics. WHO was also responsible for ensuring coherence and integration of its activities, both at headquarters and between headquarters and regional and country offices, as had been discussed in regard to the draft Medium-term strategic plan 2008–2013. One example of such internal coherence was the cancer action plan, to be launched the following week, which brought together three departments and IARC. Activities should be integrated and duplication avoided. At the meeting of the Governing Council of IARC the previous week, France had also advocated more visible integration of IARC within WHO. Such integration would ensure better use of WHO's resources worldwide.

The meeting was suspended at 11:00 and resumed at 11:35.

Dr ASLANYAN (Canada) said that Canada had initiated a WHO-Canada Dialogue on Global Health Research (Ottawa, 2–4 November 2005). The first workshop had explored the role of developed countries in contributing to the Mexico Statement on Health Research of 2004. The dialogue had proved fruitful and had resulted in suggestions on how Canada and WHO could facilitate collaboration on health research between developed and developing countries.

Canada welcomed WHO's efforts to enhance its culture of research, inter alia by building up a reporting system on its activities in health research, and supported the resolution.

Dr AL-SAIF (Kuwait) said that health research was important for strengthening health services at all levels, including care and prophylaxis. Countries needed to spend more on health research. Health research demanded full respect for ethics and the principle of following scientific evidence. Studies were being conducted on those issues at the Kuwaiti Research Institute and within the Ministry of Health. Kuwait attached importance to health research and appropriate budgetary allocations, and supported the draft resolution.

Dr BUDIHardja (Indonesia) said that Indonesia's health policy was to improve the health of the population by providing health services of a common standard to all citizens, minimizing knowledge gaps, strengthening health systems and using research findings and data from health information systems to guide health policy.

He supported the WHO-cosponsored research programme into tuberculosis, malaria and AIDS, and recognized the contribution to strengthening research capacity in Member States. He therefore fully supported the draft resolution.

He stressed, however, that research activities across the entire spectrum of health, medicine and behaviour should be directed, as a matter of priority, to enhancing the performance of the existing health system.

Mr ADLIDE (Australia) endorsed the preambular statement in the draft resolution that WHO should lead by example in the use of research findings to inform decisions about health. Australia was committed to increasing support for health research within its development assistance programme. However, setting targets for research expenditure within aid programmes was problematic, partly because decisions about aid expenditure were made jointly with aid partners whose needs differed.

Mr MÄUSEZAHN (Switzerland) said that adoption of the resolution would be the culmination of a three-year process and the inception of a strong WHO strategy in health research. He concurred with the Nordic statement that the strategy should clarify the organization and management structure of all health research activities within WHO, as well as developing a strong vision of its role in health research. Switzerland had repeatedly stressed that such a process should be inclusive, involving all stakeholders in health research. During the 120th session of the Executive Board in January 2007, it had been announced that an expert advisory group would be convened;¹ he sought further information on its composition, working methods and timeline for its work. He endorsed the amendment concerning a ministerial conference, proposed by Mali, which, he observed, was in line with resolution WHA58.34 on the Ministerial Summit on Health Research.

Professor FAIZ (Bangladesh) said that the draft resolution provided an opportunity to rethink WHO's responsibility in the promotion of health research, particularly the strengthening of research capabilities in developing countries. Those countries should concentrate more on translational or operational research than on basic research. Furthermore, given the tendency of research scientists in the developing countries to emigrate to the developed world, WHO had a crucial responsibility to initiate measures aimed at retaining such human resources in the developing countries.

Ms NGAUNJE (Malawi) said that health research should be encouraged, especially in the developing countries, facing as they did specific challenges – notably the brain drain. Incentives to undertake research fostered ownership and leadership, and helped in policy formulation. However, the developing countries also needed resources for their health research.

Dr MAKUBALO (South Africa) welcomed WHO's growing recognition of the role of research in achieving the important health goals being considered by the Health Assembly. Countries should make a sustained investment of 2% of their national health budget in research. The entire spectrum of research was important, as were the strengthening of mechanisms and regulatory frameworks, and the management of national health research systems.

She sought further clarification on the mechanisms for streamlining research initiatives inside WHO, urging the Secretariat to pay adequate attention to research in countries with a high disease burden, without overlooking the increasing burden of noncommunicable diseases. She urged support for initiatives to identify ways of generating and synthesizing knowledge and of translating research findings into programme implementation and policy formulation.

South Africa had made steady progress on a research infrastructure and oversight system. It had recently hosted a meeting attended by at least 20 southern African countries, aimed at coordinating and harmonizing registration and regulatory frameworks for clinical trials.

Mr A.P. SINGH (India) affirmed the need for further increasing WHO's role in health research in the face of widening disparities between nations' access to technology and research in medicine and health care. There was a perceived threat, particularly among developing countries, relating to the intellectual property regime, which would not promote innovations on neglected diseases, or in countries with limited capacity for technical innovation. WHO should provide professional help on the single-window system to scientists in order to protect and exploit new intellectual property generated through industry participation. WHO also needed to sensitize scientists to identifying gaps in knowledge and application. WHO could play an important role in the prompt protection of intellectual property.

In order to increase technology management skills in developing countries, WHO could facilitate the establishment of offices for technology transfer in major publicly-funded institutions with strong research and development. WHO could also assist in building the capacity of institutions to

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

conduct clinical trials, to strengthen their regulatory infrastructure, and to streamline the registration of ongoing trials.

Referring to the draft resolution and the recommended investment targets, he said that India was thought to be meeting those targets; however, in the absence of sufficient data, it was impossible to make a categorical pronouncement on the matter.

Mr BENTO ALCÁZAR (Brazil), rising to a point of order, pointed out that there was no mention of agenda item 12.20, on public health, innovation and intellectual property, in the day's *Journal*. It had disappeared from the list of items earlier displayed on the monitor outside the conference room. He wanted time for Brazil to make a presentation on the subject, and sought assurance that there would be time for a working group to consider the related draft resolution, proposed by Brazil, for a full day, namely the following Monday.

Mr Zeltner resumed the Chair.

The CHAIRMAN said that agenda item 12.19, Health technologies, had been postponed at the request of Mexico, but that the timing of item 12.20 had not yet been discussed.

Dr DAYRIT (Secretary) said that the omission of item 12.20 from the *Journal* was simply a mistake.

Mr BENTO ALCÁZAR (Brazil) proposed that item 12.20 should be considered before items 12.17 and 12.18.

Mr ABDOO (United States of America), supported by the delegates of the United Kingdom and Germany, opposed any reordering of agenda items. The draft resolutions on items 12.16, 12.17 and 12.18 had been on the table for some time, and there was no reason to rush into item 12.20.

The CHAIRMAN said that the order of items would remain the same, and the delegation of Brazil would be able to present its proposed resolution on item 12.20, and the related issue of the need for a working group, during the afternoon session.

Mr BENTO ALCÁZAR (Brazil) asked whether it could be guaranteed that the item would be considered during the afternoon.

The CHAIRMAN said that it depended on how fast the Committee as a whole disposed of the intervening items.

Mr BENTO ALCÁZAR (Brazil) suggested that it was in the Chairman's power to allocate extra time and thus to guarantee that the item would be considered during the afternoon.

Mr AITKEN (Office of the Director-General) explained that the question of the establishment of a working group could not in any event be resolved at that time, as the decision to establish working groups lay with the Committee, not the Secretariat, and would normally be taken during consideration of the item concerned.

Dr EVANS (Assistant Director-General) said that delegates' comments had been duly noted. Replying to the question from the delegate of Switzerland, he said that the external consultative group on the development of WHO's research strategy would comprise about 30 people, drawn from national health research councils, science and technical advisory committees, major funders, nongovernmental organizations with an interest in research, industry, and so on. It aimed to cover the whole range of research issues that the WHO research strategy was expected to need to accommodate. Invitations to join the group had recently been sent out by the Director-General.

Dr DAYRIT (Secretary) read out the proposed amendments. The delegate of Mali had proposed to add a preambular paragraph reading: “Recognizing the need to evaluate progress in health research since 2004 and to discuss the future needs of all Member States with regard to the promotion of fact-based health research and policies”, and to add a paragraph 3(18), reading: “to convene a ministerial conference on health research open to all Member States in Bamako in November 2008”.

The delegate of France had proposed the addition of the word “its” before “research proposals” in paragraph 3 (7).

Mr ABDOO (United States of America) asked what the cost implications were of the proposed additional subparagraph (18).

Dr EVANS (Assistant Director-General) said that the cost of preparing the proposed conference was already covered in the budget for the biennium 2006–2007, while that of holding it was included in the budget for the biennium 2008–2009, recently approved.

The draft resolution, as amended, was approved.¹

Progress in the rational use of medicines: Item 12.17 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R12, and A60/24)

Dr SADASIVAN (representative of the Executive Board), introducing the report, recalled that at its 120th session the Board had recognized the urgent need to promote rational use of medicines. The Board had adopted resolution EB120.R12, recommending adoption by the Health Assembly of a resolution that advocated a cross-cutting health-systems approach, particularly through multidisciplinary national monitoring bodies. It had been agreed that national programmes would vary between countries; however, the components listed in paragraph 5 of document A60/24 represented a good start.

Mrs NANHOE-GANGADIN (Suriname) supported the draft resolution contained in resolution EB120.R12, but proposed inclusion of the rational use of traditional medicines; their use was gaining ground and had to be dealt with by health-care systems. Traditional medicines had not yet been formally recognized in her country but, as part of the Government’s newly developed pharmaceutical policy, traditional healers and their products were being assessed, and regulations and legislation on traditional medicine were being prepared. Implementing the measures would require the support of WHO, PAHO and those Member States with relevant experience.

Dr AL GHAFIRI (Oman) said that WHO’s work on the rational use of medicines was a priority as medicines were a common denominator of work in other areas. Patients could only enjoy their right of access to medicines if the medicines were correctly provided and used. Her country had since 2000 had a department for promoting the rational use of medicines, and such use was included in the national Five-Year Health Development Plan. Considerable success had been recorded in the rational use of medicines on the same prescription, and the number of prescriptions for antibiotics had fallen because of the focus on more appropriate care. In addition to improving health, rational use had reduced financial and pharmaceutical waste.

Dr AL THOO (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, described irrational use of medicines as a tragedy. Developing countries were spending on average 30% to 40% of their regular budgets on medicines, yet half that amount was wasted through improper prescription and use. Consequently only 35% of people in developing countries had access

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA60.15.

to medicines in a way that benefited them. All the hard work to improve access to medicines was wasted if medicines were not used appropriately, and irrational use could actually damage health. Despite the international concern about lack of access, the issue of rational use of medicines was not high enough on the political agenda. She therefore fully supported the draft resolution. She reiterated support for the Executive Board's decision to delink the issues of rational use of medicines and better medicines for children, and to present them to the Health Assembly as two separate items. Expressing satisfaction at WHO's continuing work in the area, she noted the Organization's participation in two international conferences that had collated considerable evidence indicating that ad hoc efforts to promote rational use did not work. Conversely, sufficient knowledge existed about successful interventions to enable rational use to be improved. Commitment, coordination and resources were needed at country level in order to translate such knowledge into action, which would save resources and improve health outcomes.

Ms JOHRI (India) said that her country recognized the need for rational use of medicines as the world was increasingly dependent on medication. Her Government had been promoting the rational use of medicines, including publishing standard guidelines, preparing a list of essential medicines and enacting or amending legislation. She supported the draft resolution and suggested that the Secretariat should increase the capacity of Member States, particularly developing countries, to undertake activities including: encouraging participation of stakeholders (including drug manufacturers, health professionals and consumer organizations) in disseminating information on rational use of medicines; training health professionals and medical students to withstand the pressures exerted by patients and aggressive pharmaceutical promotion; and monitoring pharmaceutical indicators in order to assess the impact of rational prescription and appropriate use of medicines. India would shortly be establishing a national drug authority that would respect world-class standards and practices. She urged that similar principles be incorporated in the resolution.

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

The meeting rose at 12:30.

FIFTH MEETING

Friday, 18 May 2007, at 14:40

Chairman: Mr T. ZELTNER (Switzerland)

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

Progress in the rational use of medicines: Item 12.17 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R12, and A60/24) (continued from the fourth meeting, section 3)

Ms IMAI (Japan) said that in Japan the importance of raising awareness about the nature of medicines, and especially the possibility of their adverse effects, had been recognized in discussions to revise the sales system of non-prescription medicines, and the law on pharmaceutical affairs contained an article to that end. Promotion of rational use called for a comprehensive approach, involving human resources in health services, the strengthening of health systems and information for consumers, and implementation of policy in areas such as safety measures and the monitoring of promotion of medicines. In that light, she supported the draft resolution. WHO should continue to lead in that area.

Dr SOMBIE (Burkina Faso), speaking on behalf of the 46 Member States of the African Region, said that, despite the progress made, medicines (including those for children) were not always well prescribed, dispensed or sold, and half the patients failed to take them correctly. Roughly 10 million children died each year from infections, many of which could have been effectively treated by medicines that were, however, not always available because, for example, of cost or inappropriate formulation. Irrational use was more alarming in the case of children, in that the non-availability of appropriate medicines often resulted in the use of an unsuitable substitute. Information was lacking, at all levels, about the availability and cost of children's medicines. The list of essential medicines did not include all children's medicines.

Wrong use led to wasted resources and endangered health. Irrational use was more prevalent in the private than the public sector, because the former failed to apply appropriate policies and strategies, and the situation was exacerbated by the progressive privatization of health services and vertical programmes to promote improved access that did not invest in rational use.

As part of its medicines strategy for 2004–2007, WHO was supporting a number of Member States in developing and revising national lists of essential medicines, standardizing treatment guides, disseminating information, establishing pharmaceutical treatment committees, and adopting best prescription and dispensation practices.

He supported the draft resolutions contained in resolutions EB120.R12 and EB120.R13.

Mr ZHOU Jun (China) said that WHO should play its organizational and guiding role, promoting the exchange of experience and providing technical and financial guidance to developing countries and countries in economic transition. The rational use of medicines called for cooperation in a number of fields, such as the use of antibiotics in food production and animal husbandry. In addition, pharmaceutical companies should pay due attention to the rational use of medicines.

He supported the draft resolution.

Dr TIPICHA POSAYANONDA (Thailand), speaking on behalf of the Member States of the South-East Asia Region, supported the statement made by the delegate of India. Irrational use of

medicines occurred throughout the world, irrespective of national, social and economic development levels. It increased medical care costs, for reasons such as adverse reactions. A wide range of factors encouraged improper prescription and dispensing. She emphasized evidence-based policy development and appreciated the outcome of the Secretariat's efforts, as reflected in resolution EB120.R12.

Correct use of pharmaceutical products called for strong political will and reforms at all levels. Educational programmes alone could not suffice, especially in the face of unethical targeting and advertising. Experience suggested that proper health financing and auditing of care provision could curb unnecessary prescribing. Promoting rational use of medicines depended on a broad range of partners and interventions. A national policy was therefore needed, supported by a multidisciplinary national body for monitoring and evaluation, in order to harmonize work towards high-quality use of medicines in both the public and private sectors.

She strongly supported the draft resolution and urged all Member States to promote the rational use of medicines.

Mr NIBLETT (United Kingdom of Great Britain and Northern Ireland) strongly supported the draft resolution. His country had considerable experience in the rational use of medicines, both within its own health service and in its development work. The benefits of affordable medicines were not being fully realized because people tended to buy expensive medicines rather than the cheaper but effective generics that were available – an important issue for all countries. The United Kingdom had been in the forefront of studying the cost and clinical effectiveness of medicines, through its National Institute for Health and Clinical Excellence. WHO should in particular make its various guidelines and recommendations coherent and link them with the international community's commitment to increasing access to antiretroviral medicines for AIDS, new medicines for multidrug-resistant tuberculosis, and artemisinin-based combination therapy.

The United Kingdom supported European Union legislation to prevent direct promotion of medicines to the consumer, which caused part of the problem. It was encouraging that the Code of Pharmaceutical Marketing Practices of the International Federation of Pharmaceutical Manufacturers and Associations was applied in developing countries.

The United Kingdom was developing the multi-donor Medicines Transparency Initiative in order to improve transparency in the pricing, availability and quality of essential medicines. The draft resolution was crucial for that purpose. His Government would work with WHO in order to make spending on medicines more effective.

Mr ABDOO (United States of America) strongly supported the rational use of medicines and recognized the serious consequences, both human and financial, of their irrational use. The matter was complex and problems could arise at patient, physician, pharmacy, hospital or dispensing level. Notwithstanding that complexity, the report failed to focus on practical, sustainable and measurable action to which the Organization could contribute. He concurred with some of the interventions suggested in the report to promote more rational use, but was unsure that a "one-size-fits-all" solution – a government-run national programme – was the best option. Member States should develop programmes and policies based on their national contexts. With regard to national legislation on advertising and promoting medicines, the United States already had mechanisms for providing consumers with information that could facilitate treatment. The Food and Drug Administration would continue to monitor and, where appropriate, regulate promotional activities aimed at the medical community. It would be pleased to share its experience with other Member States.

He supported the draft resolution.

Ms TJIPURA (Namibia) said that her country had established its National Medicines Policy in 1998 and later the National Pharmaceutical Master Plan, which set forth broad objectives and strategies. The Government promoted the rational use of medicines in coordination with the regions, the private sector, professional associations and medical aid funds. The latter currently paid only for generic medicines, where available; patients paid the price difference if they insisted on the prescribed

branded product. The Essential Medicines Committee reviewed and approved medicines for the Namibia Essential Medicines List, which contained generic medicines for all the country's prevailing health conditions. Regular surveys of medicine use had revealed failure to comply with treatment guidelines for the use of antibiotics and of injections when oral dosage forms were available.

Despite some success, inadequate human resources hampered progress; as a result, the training of pharmacists and other health professionals had been accelerated. Since the country had no medical or pharmacy school, pharmacists and doctors employed in public health were trained at institutions where training programmes might not coincide with national treatment guidelines. In addition, private practitioners, as in other countries, were reluctant to comply with those guidelines.

She supported the draft resolution.

Mr ROSALES (Argentina) said that in his country access to medicines had been affected by the national crisis at the end of 2001. The Ministry of Health had introduced more equitable access to medicines through the "Remediar" programme, part of a strategy to reform primary health care, under which medicines were provided free to primary health-care establishments. A subprogramme on the rational use of medicines consisted of training for professional prescribers and community information. Developed in agreement with all provinces and taught in the country's medical faculties, it was an unprecedented instance of institutional and interprovincial collaboration in human resources training. About 5000 students from all the provinces' primary care centres were taking the course, which was financed entirely by the Ministry of Health.

Ms HELA (South Africa) said that strategies to promote rational use of medicines in developing countries needed to be evaluated in order to establish their appropriateness for different settings. The tendency had been to adopt models from elsewhere without sufficient adaptation to local communities, medical literacy, cultural norms, financial and human resources, and even geographical conditions of access. South Africa had implemented many of the strategies proposed in WHO's medicines strategy. It had issued an essential paediatric medicines list and standardized treatment guidelines in 1998; a second edition had been revised in 2006. The country also had legislation to prohibit perverse financial incentives, had introduced a single price from manufacturers and encouraged ethical promotion of medicines, but it still faced challenges, notably relating to traditional medicines. Legislation and regulations, monitored by a statutory body, also required medical insurance schemes to use evidence-based principles when drawing up their formularies.

She urged WHO to review the thresholds for rational use of some medicines, for example in regard to antibiotics for opportunistic infections associated with AIDS in countries with a high HIV prevalence; to strengthen evidence for the use of alternative therapies and traditional medicines; and to facilitate sharing of best practices for use of medicines in the private sector.

She supported the draft resolution.

Dr MAZHANI (Botswana) fully supported the draft resolution. A study on medicine use in Botswana had identified problems, including overuse of antibiotics and injections, short dispensing times, and failure to provide accurate information to patients. The Botswana Essential Drugs Action Programme continued to enforce and monitor the national medicines policy, but the country was short of skilled staff, particularly pharmacists. He urged WHO to continue providing technical support to countries like his for the sake of improved use of medicines.

Dr LEE Kang-hee (Republic of Korea) said that much remained to be done to promote the rational use of medicines. There were still cases of antibiotic overuse, adverse side effects and unreasonable spending. Her Government was monitoring implementation of a policy introduced in 2000 to separate prescribing and dispensing. From February 2006, all medical institutions in the country were required to publish their prescribing practices for antibiotics for upper respiratory tract infections and were discouraged from prescribing antibiotics unnecessarily. In 2006 the Government had adopted a system to list safe and effective medicines after evaluation of their economic and

therapeutic values. It would continue to reflect WHO's strategies in its domestic policies. She strongly supported the draft resolution.

Dr AL-MUDEHAF (Kuwait) supported the draft resolution. The rational use of medicines must be a priority because their irrational use harmed patients and led to drug resistance, wasting financial resources. Kuwait had tackled antibiotic resistance by preparing a protocol. Committees had also been set up to review medicine use in hospitals. Periodic reviews of drug resistance were made, lists of essential medicines drawn up, and users informed about the rational use of medicines with training for primary health-care workers. Prophylactic profiles were being drawn up for various diseases. Several decrees regulated the use of medicines in both the public and the private sector. WHO should continue to provide support to all Member States on the issue of the rational use of medicines.

Ms ALVES (Consumers International), speaking at the invitation of the CHAIRMAN, said that Health Action International, of which Consumers International was a member, was a global network that had been involved with the rational use of medicines for more than 25 years. It strongly supported the draft resolution and had been active in framing it from the outset.

Poor prescribing, medicine overuse, increased adverse drug reactions and hospital admissions, artificially high expenditure on medicines, antimicrobial resistance, and increased morbidity and death were consequences of the irrational use of medicines. Without adequate monitoring of the extent and consequences of irrational medicine use, the problem would remain. The draft resolution established a framework on which to base a long-term programme of rational use.

Effective policy solutions were available and had been applied successfully in some Member States. The draft resolution would bridge the gulf between policies on paper and their implementation, providing for integrated programmes and reflecting national contexts. It would facilitate the enactment and enforcement of legislation banning unethical promotion of medicines, based on WHO's criteria. Its framework enhanced initiatives to contain antimicrobial resistance and achieve cost-effective outcomes.

She called on Member States to engage with all stakeholders and observed that civil society groups were ready to apply their expertise in the matter of implementation.

Mr CHAN Xuanhao (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that his organization aimed to improve access to and the value of appropriate medicine use worldwide. The consequences of irrational use and the urgent need for action were clear, especially given the emergence of deadly multidrug-resistant strains of certain infectious agents. He urged improved rational use of medicines in both hospital and community settings and recognition of the value of pharmacists and their expertise at all levels of the health-care system. He drew attention to the WHO/International Pharmaceutical Federation statement on good pharmacy practice and to resolution WHA47.12 on the role of the pharmacist.

He supported the draft resolution.

Dr OMBAKA (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the Christian Medical Commission of the World Council of Churches had introduced its Ecumenical Pharmaceutical Network more than 25 years before. Members included intergovernmental organizations such as WHO, and the Network highlighted grass-roots issues. In sub-Saharan Africa, churches provided as much as 40% of the formal health-care services, especially in rural areas; rational use of medicines was crucial to their work.

It was of great concern that, 30 years after the concept of essential medicines had been introduced, about half the people in sub-Saharan Africa still did not have access to basic medicines. Even worse, of those who did, more than half received them in an irrational manner. It was encouraging that the draft resolution called for the establishment of multidisciplinary national bodies in order to address irrational use of medicines in a manner appropriate to national contexts. She supported the draft resolution and urged Member States to carry it forward into their national plans.

Dr ZUCKER (Assistant Director-General) welcomed the comments made by all delegations and nongovernmental organizations on the agenda item. Responding to the concern raised earlier by the delegate of Suriname, he said that traditional medicines were understood to be included under the umbrella term “medicines”. As mentioned by several speakers, the issue of rational use of medicines would indeed require effort at all levels and he looked forward to working with everyone on it.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB120.R12.

The draft resolution was approved.¹

Better medicines for children: Item 12.18 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R13, and A60/25)

Dr SADASIVAN (representative of the Executive Board) said that at its 120th session, the Board had examined a report on better medicines for children, which contained proposals on improving access for children to essential medicines. The Board had adopted resolution EB120.R13 on better medicines for children, which contained a draft resolution recommended to the Health Assembly for adoption with proposals to improve the selection of essential medicines for children, research on appropriate dosage forms of medicine for children, quality testing and guidelines for improving the use of medicines for children.

Mr BENTO ALCÁZAR (Brazil) said that he strongly supported modifying paragraph 1(7), whose language was too vague for such an important resolution. The wording should express the needs of developing countries, and should state that countries would use the full set of flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS agreement) in order to guarantee access to medicines for children.

Dr DUQUE III (Philippines) welcomed the Secretariat’s report. The Philippines was committed to strategies for better medicines for children. He supported the strategic core of the draft resolution and advocated accessibility of essential medicines in a decentralized system, rational prescribing, affordable and available medicines, documenting good practices, and updating protocols with new recommended medicines for the treatment of pneumonia.

He proposed the inclusion of a new paragraph after paragraph 1(2), which would read: “to conduct antimicrobial resistance surveillance of the locally available and commonly prescribed medicines for children”.

Mr POMOELL (Finland) said that, although children accounted for nearly a third of the world’s population, few medicines were developed for them. Children had characteristics that varied with their age and development; prescribed treatment was not the same as for adults. In particular, paediatric medicines needed to have certain features in terms of pharmacokinetics, efficacy and avoidance of undesirable effects, and required appropriate pharmaceutical formulation to ensure easy and safe administration. Many medicines given to children had not been specifically evaluated for paediatric use and therefore did not have marketing authorization for children and did not meet the quality, safety and efficacy criteria required in the case of adults. The lack of appropriate medicines for children was a global problem, making it difficult to reach some of the Millennium Development Goals related to children. Better medicines would also contribute to the rights of the child. There had so far been no comprehensive global consideration of those issues. He was satisfied with the report and supported the draft resolution.

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA60.16.

Ms IMAI (Japan) supported the draft resolution. Problems relating to medicines for children included the fact that standard dosages and administration for children had not been determined and the safety of medicines had not been established. In order to promote evidence-based prescribing, scientific information on efficacy and safety must be gathered, evaluated and disseminated to health workers. Various measures had been taken in Japan to assist industry and the medical community in promoting the clinical development of medicines for children. The outcome of such an approach would also be beneficial at the international level. The issues surrounding medicines for children represented a major challenge in both developing and developed countries. From that point of view, WHO should examine the scope of activities from a broad perspective.

Mr ZHOU Jun (China) said that the issue of medicines for children needed more attention from the drug regulatory authorities, pharmaceutical companies, service providers and society as a whole. Furthermore, significant challenges remained to achieving the Millennium Development Goals of reducing child mortality and of halting and beginning to reverse the spread of HIV/AIDS by 2015. He supported the draft resolution.

Dr SINGAY (Bhutan) noted that, whereas medicines for adults were developed regularly, children were an underserved segment of the population. There was a lack of information on, and formulation of, medicines for children. Formulations for children were currently based on adult data and extrapolation rather than actual evidence. Paediatric formulations should be tested for safety and efficacy, but they should not be developed at the cost of access to medicines; they must remain affordable. Better medicines for children were crucial to achievement of the health-related Millennium Development Goals. The draft resolution was consistent with that on "Rational use of medicines", through the provision of medicines for a specific population and the specific adaptation of tools such as treatment guidelines and information on dosage and safety aspects. He supported the draft resolution.

Ms FARSAI CHANJARUPORN (Thailand) recognized the need for better medicines for children. In the light of constraints in the areas of discovery, development and delivery, including irrational use of medicines, and with a view to widening access to paediatric formulations, collaborative strategies were needed in the health sector and the broader areas of socioeconomic development and international trade.

She endorsed the draft resolution, even though some aspects were already well integrated into existing frameworks. In Thailand, the National List of Essential Drugs had since 1981 covered medicines for children and vaccines used in the Expanded Programme on Immunization. Many mechanisms promoted the use of the List and helped to distribute paediatric formulations to populations in need. It was not necessary to separate the development of essential medicines for children, and mechanisms for ensuring access to those products, from the process relating to medicines for adults. However, areas in which medicines for children were completely neglected or which required specific expertise and knowledge might benefit from new programmes.

She drew attention to the plan of action being drafted by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. The plan's goal was to ensure access to essential medicines by removing international trade barriers. Most of the initiatives referred to in the draft resolution should be taken into account in the drafting of the plan, and she wished to insert a preambular paragraph in the draft resolution recognizing the parallel efforts of the Working Group and requesting the Director-General to ensure harmonization of all activities falling within WHO's mandate.

Considering how the TRIPS agreement and patenting systems could influence access to essential medicines for children, she proposed amending subparagraph 2(5) to read: "to collaborate with governments, other organizations of the United Nations system, donor agencies, the WTO, WIPO, nongovernmental organizations and the pharmaceutical industry in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children".

Mr ABDOO (United States of America) said that all countries needed better medicines for children. The consequences of using ineffective, unsafe or improperly dosed medication in children were often serious, and included impaired development. Innovation and related incentives must be fostered with a view to developing better medicines for children, and information was essential. There was a paucity of: data on the frequency of use of medicines in children; treatment guidelines for nearly all paediatric diseases; paediatric prescribing information; age-appropriate paediatric dosage forms and strengths; and safety information. In order to fill those substantial gaps in information, the Secretariat should help to build the capacity of medicines regulatory authorities in Member States to evaluate the safety and effectiveness of medicines and biological products in paediatric patients. In addition, Member States should ensure that their national formularies included paediatric formulations, and that their social and private insurance systems provided reimbursement for them. The Secretariat could help to build capacity of Member States, particularly developing countries, to conduct clinical trials in children, to fill gaps in scientific information, and provide evidence for regulatory agencies and health ministries. He supported the draft decision.

Ms NGAUNJE (Malawi) drew attention to the high mortality rate in children under five years of age in Africa. In Malawi, infant mortality was 76 per 1000 live births, and under-five mortality was 133 per 1000. By December 2006, almost 85 000 people had been receiving antiretroviral treatment, of which 9% were children. Because essential medicines, including antiretroviral treatment and those for opportunistic infections, were not available in dosage forms for children or in suspension, "pill-cutters" were used in order to split adult doses, but uncertainty remained concerning the effective dose of such medicines for children. She welcomed the establishment of an expert subcommittee on selection and use of essential medicines for children with the terms of reference set out in paragraph 13 of the report. She supported the draft resolution.

Mr A.P. SINGH (India) said that in India the existing guidelines for the development of paediatric medicines required clinical trials and comparative bioavailability studies of paediatric and adult medicine formulations to be performed in adults and in the appropriate paediatric age groups. The National List of Essential Medicines promoted listed medicines, many of which were also available in paediatric dosage form.

The therapeutic strategy for children living with AIDS focused on early diagnosis and initiation of antiretroviral therapy in order to prevent disease progression and reduce the development of resistant viral strains. Advances had been made in the clinical management of HIV-infected children following the introduction of antiretroviral combination therapies for children. Various new formulations had been approved for the treatment of HIV infection in children.

He thanked partners, including WHO, for the support received by the National AIDS Control Organization and referred to WHO's recommendations which provided guidance to paediatricians on prescribing antiretroviral medicines.¹

Dr ALLEN-YOUNG (Jamaica) recalled that, during the recent outbreak of malaria in Jamaica, tablets had had to be crushed in order to make a suspension for children because of the unavailability of paediatric dosage forms. Children should be perceived as individuals in their own right, with specific requirements; hence she supported the draft resolution. She commended the paediatric volumes of the British National Formulary, whose publication should enhance the focus on medicinal products and posologies for children.

Ms WISEMAN (Canada) highlighted the fact that many of the children under five years of age who died every year had died from treatable diseases. Despite the success of the WHO Essential

¹ *Antiretroviral therapy for HIV infection in infants and children: towards universal access. Recommendations for a public health approach.* Geneva, World Health Organization, 2007.

Medicines List, many medicines that were essential for children were not on the List and many that were included were not supplied in dosage forms suitable for children. A paediatric essential medicines list must be created. Educational materials must be provided to health-care workers for early diagnosis and intervention; research and development of paediatric formulations were required; regulatory registration must be supported; and the cost of medicines for children must be addressed. She strongly supported the draft resolution.

Dr NKURUNZIZA (Burundi) said that Burundi had adopted a strategy to reduce maternal and infant mortality by providing free health care for children under five years of age and free obstetric care. That had resulted in a significant increase in the number of children attending health centres and in the number of deliveries in health services. Before that, financial considerations and the absence of appropriate paediatric medicines had constituted major obstacles. She welcomed the draft resolution and thanked WHO, UNICEF and other partners for enabling free health care for children under five years of age to be introduced.

Dr HOPPU (International Pediatric Association), speaking at the invitation of the CHAIRMAN, emphasized that access to safe and reliable medicines for children worldwide was essential to newborn and child health and the achievement of the Millennium Development Goals. The Association regretted that lack of access to, and rational use of, medicines for children remained a worldwide problem – concerns shared by paediatric pharmacologists, with whom an International Alliance for Better Medicines for Children had been formed. Many children, particularly in the developing world, did not have access to safe and effective medicines, for reasons including: lack of suitable formulations for children; lack of evidence-based treatment guidelines and definitions of essential medicines for children; inadequate training of paediatricians, pharmacologists, pharmacists and other child health providers; inadequate emphasis on research; widespread use of paediatric drugs which had not been tested in children; lack of global principles to guide safe and valid clinical trials in children; inadequate regulatory capacities; and insufficient focus of the WHO Essential Medicine List and formularies on the unique requirements of children.

It was important to base decisions concerning medicines for children on evidence of disease burden at country and regional levels, and the unique physiology of childhood. He supported the draft resolution.

Speaking on behalf of the International Union of Basic and Clinical Pharmacology, he noted growing recognition of the need to give children access to appropriate medicines; the United States of America and the European Union had already implemented measures to that end. Although such measures were intended primarily to improve the public health of their respective paediatric populations, they had global consequences: about half the children involved in recent paediatric studies in the United States had been recruited in other parts of the world. The same could apply to the European Union with its new paediatric regulations. The need for better medicines for children and the burden of associated clinical trials required for their development were global, and the benefits of the trials should also become available globally.

Innovation must be fostered in order to develop new solutions and design ethical trials that demonstrated efficacy and safety. Researchers were needed to plan and perform the studies, as was the participation of children and families in the studies; regulators familiar with paediatric medicine were needed for assessing the medicines and clinical trials; and the pharmaceutical industry was needed in order to produce the medicines. He supported the draft resolution.

Dr ZUCKER (Assistant Director-General), welcoming all the comments, said that the Secretariat was working strenuously to address the issue of adult medicines having to be crushed to enable paediatric doses to be prepared.

The CHAIRMAN suggested that the Committee should resume its consideration of the agenda item once a new version of the draft resolution incorporating the proposed amendments had been issued.

It was so decided.

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

Public health, innovation, and intellectual property: progress made by the Intergovernmental Working Group: Item 12.20 of the Agenda (Document A60/27)

The CHAIRMAN drew the Committee's attention to a draft resolution proposed by the delegation of Brazil, which read:

The Sixtieth World Health Assembly,

Recalling the resolution WHA59.24 establishing an intergovernmental working group for the purpose of elaborating a draft global strategy and plan of action to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property, Innovation and Public Health, to secure, inter alia, an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

Recalling the Doha Ministerial Declaration on the TRIPS Agreement and Public Health, which confirms that the Agreement does not and should not prevent Members from taking measures to protect public health;

Concerned that 4800 million people live in developing countries (80% of the world population) and of those 2700 million live with less than US\$ 2 a day (56.25% of the world population);

Concerned that communicable diseases account for 50% of the developing countries burden of disease, and that access to medicines, vaccines and laboratory kits is hampered by prices that are beyond the reach of many in the developing world;

Concerned that noncommunicable diseases have an increasing impact on the burden of disease of developing countries;

Noting the growing criticism in developed and developing countries alike of the barriers to access posed by proprietary rights over treatment and care;

Concerned that sources of generic versions of new medicines are being limited as pharmaceutical product patents are adopted by almost all Members of WTO, and recognizing the importance of competition between manufacturers in reducing the price of medicines and other health products;

Recalling that in the Millennium Declaration, the Heads of State and Government recognized that, "in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world's people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs";

Recalling the commitment of Heads of State to the Millennium Development Goals that will be achieved only through, among other things, the availability and affordability of medicines, vaccines and laboratory kits of good quality, effective, in sufficient quantities, and in acceptable forms;

Stressing that the global strategy and plan of action should constitute an agreed framework of reference to ensure the complete and unobstructed implementation of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;

Considering that the Intergovernmental Working Group should (i) establish a research and development agenda that covers the health needs of developing countries, in accordance with the purpose of resolution WHA59.24; (ii) propose partnerships to implement such an agenda; (iii) propose an innovative mechanism to finance the activities needed to implement the

agenda; (iv) propose a governance system for such a mechanism; and (v) ensure that the health products that result from the medium-term framework, necessary for developing countries, namely medicines, vaccines, and laboratory kits, are affordable for public health or individual users, available in sufficient quantities to satisfy demand, acceptable to users, and effective and of good quality;

1. REQUESTS Member States fully and actively to support the Intergovernmental Working Group process and to provide adequate resources to WHO for this purpose;
2. REQUESTS the Director-General:
 - (1) to be proactive and provide technical and policy support to countries that intend to make use of the flexibilities contained in TRIPS in order to increase access to existing medicines and to implement the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;
 - (2) to express support for countries that make use of the flexibilities contained in TRIPS in order to increase access to medicines;
 - (3) to encourage, for discussion at the Intergovernmental Working Group, the development of proposals for research and development driven by health needs that separate the cost of research and development from the price of medicines;
 - (4) to take the lead in developing a methodology for setting priorities in essential research and development driven by health needs that specifies innovation in prevention, diagnosis and treatment for a number of priority health problems, especially those that disproportionately affect developing countries;
 - (5) to provide support for the development of proposals for the pro-health management of intellectual property through, for example, patent pools for medicines.

The DIRECTOR-GENERAL expressed her commitment to the important work of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property. Although her background as a drug regulator had ensured her understanding of the issues, since taking office she had become increasingly aware of their importance for Member States, and struck by their complexity. Following extensive technical briefings she was much better informed about the subject and what was needed.

She would participate in the Working Group's process in the following months. She needed to commit more resources, as had been advocated during the discussion of the Programme budget. She was aware of the need to supplement the Organization's expertise in some crucial areas. She sought confirmation from Member States of her understanding that the Secretariat was expected to produce, by July 2007, a working document that would form the basis of negotiations, so that regional consultations with key stakeholders could take place between July and November 2007. She would try to ensure that the second session of the Working Group allowed all Members an equal opportunity to join the debate and reach consensus.

Mr SILBERSCHMIDT (Switzerland) said that, having participated in the elaboration of resolution WHA59.24, his country remained engaged in working towards an ambitious, sustainable global strategy and plan of action.

An interministerial group had been set up that brought together the ministries responsible for economics and trade, health, research, development, human rights, foreign affairs, drug approvals and intellectual property. An achievement had been to build trust between the different players in Switzerland; overcoming lack of trust at the international level was also crucial. The interministerial group had analysed the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health and looked at what more could be done.

The revision of Swiss patent law would introduce an early working exemption in order to allow generics into the market and a broad exemption on research. Switzerland was about to implement the flexibilities to the TRIPS agreement allowing it to export medicines, under compulsory licenses to

countries without adequate production facilities. In WTO, it was proposing to waive tariffs for pharmaceutical products.

He concurred with the Director-General's understanding that the Working Group had mandated the Secretariat to produce a draft global strategy and draft plan of action by July 2007, which should be a negotiable text. The texts would take into account comments and suggestions by Member States. The draft texts would be the subject of national, subregional or regional consultations at the technical level, and discussed in all the WHO regional committees, before becoming the basis for negotiations at the second session of the Working Group in November 2007. Some regions would need support in order for those consultations to take place. Member States would need the "spirit of Geneva" if they were to achieve consensus and a meaningful plan of action. Switzerland would provide support for the process, including financial support, to regions in need.

Mr SCHRÖER (Germany), speaking on behalf of the European Union, said that he welcomed the Director-General's commitment to that complex issue. He confirmed the Director-General's understanding of the Intergovernmental Working Group process, and summarized developments within the European Union since the 120th session of the Executive Board. In February 2007, the European Union had submitted written comments on the draft action plan to the secretariat of the Working Group. On 2 April 2007, the European Commission had organized an expert workshop on "Public Health, Innovation and Intellectual Property Rights: European Union input to the global debate", which had focused on three issues: how to improve access to medicines for neglected diseases; how research and development could be improved to prevent and treat neglected diseases; and what mechanisms were needed in order to support research and development. The workshop had concluded that there was unlikely to be a "one-size-fits-all" solution and that existing approaches should be developed, taking into account issues specific to certain countries and diseases. The workshop had recognized a need to provide additional support in order to promote research and development into neglected diseases, often viewed as unprofitable by commercial investors and for which affected countries lacked infrastructure and capacity. Existing initiatives should be scaled up, especially public-private partnerships, such as the Drugs for Neglected Diseases initiative, the European and Developing Countries Clinical Trials Partnership Programme, and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. Research and development relied strongly on industry and vice versa. WHO should be closely involved in the clinical stages of development and in arrangements for the marketing of prioritized medicines. Civil society organizations should also play an important role, for instance by sharing their analyses.

Regarding improved access to medicines, the plan of action should clearly reflect the recommendations contained in the report of the Commission on Intellectual Property Rights, Innovation and Public Health. Creating and expanding pharmaceutical production facilities in least developed countries was a promising option, where economically and legally feasible. The pharmaceutical industry should contribute to improved access by applying tiered pricing schemas when marketing medicines in developing countries.

WHO should play a major role, alongside other international organizations such as WIPO and WTO, in improving access to research data and promoting innovation; it should assess and monitor, from a public health perspective, the impact of intellectual property rights and other factors on the development of new products and access to medicines and other health-care products in developing countries; and it should issue health research and development reports that identified needs related to pharmaceuticals.

During the 120th session of the Board, the European Union had drawn attention to the need for documents from the Working Group on the eight proposed elements in the plan of action. Those documents, including one matrix on ongoing activities and current gaps and another on current proposals (referring to stakeholders and the financial implications), should be received before August 2007 so that Member States could prepare for regional consultations.

Mr BENTO ALCÁZAR (Brazil) welcomed the Director-General's reassurance. He recalled that, despite the "spirit of Geneva", at the conclusion of the first session of the Intergovernmental Working Group in December 2006, the process had lacked sense and direction. Given the lack of any criteria to guide the Secretariat in formulating a draft text, he suggested giving the Director-General a mandate to produce a text that could serve as a basis for negotiations. The draft resolution proposed by his delegation was intended to provide the sense and direction. He did not expect a substantive discussion at that juncture and was aware that many countries had different views, but the text of the draft resolution should help progress. He briefly explained its contents.

The first preambular paragraph referred to resolution WHA59.24, which spelt out the mandate of the Working Group. The ensuing preambular paragraphs concerned the general situation. He highlighted the passage in the Millennium Declaration in which the Heads of State and Government recognized their "collective responsibility to uphold the principles of human dignity, equality and equity at the global level"; that was a crucial responsibility for WHO.

The last preambular paragraph concerned the sense and direction of the Working Group. All five elements were open to discussion. The first four concerned a research and development agenda covering the health needs of developing countries; partnerships to implement such an agenda; innovative mechanisms to finance the activities; and a governance system for those mechanisms. The fifth element referred to the very purpose of the strategy and plan of action, namely, to ensure that the resulting health products (i.e. medicines, vaccines and laboratory kits) were affordable, available in sufficient quantities, acceptable to users, effective and of good quality. The centre of gravity of the draft resolution was the request to the Director-General set out in five operative subparagraphs.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the countries in the Eastern Mediterranean Region, said that the issues of innovation and intellectual property rights in public health were multidimensional, especially in the context of developing countries. Some concerned the harmonization of intellectual property regimes required by the TRIPS agreement, while others focused on minimum levels of investment in research and development for medicine. The two aspects were linked and raised the question of why increased protection for intellectual property rights had not persuaded pharmaceutical companies to invest in medicines needed for neglected diseases in developing countries. The answer lay in the inherent difficulties of market-driven mechanisms in responding to public health needs, which the international community must face.

The lack of research and development for medicines perceived as insufficiently profitable by investors raised the issue of the role of the State in overcoming such a deficiency. Innovative solutions were required, as was a shift in patent protection in the context of developing countries. The report of the Commission on Intellectual Property Rights, Innovation and Public Health contained more than 60 recommendations and the Fifty-ninth World Health Assembly had established a Working Group to develop a global strategy and plan of action. However, its first session, in December 2006, had resulted in little progress in terms of action; it had given the impression that innovation beyond the recommendations of the Commission's report would be difficult. Major issues included how research and development could be enhanced if intellectual property rights incentives failed to work; the search for alternatives; research and development capacity building; the transfer of technology; and the delivery of medicines on the basis of needs rather than ability to pay. In addition there were questions concerning the use of flexibilities in the TRIPS agreement in order to increase access to patent-protected medicines.

He urged WHO to strengthen the process by strong leadership and commitment. His Region firmly supported the process but all options should be examined, including such ideas as a research and development treaty, patent pools and innovative public-private partnerships. The Regional Office for the Eastern Mediterranean would convene a consultation in Cairo in August 2007 in order to expand regional input into the process.

Dr OKEYO (Kenya), welcoming the Director-General's commitment, said that the Working Group session in December 2006 had given the Secretariat a clear mandate to prepare the first draft of the global strategy and plan of action. One problem area was building trust among the players

concerned. The issues were complex and of major concern to African countries. Nearly five million children died every year from preventable diseases and nearly one quarter of a million women died from diseases for which simple, cost-effective treatment existed. Some people received no treatment because of the lack of research and development. For Africa, therefore, it was a very important process.

He welcomed the Director-General's remarks on funding. The African Region, which was supposed to play a key role in the process, had not held a consultative meeting, whereas the European Region had held more than four. The Director-General should help the African Region to discuss the issues among themselves and inform the process. Indeed, in some ways, the process was more important than the final product. If the process was not representative or did not build the necessary trust and confidence among the players, it would not work, whatever the outcome. At the first session of the Working Group, none of the experts appointed had been from Africa. In the interests of transparency and confidence in the outcome, there must be adequate representation of the region most affected.

The Working Group's process needed to be accelerated and he looked forward to collaboration by all key players.

Mr WATERBERG (Suriname), speaking on behalf of the member countries of the Caribbean Community, said that in establishing the Working Group WHO had shown its concern that developing countries remained largely excluded from the benefits of modern science and technology. He reaffirmed support for resolution WHA59.24 and welcomed the inclusion of health products in the WHO Model List of Essential Medicines, regardless of patent status, and the reference to medical devices and disposables for the treatment of noncommunicable diseases. However, the translation of TRIPS flexibilities into national law was a first step for many Caribbean countries, though Suriname lacked expertise in that very specialized area. He recalled that the 47th Directing Council of PAHO had urged Member States to "study the possibility to adapt, as needed, national laws to take full advantage of the flexibilities foreseen in the TRIPS agreement".¹ However, the burden of successful use of those flexibilities remained great for the economies of small countries; their limited human and financial resources made special treatment necessary, and WHO's support in that regard was needed. At global and regional levels, WHO should negotiate with organizations such as WTO to ensure that international public health was given prominence in trade policies. Innovation could not rely entirely on patent rights and free market forces. WHO and governments should become more involved. New mechanisms and sources of funding would sustain research and development and improve access.

He awaited the practical recommendations and action plan of the Working Group. Time would be needed for building capacity and human resources for innovation – matters of concern to small countries. He supported the draft resolution proposed by Brazil, with the following amendments: in the first preambular paragraph, the word "diseases" should be replaced by "health problems"; in the ninth preambular paragraph, recalling the commitment of Heads of State, the word "access" should be inserted after "the availability"; in the tenth preambular paragraph beginning "Stressing that the global strategy...", the words "the complete and" should be deleted; and in the final preambular paragraph a sixth action should be inserted, worded: "(vi) hold broad consultations within each regional setting in order to ensure coverage of the health needs of developing countries for the development of the global strategy and plan of action". In paragraph 2(2), the words "to express support for countries" should be amended to read "to support countries".

Ms DE HOZ (Argentina) commended the importance attached by the Director-General to the subject under consideration. The approaches contained in the report were appropriate and she supported the strategy. WTO's rules made it possible to impose limits on patent holders for reasons of public health under Article 5.2 of the Paris Convention for the Protection of Industrial Property,

¹ Resolution CD47.R7.

Article XX of the 1947 General Agreement on Tariffs and Trade, Articles 8, 27, 3, 30 and 31 of the TRIPS agreement and the Doha Declaration on the TRIPS Agreement and Public Health. More efficient use should be made of prevailing international rules concerning intellectual property, without amending the TRIPS agreement. Argentina shared the concerns expressed in the report regarding the intentions of developed countries to incorporate additional protective measures that could reduce access to medicines in developing countries. In that connection, Argentina had refrained from including provisions on intellectual property in agreements under negotiation, such as that between MERCOSUR and the European Union and, in the context of WTO, did not agree to the inclusion of protective measures over and above the TRIPS agreement. The Region of the Americas was committed to the Doha Declaration, and especially the decision of the WTO General Council of 30 August 2003 on the regulation of paragraph 6 of the Declaration, referring to the issuing of compulsory licences and the use of parallel import mechanisms. Regional dialogue on patent protection activities, access to medicines and the exchange of experiences had all been emphasized.

She supported the draft resolution presented by Brazil but proposed two amendments. In the last preambular paragraph, the wording of the phrase referring to the fourth action should be amended to read “consider the desirability of establishing a governance system for this mechanism”. At the end of paragraph 2(1), the following phrase should be added: “in particular the decision of 30 August 2003 of the WTO General Council on the application of paragraph 6 of that Declaration”.

Ms LANTERI (Monaco), rising to a point of order, said that as the draft resolution had been tabled only the previous morning it was too early, under Rule 52 of the Rules of Procedure of the World Health Assembly, to discuss any amendments to the text of the draft resolution.

The CHAIRMAN confirmed the correctness of the previous speaker’s remark, but pointed out that no discussion or negotiation had yet taken place.

Mr A.P. SINGH (India) said that the Member States of the South-East Asia Region, on whose behalf he was speaking, had adopted a regional resolution pledging their support for the Working Group. They had held two regional consultations on the complex and interrelated subjects of public health, intellectual property rights, innovation and access. Despite their varying nature, size, levels of development and capacity in terms of pharmaceutical and vaccine research and development, Members in the Region were working in a spirit of cooperation. Their joint submission provided input for the first session of the Working Group, in which they had stressed collaboration, access to technology, and the need for radical thinking on access. New ideas would be required in order to finance research and development, such as patent pools or funded research and development for neglected diseases. Such new ideas would enhance the current systems, and the Working Group should explore them seriously. It was crucial to maintain the momentum and to keep to the timelines. The Region supported the draft resolution proposed by the delegate of Brazil.

Ms WISEMAN (Canada) appreciated the Director-General’s commitment. Canada was committed to the Working Group, and did not underestimate the challenge of reaching agreement on the discovery of new medicines, the development of safe and effective products, and providing access to those in need of them. All Member States must prepare for the next session of the Working Group in November. Although she appreciated the importance that the delegate of Brazil attached to the questions put forward in his draft resolution, many of them would undoubtedly enter into the deliberations of the Working Group and she did not wish to see the Health Assembly pre-empting its work.

Mr HOHMAN (United States of America) supported previous commendations of the Director-General’s commitment to the Working Group. Disappointment over the outcome of the first session of the Working Group was understandable, but an intergovernmental process always started slowly and struggled to build momentum. It was important to have strong support from the Secretariat in order to provide Members with a base for their work. Delegates, in their statements, should drive

home the message about the importance of the process, and continue giving the Director-General and her team their views on how to move it forward. They had done so at the 120th session of the Executive Board, the current Health Assembly, regional meetings and other intersessional events; and the Director-General had clearly taken those views into account. He was looking forward to seeing how they would be reflected in the document that the Secretariat was preparing to circulate in July 2007, and put a great deal of faith in its ability to serve as an effective and useful negotiating document.

Ms COPA ROMERO (Bolivia) thanked the Director-General for her words on intellectual property, a subject that affected the most vulnerable sectors of Bolivian society. Intellectual property rights must no longer hamper access of the populations of developing countries to health care, and new ways must be found to support innovation. To that end, her country would take an active part in the Working Group. In February, her delegation had put forward proposals calling, *inter alia*, for investigation into the collective management of intellectual property rights through procedures such as jointly held patents, and examination of the benefits of changing private incentives for research and development so that they were no longer linked to the price of medicines. She endorsed the draft resolution proposed by the delegation of Brazil.

The CHAIRMAN, recalling his experience with a working group set up to improve the working methods of the Executive Board and Health Assembly, said that shaping the intergovernmental process was a task not just for the Secretariat but for the whole community of Member States. It must come to a satisfactory and timely conclusion and must lose neither its momentum nor its spirit.

Dr ALLEN-YOUNG (Jamaica) said that she shared the concerns of developing countries over the still unresolved matter of intellectual property rights and medicines. The intergovernmental process must progress towards a global strategy that would include capacity building for small countries, whose slowness in introducing legislation and in grasping the subtleties of the TRIPS agreement had prevented them from taking measures to protect public health and to secure access to medicines. She looked forward to an effective and timely conclusion to the matter.

Following a procedural discussion involving Mr BENTO ALCÁZAR (Brazil), Mr HOHMAN (United States of America), Ms KONGSVIK (Norway) and Mr BURCI (Legal Counsel), the CHAIRMAN suggested that an informal meeting should be held the next day to enable delegates to discuss ideas on the draft resolution.

It was so agreed.

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

The meeting rose at 17:40.

SIXTH MEETING

Monday, 21 May 2007, at 10:10

Chairman: Mr T. ZELTNER (Switzerland)

later: Dr A.A. YOOSUF (Maldives)

1. SECOND REPORT OF COMMITTEE B (Document A60/57)

Mr BIN AL-FAKHERI (Saudi Arabia), Rapporteur, read out the draft second report of Committee B.

The report was adopted.¹

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

Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group: Item 12.20 of the Agenda (Document A60/27) (continued from the fifth meeting)

The CHAIRMAN drew attention to the following draft resolution, proposed and revised by the delegate of Brazil following informal consultations:

The Sixtieth World Health Assembly,

Recalling the resolution WHA59.24, ~~establishing an intergovernmental working group for~~ **through which the IGWG was created with** the purpose of elaborating a draft global strategy and plan of action to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property, Innovation and Public Health, to secure, inter alia, an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

Recalling the Doha ~~Ministerial Declaration on the TRIPS Agreement and Public Health,~~ which ~~confirms~~ **stresses** that “the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health”;

Concerned that ~~4800 million people live in developing countries~~ **2,7 billion (56.25%) of the 4,8 billion** (80% of the world population) **people living in developing countries live on** ~~and of those 2700 million live with~~ less than US\$ 2 a day ~~(56.25% of the world population)~~;

Concerned that communicable diseases account for **approximately** 50% of the developing countries burden of disease; and that access to medicines, vaccines and ~~laboratory kits~~ **diagnostic tools** is hampered by prices that are beyond the reach of many in the developing world;

¹ See page 313.

Concerned that noncommunicable diseases have an increasing impact on the burden of disease of developing countries;

Noting ~~the~~ **that** growing criticism **has been registered**, in developed and developing countries alike, **on** ~~of~~ the barriers ~~to access~~ posed by proprietary rights over **access to** treatment and care;

Concerned that sources of generic versions of new medicines are being limited as pharmaceutical product patents are adopted by almost all ~~Members of~~ **WTO Members**, and recognizing the importance of competition between manufacturers in reducing the price of medicines and other health products;

Recalling that ~~in~~ **according to** the Millennium Declaration, the Heads of State ~~and Government~~ recognized that, “in addition to our separate responsibilities to our individual societies, we have a collective responsibility to uphold the principles of human dignity, equality and equity at the global level. As leaders we have a duty therefore to all the world’s people, especially the most vulnerable and, in particular, the children of the world, to whom the future belongs”;

Recalling the commitment of ~~the~~ **the** Heads of State ~~to~~ **with** the Millennium Development Goals ~~that will only be achieved only through~~, among other things, **with** the availability, **accessibility** and affordability of medicines, vaccines and **diagnostic tools** ~~laboratory kits of good quality, effective~~, in sufficient quantities, **of good and efficient quality** and in acceptable forms;

Stressing that the global strategy and plan of action ~~should~~ **shall** constitute an agreed framework of reference to ensure ~~the complete and~~ unobstructed implementation of the **TRIPS** flexibilities ~~contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;~~

Considering that the Intergovernmental Working Group should (i) establish a research and development agenda that covers the health needs of developing countries, in accordance with the purpose of resolution WHA59.24; (ii) propose partnerships to ~~implement such~~ **carry on the above R&D** ~~an~~ agenda; (iii) propose ~~an~~ innovative ~~mechanisms~~ **financial with a view to** finance the activities ~~needed to implement the~~ **that result from the R&D** agenda; (iv) propose a governance system for ~~such a~~ **the innovative financial** mechanism; ~~and~~ (v) ensure that the health products that result from the medium-term framework, necessary for developing countries, ~~namely - medicines, vaccines, and diagnostic tools laboratory kits, - are~~ **shall be** affordable for public health or individual users; **shall be** available in sufficient quantities to satisfy demand; **shall be** acceptable to users; ~~and~~ **shall be effective efficient** and of good quality **and shall be acceptable**; ~~effective and of good quality~~; (vi) **hold broad consultation within the different regional settings in order to ensure coverage of the health needs of developing countries**;

Welcoming, with enthusiasm, the commitment of the Director-General to the process spearheaded by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property;

EXPRESSES appreciation to the Director-General for her commitment and encourages her to guide the process to draw up a global strategy and plan of action that will provide a medium-term framework for needs-driven essential health research and development;

1. ~~REQUESTS~~ **URGES** Member States **to** fully and actively ~~to~~ support the Intergovernmental Working Group process and ~~to~~ provide adequate resources to WHO ~~for this purpose~~;

2. REQUESTS the Director-General:
- (1) to ~~be proactive and~~ provide technical and policy ~~support~~ **assistance** to countries that ~~intend~~ **want** to make use of the **TRIPS** flexibilities ~~contained in TRIPS in order~~ to increase access to ~~existing~~ **medicines, vaccines, diagnostic tools and other health-care products in** and to implementing the Doha ~~Ministerial Declaration on the TRIPS Agreement and Public Health;~~
 - (2) to ~~express~~ **provide technical and financial** support for ~~countries that make use of the flexibilities contained in TRIPS in order to increase access to medicines~~ **regional consultative meetings in order to set regional priorities that will inform the work of IGWG;**
 - (3) to encourage, ~~for discussion at the Intergovernmental Working Group, the development of proposals for research and development driven by a health needs that separate the cost of research and development from the price of medicines~~ **-driven R&D system for discussion at the IGWG that separates paying for the cost of R&D from the price of medicines, vaccines, diagnostic tools and other health-care products.**
 - (4) ~~to take the lead in developing a methodology for setting priorities in essential research and development driven by health needs that specifies innovation in prevention, diagnosis and treatment for a number of priority health problems, especially those that disproportionately affect developing countries;~~
 - (5) ~~to provide support for the development of proposals for the pro-health management of intellectual property through, for example, patent pools for medicines.~~

The financial and administrative implications of the draft resolution were:

1. Resolution Public health, innovation, and intellectual property	
2. Linkage to programme budget	
Area of work:	Expected results
Essential medicines	1. Implementation and monitoring of medicines policies based on the concept of essential medicines, monitoring the impact of trade agreements on access to quality essential medicines, and building capacity in the pharmaceutical sector all advocated and supported.
Communicable disease research	2. New and improved tools, including drugs, vaccines and diagnostic tools, devised for prevention and control of infectious diseases. 5. Partnerships established and adequate support provided for strengthening capacity for research, product development and application in disease-endemic countries.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution builds on resolution WHA59.24 and is consistent with the above-mentioned areas of work and expected results. Additional work resulting from this resolution is consistent with the expected results proposed under strategic objectives 1, 2, and 11 in the Medium-term strategic plan 2008–2013.	

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\$ 950 000 over three years to cover both the remainder of the biennium 2006–2007 and the biennium 2008–2009 (US\$ 450 000 for staff costs and US\$ 500 000 for operational costs, including coordination, technical assistance and activities).

(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities) US\$ 220 000**(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? None.****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)**

Headquarters and all regional offices will be involved. Normative, technical and coordinating work will largely be performed at headquarters.

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

In order proactively to provide technical and policy support to countries, one additional full-time professional staff member with technical expertise in public health and the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) will be required at headquarters.

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

Some of the proposed actions are currently being implemented; implementation of the other actions will be initiated during the present biennium. The implementation of the resolution will be part of the programmatic work in the areas of work mentioned above, and will therefore be subject to the same periodic evaluation as WHO's other activities in these areas. Proposed actions to be undertaken in the biennium 2008–2009 will be subsumed under the relevant strategic objectives, and monitored and assessed in accordance with the Organization's accountability framework.

Ms IMAI (Japan) said that developing new medicines and enhancing access to medicines for diseases that disproportionately affected developing countries were global challenges. Japan was contributing to the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Technical cooperation was being provided in the public and private sectors through training courses and by deploying experts in the areas of medicines, vaccines and intellectual property. Her Government supported the views expressed by the delegates of Canada and the United States of America and would participate actively in the discussions of the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property, whose outcome should not be prejudged by the Health Assembly.

Dr OGWELL (Kenya), speaking on behalf of the 46 Member States of the African Region, said that the global strategy and plan of action could be expected to secure a sustainable basis for essential health research and development, especially for diseases that disproportionately affected the poor, together with objectives, priorities and funding estimates.

At its first session in December 2006, the Working Group had considered a draft plan of action. The document due to be prepared later in 2007 on the basis of that discussion and Member States' submissions would be the subject of regional consultations before the second session of the Working Group in November 2007, but that session might not be sufficient to achieve consensus. Since no

structured consultations had been held so far in the African Region, he urged the Secretariat to facilitate regional consultations before the annual sessions of the regional committees. He stated that all Member States of the African Region endorsed the submission made by Kenya to the Working Group. In addition, the Secretariat should make the draft plan and other reference documents available in all six working languages as soon as possible, and secure resources so that, should negotiations not be completed at the second session of the Working Group, a follow-up session could be held in early 2008 before submission of the report to the Sixty-first World Health Assembly.

He supported the proposed draft resolution with the following amendments: the insertion in the eleventh preambular paragraph, subparagraph (iii), of the word “mechanisms” after the word “financial”; and the inclusion of a new subparagraph 2(5) to read: “to provide technical and financial support to the Intergovernmental Working Group and ensure that it completes its tasks in time for the report to the Sixty-first World Health Assembly”.

The CHAIRMAN said that amendments to the revised draft resolution would be considered later.

Dr ZAVARZINA (Russian Federation) said that in recent years the Russian Federation had emphasized the introduction of new health-care technologies, through innovation and a focus on the relationship between treatment, diagnostic technologies, and the production of pharmaceuticals. Application of research findings had been facilitated by the strengthened links between business and the development of new technologies. The national focus on innovation and intellectual property had coincided with WHO’s strategic directions. Exchange and coordination with WHO should be enhanced through a permanent forum, bringing together representatives of academic circles, pharmaceutical, biotechnological and other technological organizations, medical research councils, private and public partners, and civil society organizations.

The Russian Federation supported the Working Group’s draft plan of action in eight priority areas, and would participate in the consultation process for the elaboration of documents in the area of intellectual property.

Ms VIELMA (Bolivarian Republic of Venezuela), referring to the first session of the Working Group, endorsed the view expressed by Member States that transfer of technology and management of intellectual property should be highlighted and added as separate elements to the draft action plan.

Turning to the annex to the report, she drew attention to paragraph 6, which seemed to encourage an approach that would foster an individualistic, rather than collective, culture in developing countries based on protectionist patenting policies. Such a practice produced few benefits for public health in developing countries; only solidarity, cooperation and joint efforts could help them to benefit from and apply research. With regard to the principle that countries should provide in their legislation powers to use flexibilities allowed under the TRIPS agreement, such powers might be useful in promoting research relevant to the health problems of developing countries, but it was unclear how public health would take precedence over intellectual property and patents.

Referring to paragraph 10 of the annex to the report, she suggested that the word “innovative” should be deleted. In paragraph 11, the word “licensing” should also be deleted. Throughout paragraph 12, the phrase “public–private partnerships” should be replaced by “partnerships between the various funding sectors” and in the sentence beginning with “the pharmaceutical industry” the phrase “as a proportion of their earnings” should be inserted after the word “activities”. In paragraph 14, the words “advance-purchase” should be replaced by “procurement with replenishment of the investment”, the word “essential” should be inserted before “medicines”, and the phrase “which are considered to have a major impact on public health” should be added.

Intellectual property rights must not hinder access to medicines or policies aimed at protecting public health through development, research and public sector investment.

Mr WU Peixin (China), welcoming the plan, said that China would continue to lend its support to regional negotiations. His Government agreed on the areas for early implementation. The recommendations formulated should take into account the public health requirements of developing countries. WHO should prioritize existing recommendations, enhance coordination of health research, set up long-term financial mechanisms for supporting innovation, undertake priority research on major diseases in developing countries and build up the latter's own research capacity. Innovation and intellectual property must be protected and encouraged, while public health requirements must also be respected, so as to achieve an appropriate balance.

Dr SADRIZADEH (Islamic Republic of Iran) said that at the second session of the Working Group his country would continue to advocate promoting public health by making intellectual property rules more flexible, rather than the inverse. That was why discussions were taking place under the auspices of WHO. He supported the draft resolution as amended.

Mr PHAM HONG NGA (Viet Nam) observed that Member States remained divided over whether intellectual property rights had an impact on public health, perhaps for want of evidence, particularly with regard to access to medicines. The Working Group should consider including further, more concrete studies in that field. It was important to reach agreement on WHO's role. He supported the view that WHO was the only international organization with a specific health perspective. WTO had been established to deal mainly with trade issues, and WIPO to concentrate on intellectual property rights; however, WHO was the most relevant agency to bring all three areas together for discussion in a global forum such as the Health Assembly, using Member States' expertise in all three fields. WHO should find ways to help developing countries regulate the prices of health services and of patented and generic medicines.

Dr PONGSADHORN POKPERMDEE (Thailand) said that intellectual property protection was important in encouraging research and development for medicine and technology. However, it was vital to ensure access to essential medicines and health technologies at affordable prices, particularly for developing countries. He welcomed the Director-General's commitment to the Working Group process and supported the draft resolution. It was important to speed up the work of the Working Group.

Dr BALE (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the opportunity for Member States and others, through the Working Group, to elaborate and enhance constructive measures to promote research and development into diseases, particularly those affecting developing countries. The Working Group should base its work on accurate and up-to-date knowledge. There were at least 17 drugs and two vaccines in development for tuberculosis, a research and development laboratory in Bangalore, India, entirely dedicated to innovative tuberculosis drug research, 740 ongoing clinical trials for tuberculosis drugs and vaccines worldwide, and 43 drugs and vaccines in development for neglected tropical diseases; those activities were being carried out by companies alone or in public-private partnerships. WHO needed to ensure that the framework paper being prepared for the Working Group included information on what was already being done and what needed to be done, to prevent the Working Group from making serious mistakes in its policy recommendations. The successful work of the public-private partnerships could perhaps be translated into measures that would encourage them to do more. His industry was committed to contributing to the work of WHO and the Working Group in support of fact-based policy.

Mr BALASUBRAMANIAM (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, spoke on behalf of his, and other organizations, including Knowledge Ecology International, Health Action International and the *Médecins sans Frontières* Campaign for Access to Essential Medicines. The Working Group had been asked to implement the recommendations of the Commission on Intellectual Property Rights, Innovation and Public Health, including the need to protect access in order to obtain affordable products. He supported Brazil's proposals for research and

development that separated paying for the cost of research and development from the price of medicines.

A *Médecins sans Frontières* symposium held in January 2007 had endorsed the idea of a research and development treaty for sustainable sources of financing for research and development for diseases such as tuberculosis. Participants had suggested that the Working Group should develop proposals for de-linking incentives from drug prices in order to reward the impact of inventions according to health-care outcomes. Knowledge Ecology International had proposed taking some of the budget of the Global Fund to Fight AIDS, Tuberculosis and Malaria for drug purchases in order to create a prize fund that would reward developers of second-generation drugs in return for licensing their inventions to a patent pool that would facilitate generic competition for products.

The Working Group should encourage public submissions on matters of substance and procedures. A group of nongovernmental organizations had set up collaborative brainstorming on new paradigms and provided technical support to country delegations.

Dr ZUCKER (Assistant Director-General) agreed that the issue was complex and challenging; however, all Member States wanted better public health, which was central to ensuring a positive outcome to the discussions. WHO would provide all documentation relating to a global strategy and plan of action, as well as background documents; the concerns raised and the comments made would be addressed as soon as possible. The Organization would continue to work with WIPO and WTO, bearing in mind that there was no “one-size-fits-all” answer, and that capacity building would need to be specific to countries’ needs. The eight elements in the draft action plan would be dealt with fully. Intersessional meetings would begin in the coming months and, once Member States had received the documents, they would have a starting point for their discussions. Regional activities would be convened in parallel with the intersessional meetings. WHO would hold regional consultations in preparation for its regional committee sessions, especially in the African Region, which had grave concerns on the issue. He acknowledged the need to expand the pool of experts, ensuring balanced representation in terms of region and gender, and of developing and developed countries; and the Secretariat would work with all Member States on that issue.

He thanked the Brazilian delegation in particular and all the Member States for their passionate approach, acknowledging the need to move forward on the issue.

The CHAIRMAN opened discussion on the revised draft resolution.

Mr BENTO ALCÁZAR (Brazil) explained that there had been an informal meeting on the draft resolution proposed by his delegation. Many amendments had been introduced to improve the English of the original draft. Two new paragraphs had been added to the end of the preambular part. All amendments were highlighted in bold type.

Ms DE HOZ (Argentina) supported the draft resolution as amended, indicating that progress had been made and welcoming the reference to the Director-General’s commitment to the process. She suggested two amendments: in the eleventh preambular paragraph, section (iv), the word “propose” should be replaced by the phrase “consider the value of establishing”; and in paragraph 2(1), the phrase “in particular the decision of 30 August 2003 of the WTO General Council, on the application of paragraph 6 of that Declaration” [original Spanish] should be added after the words “... implementing the Doha Declaration on TRIPS and Public Health”.

Ms BLACKWOOD (United States of America) noted that the informal group was moving in the right direction. She acknowledged that the proposed amendments to the draft resolution aimed to tighten up the text and emphasized respect for the Working Group process.

Mr SCHRÖER (Germany), speaking on behalf of the 27 Member States of the European Union, expressed the European Union’s unconditional commitment to the Working Group, which had the technical expertise to ensure a positive and balanced outcome. He agreed with the delegate of the United States of America, but was unsure about some of the proposed amendments, which seemed to

be more than just improvements to the English. He envisaged a process-oriented resolution endorsing the personal commitment of the Director-General, but it would be necessary to consider the draft resolution carefully to achieve that. He asked the Chairman to clarify how discussion on the draft resolution might proceed.

Ms COPA ROMERO (Bolivia) supported the draft resolution. Her Government considered the issue a priority, and Bolivia had made an important contribution to the Working Group in preparing a global strategy and plan of action. She expressed satisfaction at the commitment of the Director-General which would be manifested in how WHO directed the activities of the Working Group.

Mr SANTA CRUZ (Chile), noting that in the sixth preambular paragraph the term “proprietary rights” in English had been translated into Spanish using the word for patents, asked for the Spanish text to be brought into line with the English.

In paragraph 2, the phrase “and other international agreements” should be added after the words “... the Doha Ministerial Declaration on TRIPS and Public Health”, because the technical assistance provided by WHO with regard to flexibilities related not only to the TRIPS agreement but also to other multilateral or bilateral international agreements. In the same paragraph, in the fourth line of the English version, he proposed that the word “in” should be replaced with “and”.

Mr BEYER (Switzerland) fully supported the Working Group process and looked forward to contributing to the negotiations on a global strategy and action plan in November 2007. He supported the comments made by the delegate of Germany on behalf of the European Union, and by the delegate of the United States of America, on the draft resolution; however, with only five months until the second session of the Working Group, he saw no need for a further resolution. Resolution WHA59.24 gave a clear mandate and a defined process. He welcomed the Director-General’s commitment to the process and was confident that the Secretariat would provide a comprehensive draft in July 2007 as the basis for the discussions the following November. The draft resolution pre-empted the ongoing process in the Working Group, because it addressed substantive points that would have to be discussed in the Working Group. Any draft resolution at the current time should focus on the ongoing process, in order not to prejudge the work of the Working Group in November. Changes to the original draft resolution went in the right direction but further substantial amendments were still necessary.

Dr RODRÍGUEZ (Ecuador) expressed his country’s support for the draft resolution, especially the part dealing with patents and quality control. Mechanisms were needed to enable laboratories to certify the quality of medicines. Countries also needed to be able to prevent contraband medicines from being marketed or sold in pharmacies, and public establishments needed to be able to control the quality of the large quantities of generic medicines they bought. He urged the Director-General to support the improvement of quality-control mechanisms, so as to enhance drug safety and efficacy.

Ms WISEMAN (Canada) expressed her appreciation of the work done at the informal meeting. However, the draft resolution should focus on advancing the Working Group process and not pre-empt the work it had been set up to do. Canada would propose some amendments to the text in order, for example, to ensure recognition of relevant international organizations and avoid a narrowing of the focus of the Intergovernmental Working Group’s work. There was currently an excessive focus on pricing, whereas it was widely accepted that broader factors affected people’s access to medicines.

The CHAIRMAN said that, in view of the number of amendments proposed, it was clearly desirable to set up a drafting group open to all Member States. He suggested that it should be chaired by Dr Shangula (Namibia).

It was so decided.

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

Health technologies: Item 12.19 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R21, A60/26 and A60/26 Add.1)

Dr SADASIVAN (representative of the Executive Board) said that a report and a draft resolution prepared by the Secretariat had been considered by the Executive Board at its 120th session. The Board had identified three areas of concern with regard to the draft resolution. The first had been met by deletion of the word “essential” from the title. The Board had considered that further work was needed to resolve the other two areas, namely, the scope and the listing of health technologies. It had requested the Secretariat to amend its report and remove any references to those concerns, to consult with experts nominated by Member States, regarding such issues, and to place the subject on the agenda of the forthcoming session of the Board. The Board had adopted a resolution for consideration by the Health Assembly urging Member States, *inter alia*, to draw up national guidelines and plans for the assessment, procurement and management of health technologies and asking the Director-General to support Member States as necessary in the prioritization, selection and use of health technologies. The Board recommended that the Health Assembly should adopt the draft resolution contained in resolution EB120.R21.

Mr SALEHI (Afghanistan), speaking on behalf of the countries of the Eastern Mediterranean Region, said that inappropriate investments led to the wastage of already meagre resources, while the improper selection, management and use of such technologies increased the cost of health care. Proper management of health technologies was essential. Indeed, despite the enormous sums of money spent, most Member States did not regard such management as an integral part of public health policy. In developing countries, a high proportion of medical technology did not meet local needs or was used ineffectively. Inadequate data made actual use at all levels difficult to assess. Many countries lacked national policies and regulations, experienced inequitable access, unavailability or irrational use, had no systems to monitor quality and safety, and were affected by poor management and maintenance.

The Regional Office for the Eastern Mediterranean had promoted the use of appropriate and essential technologies, *inter alia*, by adapting a global action plan on the management, maintenance and repair of medical equipment, and by issuing a series of guidelines on health-care technology management. In 2006, the Regional Committee had adopted a resolution on medical devices,¹ which had called on Member States to collect information, develop national plans and establish regional centres of excellence for assessment, selection and management of such devices.

It was most important to contain burgeoning costs by establishing priorities. The proposed resolution was commendable; however, its implementation was a matter of concern. Regional strategies were needed in order to contain cost inflation and inefficiencies in health technology assessment and management. In addition, the Secretariat should help Member States to determine the technologies needed at each level of health care, to promote centres of excellence and the sharing of experience, and to develop guidelines.

He requested the Secretariat to help countries to develop national programmes and implement policies. It should provide guidance on essential health technologies at the various levels of health-care delivery; make available the necessary tools to enable Member States to assess the feasibility and appropriateness of technologies; develop a method for the assessment of needs and the selection, acquisition and management of health technologies; provide technical support to countries in the Region for determining the types of technology needed at each health-care level or setting; and

¹ Resolution EM/RC53/R7.

define the criteria for centres of excellence in health technology. Such centres would also deal with the quality and maintenance of equipment and capacity building.

Sound regional strategies on health technologies should cover all areas of concern discussed by the Board and include the recommendations of a meeting of experts from interested Member States. The resolution should therefore be amended to include a clear definition of the scope of health technologies and the need for a way to enable each country to develop a minimum list of necessary technologies. He accordingly proposed three amendments to the draft resolution. A new paragraph should be inserted after the first preambular paragraph, worded as follows: "Understanding that a health technology refers to the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems to solve a health problem and improve quality of lives;". A new subparagraph should be added after paragraph 1(4), to read: "(5) to collect information that interrelates health technologies, which are considered indispensable in dealing with priority public health conditions at different levels of care and in various settings and environments, with sufficient supplementary information on needed infrastructure, procedures and reference tools;". Another new subparagraph should be inserted after paragraph 2(2), to read: "(3) to develop methodological tools to support Member States in their analyses of health technology needs and health systems prerequisites at country level;".

Ms NGAUNJE (Malawi), speaking on behalf of the 46 countries of the African Region, supported the draft resolution on health technologies, and urged the Secretariat to adopt a five-pronged approach to the issue of health technologies. First, in collaboration with interested Member States and WHO collaborating centres, countries should receive support to develop a framework for the provision of safe and reliable health technologies. Secondly, where necessary, help should be provided to Member States in how to assess their national needs for health technologies and ensure their availability and use. Africa's vulnerability to counterfeit devices and substandard second-hand equipment made it imperative to ensure good manufacturing and regulatory practices, and thus high-quality, safe and efficient medical devices. Thirdly, technical guidance and support should be provided to Member States in the implementation of health technology policies. Fourthly, in collaboration with other United Nations system and international organizations, academic institutions and professional bodies, Member States should be supported in the prioritization, selection and use of health technologies. At the core of that collaboration was the linking of health technology to the burden of disease and the level of service to be provided. Lastly, the Director-General should report on implementation of the resolution to the Sixty-second World Health Assembly.

Dr ZAVARZINA (Russian Federation) said that her country had set up a federal agency in order to provide services and ensure management for the development and application of health technologies, including new methods of diagnosis. To achieve the health-related Millennium Development Goals, issues concerning health technologies had to be tackled. She therefore endorsed the Secretariat's report. It was important to provide good-quality health-care services in keeping with international standards, which were the basis for the development of health technology, and which would benefit from high-level international cooperation. In providing technical assistance, the Secretariat could help to assess needs and set priorities with regard to health technologies. Cooperation agreements should define the instruments for providing the necessary assistance in line with national priorities. The Secretariat should help to ensure that projects were carried out by joint action and took account of national priorities in the allocation of funds, since modern health technology was extremely costly. The Russian Federation was keen to set up monitoring and assessment systems so that it could follow up the implementation of programmes and projects. The principles of WHO – openness, accountability and a responsible approach – were vital to progress in health technology.

Expressing support for the draft resolution, she said that health technology must be supported by the necessary instruments, in order to contribute to prevention, treatment, diagnosis and rehabilitation; it also had to meet internationally agreed aims, especially the health-related Millennium Development Goals. In addition, it had to take account of possible changes in legislation and ensure that strategies could be implemented with due concern for quality and effectiveness. From the economic point of

view, standardization would facilitate access to health care. The technical support provided by the Secretariat and Member States should be stepped up through the development of guidelines, norms and standards for national health technology policies. It was also important to ensure the rational choice and acquisition of medical devices. Furthermore, constant attention must be paid to the education and training of specialists. WHO should support international cooperation among patients' organizations, professional organizations, and technical and educational organizations and institutions. The Russian Federation needed to work more closely with the Secretariat by setting up collaborating centres, so that future health technologies and advances in health technology research could be properly regulated in keeping with international standards. She endorsed the list of WHO's basic functions as a leader in international health care.

Dr DEMIRALP (Turkey) said that the high cost of procuring and operating essential health technologies meant that countries with limited resources relied on WHO – in cooperation with other organizations of the United Nations system, international organizations, academic institutions and professional bodies – to publish guidelines that would help them identify their population's needs, choose appropriate technologies in accordance with their disease burden, and ensure that their health staff were properly qualified to operate those technologies.

Mr BELVETT (Jamaica), speaking on behalf of the member countries of the Caribbean Community, expressed support for the draft resolution and welcomed the recommendations of the Expert Group on Health Technologies regarding the provision of interrelated sets of data, supplemented by information and analytical tools, which would support Member States in assessing their health-technology needs, and ultimately improve national health-care delivery systems. He emphasized support to countries in understanding the economic implications and preventing the widening inequities that resulted from expensive health technologies.

Ms YUAN (United States of America), observing that the use of safe, high-quality health technologies could make a decisive contribution to world health, urged Member States to develop the necessary regulatory structures. The Secretariat could act as a clearing house for evidence-based information on medical devices. She supported the original version of the draft resolution, but would need to consult with her Government before considering inclusion of the amendments suggested by the delegate of Afghanistan concerning a list of essential technologies and infrastructure.

Dr PONGSADHORN POKPERMDEE (Thailand) said that every country needed to prioritize its health-technology needs. Fair and ethical resource allocation was equally important in order to ensure that health-care systems derived maximum benefits from investment in those technologies. Thailand had set up a new agency to assess medical devices, medicines, clinical procedures and public-health interventions, and to build the necessary institutional and human capacity. Countries lacking the means to assess every health technology might be denied the information needed to make the right decisions and so might waste precious resources. The Secretariat could provide a list of health technologies suited to priorities at various levels of health care. To that end, paragraph 2(3) of the draft resolution could be amended to read: "to provide technical guidance and support to Member States, where necessary, in implementing policies on health technologies, in particular for priority burden of diseases, according to different levels of services in developing countries;".

Ms VELÁZQUEZ BERUMEN (Mexico) requested that the draft resolution should be amended to include the results of the meeting of the group of experts reported in document EB121/11; the definition set out in paragraph 3 of that document; and the proposal in paragraph 9(a) regarding a clearing house related to clinical guidelines at different levels of care. She further suggested adding a reference to planning in evaluation and procurement in paragraph 1(2) and to harmonized international practices regarding medical technologies in paragraph 1(3).

Mr BENKACI (Algeria) said that hospital managers were struggling to operate, or even to understand the purpose of, heavily marketed medical devices which were increasingly being introduced into their health-care systems, because they lacked the basic scientific and technical benchmarks. It was crucial, especially for developing countries, to have a database of information on assessed, tested and approved devices, together with instructions for use. The Secretariat could support countries that lacked the budgets to evaluate every device.

Dr OKEYO (Kenya) said that for the sake of clarity the draft resolution should include the definition of health technologies set out in paragraph 3 of document EB121/11. He further suggested adding to paragraph 2 of the draft resolution a new paragraph 2(5) reading: “to establish and update regularly an evidence-based, web-based health technologies database which provides guidance on appropriate health technology according to levels of care, setting, environment, health intervention intended, tailored to the specific needs of a country or region,” and a new paragraph 2(6) reading “to provide support to Member States with vulnerable health-care systems to identify and put in place appropriate health technology needs to facilitate access to quality health care in primary health-care settings;”. The existing paragraph 2(5) would then become paragraph 2(7).

Dr SINGAY (Bhutan) supported the draft resolution. Evidence-based, cost-effective and safe health technologies were crucial tools for meeting key public health needs. Bhutan was in the process of reviewing its health policy and prioritizing those needs, giving due consideration to quality, safety, cost-effectiveness, availability, access and sustainability. He requested the Secretariat to set standards and guidelines, and assist Member States by building a database to determine which health technologies would be best suited to different levels of health-care delivery.

Mr VAN OMMEN (Netherlands), supported by Ms BARNES (Ireland), suggested replacing the term “health technologies”, wherever it occurred in the text, by “medical devices”; inserting an additional paragraph in the preamble to read: “Noting the need to expand expertise in the field of medical devices;” replacing “national guidelines” in paragraph 1(3) by “national or regional guidelines” (given that it referred to competencies within the European Union); and adding “and a standardized glossary of definitions” after “norms and standards” in paragraph 2(1). He commended the emphasis placed on medical devices in the broadest sense of the term in the report. The draft resolution should reflect that emphasis and focus on public health considerations as opposed to cost containment since medical devices covered a wide area, extending from prevention and diagnosis through therapy to rehabilitation.

Ms KONGSVIK (Norway) recalled that establishing a list of essential medicines had become crucial for enabling Member States with limited economic resources to prioritize their needs in respect of new and expensive medicines. Would such a list be equally successful where similar guidance was required from WHO for the selection and acquisition of medical devices, a subset of health technologies? In the event, the case made by the Secretariat combined with the comments from developing countries had been compelling, and Norway was in favour of the initiative.

She requested clarification from the Legal Counsel as to whether normal procedures had been followed in setting up the group of experts; whether all the participants had been independent experts, or whether Member States’ governments had also taken part; and whether the full report would be made available.

Mr MACPHEE (Canada) said that health technologies represented a complex area with rapid innovation, evolution and breakthroughs in diagnostic and treatment medical technology. The Secretariat should provide Member States with up-to-date information and advice on those technologies together with the analytical methods for prioritizing their public-health requirements. It should accomplish that task in a transparent manner, as efficiently as possible. The draft resolution should reflect those considerations. He welcomed the amendments that had been proposed by the delegates of Kenya and the Netherlands.

Mr WU Peixin (China) said that the non-rational use of health technologies was of concern to every country, and that it was therefore important to ensure the efficiency of the work done in the field of public health policy-making. He supported the draft resolution. The Secretariat must establish standards, regulations and guidelines to help Member States to choose the appropriate medical devices and use them in a safe and efficient manner. The Organization must take account of differences in national health systems in order to provide practical advice. It should encourage exchanges of information in regard to assessment in order to help the development of national policies.

Mr PHAM HONG NGA (Viet Nam) agreed that misuse and overuse of medical devices had increased medical costs, making basic health-care services unaffordable for poor people, especially in low-income countries. The solution lay in national policies based on needs, a health technology assessment system, and multisectoral cooperation and monitoring. WHO had a role in the development of assessment standards, guidelines and tools, and attention must go to supporting poor countries in the rational use of medical devices in accordance with their own health priorities.

Dr MOOSA (Maldives) commended the current initiative in the neglected area of health technologies, which should pave the way for their rational use. The Secretariat should strengthen its capacities in that area, both at headquarters and in the regions, in order to provide clear guidance to Member States and their regulatory authorities.

Dr ZUCKER (Assistant Director-General) said that it was evident from the number of delegations taking the floor that the subject of health technologies and how they could be used to improve public health was a universal concern.

The Secretariat had convened a group of experts on the subject in order to address issues raised at the 120th session of the Executive Board. The experts, from interested Member States, had held two meetings. In response to the question from the delegate of Malawi, he said that WHO was already working on the issue with other organizations. He agreed with the delegate of the Russian Federation that priorities in health technologies needed to be established. Definitions of health technologies had been considered by the group of experts. He thanked the delegates of Jamaica and Mexico for their contributions, agreeing with the former that equity was very important. With regard to the points raised by the delegates of Kenya, the Netherlands and Ireland, he recognized that the distinction between medical devices and health technologies was complex and said that the definition proposed by the delegate of Kenya might clarify the issue. He thanked the delegate of Bhutan for his efforts in moving forward the issue of health technologies, both through work in his country and in his collaboration with the Secretariat.

Dr GROTH (Essential health technologies), replying to the delegate of Norway, said that, pursuant to an undertaking given by the Director-General at the 120th session of the Executive Board, a group of experts on health technologies had been convened for a consultative meeting (Geneva, 26 and 28 March 2007). Fifteen members of the Board had been invited to select experts to attend the meeting, based on their participation in the debate of the Executive Board. In addition to staff members from WHO headquarters, representatives of regional offices and industrial umbrella organizations had been present for the discussions. However, at the final session, where recommendations had been formulated, only the consultants selected by Board members had been permitted to participate, thus ensuring the independence of the expert group.

Dr ZUCKER (Assistant Director-General) said that the consultations on health technologies would initiate a process for closing the gap between developing and developed countries. In that regard, it would contribute to achieving the health-related Millennium Development Goals.

Ms KONGSVIK (Norway) asked for further clarification from the Legal Counsel about whether the established procedure for convening an expert group had been followed. She understood that the group was in fact an intergovernmental group rather than an independent expert group, as she had been led to believe.

Mr BURCI (Legal Counsel) said that the establishment of the group had been discussed by the Executive Board at its 120th session and the Director-General had proposed that a group comprising experts and interested Member States should be convened to discuss the outstanding issues. He therefore agreed with the delegate of Norway that it was not an expert committee, but rather an ad hoc consultation group.

The CHAIRMAN, noting that five amendments had been proposed to the resolution, asked the Secretariat to prepare a revised text taking them into account, which could be considered later.

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

Dr Yoosuf took the Chair.

Better medicines for children: Item 12.18 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R13, and A60/25) (continued from the fifth meeting)

The CHAIRMAN drew attention to the revision of the resolution contained in resolution EB120.R13, incorporating amendments proposed by the delegations, which read:

The Sixtieth World Health Assembly,

Having considered the report on better medicines for children;

Recalling resolutions WHA39.27, WHA41.16 and WHA47.13 on the rational use of drugs, WHA41.17 on ethical criteria for medicinal drug promotion, WHA43.20 and WHA45.27 on the WHO Action Programme on Essential Drugs, WHA47.12 on the role of the pharmacist in support of the WHO revised drug strategy, WHA49.14 and WHA52.19 on the revised drug strategy, WHA54.11 on the WHO medicines strategy, and WHA58.27 on improving the containment of antimicrobial resistance;

Recognizing the efforts of WHO in collaboration with governments, other organizations in the United Nations system, universities, the private sector, nongovernmental organizations and funding agencies in areas related to improving access to better medicines for children;

Aware of the core components of WHO's global framework for expanding access to essential medicines;

Wishing to promote evidence-based selection and use of medicines for children by health providers and carers;

Aware that there are regional initiatives to address inadequate access to essential medicines for children;

Wishing to ensure better access to essential medicines for children as a prerequisite for achieving health outcomes as set out in the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Aware that the lack of access to essential medicines of assured quality continues to pose significant risks of high morbidity and mortality in children, especially those under five years of age;

Recognizing the ongoing work of the Intergovernmental Working Group on Public Health, Innovation, and Intellectual Property and the need to ensure harmonization of WHO's work on access to essential medicines [Thailand];

Concerned that children can be further disadvantaged by lack of physical and economic access to essential medicines, especially in vulnerable communities;

Recognizing that many countries do not have the requisite capacity to regulate and control medicines for children;

Aware that many manufacturers of essential medicines have neither developed nor produced appropriate dosage forms and strengths of medicines for children;

Concerned that there is insufficient investment in the clinical trials, development and manufacture of medicines for children;

1. URGES Member States:

(1) to take steps to identify appropriate dosage forms and strengths of medicines for children, and to encourage their manufacture and licensing;

(2) to investigate whether currently available medicines could be formulated to make them suitable for use in children;

(3) to conduct surveillance of antimicrobial resistance of locally available and commonly prescribed medicines for children [Philippines];

~~(34)~~ to encourage research and development of appropriate medicines for diseases that affect children, and to ensure that high-quality clinical trials for these medicines are conducted in an ethical manner;

~~(45)~~ to facilitate timely licensing of appropriate, high-quality and affordable medicines for children and innovative methods for monitoring the safety of such medicines, and to encourage the marketing of adequate paediatric formulations together with newly developed medicines;

~~(56)~~ to promote access to essential medicines for children through inclusion, as appropriate, of those medicines in national medicine lists, and procurement and reimbursement schemes, and to devise measures to monitor prices;

~~(67)~~ to collaborate in order to facilitate innovative research and development on, formulation of, regulatory approval of, provision of adequate prompt information on, and rational use of, paediatric medicines and medicines authorized for adults but not approved for use in children;

~~(78)~~ to **make use of mechanisms including, where appropriate, existing international trade agreements that might impact health, in order to ensure children's access to essential medicines, where applicable;** **the flexibilities contained in the agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) in order to guarantee access to medicines for children [Brazil];**

2. REQUESTS the Director-General:

(1) to promote the development, harmonization and use of standards for clinical trials of medicines for children; to revise and regularly update the Model List of Essential Medicines in order to include missing essential medicines for children, using evidence-based clinical guidelines; and to promote application of such guidelines by Member States and international financing bodies, with initial focus on treatments for HIV/AIDS, tuberculosis, malaria and chronic diseases;

(2) to ensure that all relevant WHO programmes, including but not limited to that on essential medicines, contribute to making safe and effective medicines as widely available for children as for adults;

(3) to promote the development of international norms and standards for quality and safety of formulations for children, and of the regulatory capacity to apply them;

(4) to make available evidence-based treatment guidelines and independent information on dosage and safety aspects of essential medicines for children, progressively to cover all medicines for children, and to work with Member States in order to implement such guidelines;

- (5) to collaborate with governments, other organizations of the United Nations system, **including WTO and WIPO [Thailand]**, donor agencies, ~~and~~ nongovernmental organizations **and the pharmaceutical industry [Thailand]** in order to encourage fair trade in safe and effective medicines for children and adequate financing for securing better access to medicines for children;
- (6) to report to the Sixty-second World Health Assembly, and subsequently as appropriate, through the Executive Board, on progress achieved, problems encountered and specific actions needed to further promote better access to medicines for children.

Mr SCHRÖER (Germany), speaking on behalf of the European Union, proposed that paragraph 1(8) should be aligned with the resolution on malaria, which had already been adopted, including references to the Agreement on Trade-Related Aspects of Intellectual Property Rights that had been agreed following lengthy discussion. The paragraph would therefore be further amended to read: “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 medicines for children;”.

Dr SHEVYREVA (Russian Federation) praised the work on the plan of action to ensure access to better medicines for children. A wider range of medicines was needed to treat serious and chronic diseases in children. Pricing was also important. Infectious disease was a main cause of admission of neonates and infants to hospital. More stringent quality control of medicines to prevent and treat infectious diseases in children was needed. She supported the guidelines, adopted on second reading by the European Parliament, regulating pharmaceutical companies within the European Union that produced medicines specially adapted for children. The Russian Federation was active in research on immunobiological medicines for children and wished to cooperate with WHO in compiling a single database of clinical research, with a view to developing routine vaccines. Additional clinical research on the safety and effectiveness of medicines for children should continue, but a global approach was needed. She supported the draft resolution.

Ms KONGSVIK (Norway) concurred with the delegate of Germany that agreed language from the resolution on malaria should be used, but suggested that it would be more appropriate to use the language from paragraph 1(5) rather than 1(6).

Ms PINTO FERNÁNDEZ (Bolivarian Republic of Venezuela) said that her Government was taking action on the rational use of medicines and had established a list of essential medicines for children. A programme to facilitate the registration of new paediatric medicines should be set up. Turning to paragraph 13 of the report, she asked how the WHO model list of essential medicines would be drawn up and by whom. With regard to the suitability criteria for dosage forms of medicines for children, would there be any transfer of technologies? Would countries report on their patented methods?

In the draft resolution, the word “monitor” in paragraph 1(6), was very weak. In paragraph 1(7), she proposed deleting the term “innovative”, as it might raise issues of intellectual property. In paragraph 2(3), she proposed using the word “data” instead of “standards”. In paragraph 2(5), she suggested removing the reference to fair trade in safe and effective medicines for children, because it was a commercial issue relating to patents.

Mr BENTO ALCÁZAR (Brazil), referring to the proposal made by the delegate of Germany to amend paragraph 1(8) using language that had already been agreed in the resolution on malaria, and the proposal by the delegate of Norway to use language from paragraph 1(5) of that resolution rather than 1(6), said that neither proposal was entirely satisfactory. Paragraph 1(6) used the unclear and inadequate phrase: “where appropriate”, which was often used in texts as a safeguard against unwanted action. The paragraph went on to refer to international agreements, before stating that one such agreement was that on TRIPS. That seemed to be a reversal of priorities and only served to

weaken the emphasis on the TRIPS flexibilities. Further, the word “promote” was used, when in fact the goal of the resolution was *to guarantee* that children would have access to the medicines they needed. Paragraph 1(5) of the resolution on malaria, which the delegate of Norway proposed in substitution for paragraph 1(8) of the draft resolution, used the phrase “whenever necessary”, which was weak. It was evident that, if it were not necessary, there would be no recourse to the TRIPS flexibilities. That paragraph also used the word “promote” rather than “guarantee”.

He therefore proposed recasting paragraph 1(8) of the draft resolution to read: “to use all necessary administrative and legislative means, including the use of the flexibilities contained in TRIPS, in order to guarantee access to medicines for children;”.

Mr ABDOO (United States of America) advocated a moderate and measured approach. He disagreed with the amendment to paragraph 1(8) proposed by the delegate of Brazil for various reasons, including the fact that it did not strictly adhere to the language that appeared in the TRIPS agreement, which talked about “promoting” rather than “guaranteeing” access to medicine. WHO could not guarantee access, it could only strive to promote it. The words “where appropriate” were also very important, as they gave Member States the opportunity to take account of their own national contexts. He therefore suggested amending the proposal made by the delegate of Germany, using some of the language from the original draft resolution, so that paragraph 1(8) would read: “to make use of mechanisms including, where appropriate, international agreements, including agreements to reduce or eliminate tariffs on health-care products and the TRIPS agreement, to promote access to essential medicines for children;”.

Mr SCHRÖER (Germany), speaking on behalf of the European Union, said that the TRIPS agreement and issues relating to health and trade fell within the remit of the European Commission. He therefore requested that the representative of the European Commission, who had participated extensively in the work of the group, should be allowed to present his assessment of the situation.

Ms KONGSVIK (Norway), referring to the term “guarantee”, said that the flexibilities in the TRIPS agreement alone could not guarantee anything. Of course WHO should aim for a guarantee, but many other elements were needed before that would be possible.

Dr OKEYO (Kenya) suggested that, if a consensus could not be reached on the amended draft resolution, a drafting group could perhaps be set up to re-examine the text.

Mr RAJALA (European Commission), speaking at the invitation of the CHAIRMAN, said that it was unfortunate that the Committee was returning to an issue that had already been discussed at length in the drafting group for the resolution on malaria. If the two key contentious issues could be solved quickly, there would be no need for a drafting group. He agreed with the proposal made by the delegate of the United States of America, but said that there might be an easier solution. It had been agreed in the drafting group that the paragraph in question was not relevant for some Member States, particularly rich countries that did not have a generic pharmaceutical industry; hence the reference to “whenever necessary”. Further, as the delegate of Norway had pointed out, the TRIPS agreement alone could not guarantee anything, so the word “promote” had been agreed upon. If those two elements could be added to the amendment proposed by the delegate of Brazil, the draft resolution would then be in line with the language in the resolution on malaria.

The CHAIRMAN suggested that the Member States that had proposed amendments should hold an informal discussion to agree on a revised version of the draft resolution for consideration at the next meeting.

It was so agreed.

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

The meeting rose at 12:55.

SEVENTH MEETING

Monday, 21 May 2007, at 14:50

Chairman: Dr A.A. YOOSUF (Maldives)

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

Better medicines for children: Item 12.18 of the Agenda (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R13, and A60/25) (continued from the sixth meeting)

Mr ABDOO (United States of America) said that the delegates of Brazil, the European Commission, Norway, Thailand and the United States of America, in an informal meeting, had reached agreement on the following wording for paragraph 1(8): “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 essential medicines for children”.

The draft resolution, as amended, was approved.¹

Progress reports on technical and health matters: Item 12.21 of the Agenda (Document A60/28)

G. Sustaining the elimination of iodine deficiency disorders (resolution WHA58.24)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Argentina, Bhutan, Bolivia, Brazil, Chile, China, Cuba, Ecuador, El Salvador, Guatemala, Honduras, Indonesia, Iran (Islamic Republic of), Mexico, Panama, Paraguay, Peru, Uruguay, Venezuela (Bolivarian Republic of) and Zimbabwe, which read:

The Sixtieth World Health Assembly,

Having noted with appreciation the report on sustaining the elimination of iodine deficiency disorders;²

Noting that, although progress has been made by some Member States in the sustained elimination of iodine deficiency disorders in the past two years, between one fourth and one third of the world’s population still suffers from this micronutrient deficiency, most of them in impoverished areas of the world;

Concerned that iodine deficiency can prevent the optimal development of children’s brains, with possible consequent learning impairment with subsequent social and economic consequences;

Recognizing that the fight against iodine deficiency contributes directly to many of the internationally agreed health-related goals including those contained in the Millennium Declaration, including eradication of extreme poverty, reducing child mortality, improving maternal health, achieving universal primary education, and promoting gender equality;

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA60.20.

² Document A60/28, section G.

Applauding the support of international and bilateral development agencies and nongovernmental bodies, including Kiwanis International and the International Council for the Control of Iodine Deficiency Disorders provided to Member States in sustaining the elimination of iodine deficiency disorders, and the coordinating function of the Network for Sustained Elimination of Iodine Deficiency,

1. URGES Member States:
 - (1) to redouble their efforts to reach those people not yet protected from iodine deficiency disorders and to sustain successful programmes on a continuous basis;
 - (2) to implement the recommendation in resolution WHA58.24 to establish multidisciplinary national coalitions in order to monitor the state of iodine nutrition every three years;

2. REQUESTS the Director-General to continue to strengthen WHO's cooperation with other organizations in the United Nations system in supporting Member States in fighting iodine deficiency and report on iodine status every three years in compliance with resolution WHA58.24.

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

1. Resolution Sustaining the elimination of iodine deficiency disorders	
2. Linkage to programme budget	
Biennium 2008–2009 Strategic objective: 9	Expected result 4. Capacity built and support provided to target Member States for the development, strengthening and implementation of nutrition plans, policies and programmes aimed at improving nutrition throughout the life-course, in stable and emergency situations. (Briefly indicate the linkage with expected results, indicators, targets, baseline) The resolution will strengthen WHO's cooperation with other agencies in support of Member States' fight against iodine deficiency.
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) Nil	
(b) Estimated cost for the biennium 2006–2007 (estimated to the nearest US\$ 10 000, including staff and activities) Nil	
(c) Of the estimated cost noted in (b), what can be subsumed under existing programmed activities? Not applicable	
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) Headquarters, regional and country offices	
(b) Additional staffing requirements (indicate additional required staff full-time equivalents, noting necessary skills profile) None	
(c) Time frames (indicate broad time frames for implementation and evaluation) Reporting every three years	

Dr PRETELL ZÁRATE (Peru) welcomed the progress made in the area of iodine nutrition in the two years since the Health Assembly had adopted resolution WHA58.24, but noted that iodine deficiency remained a public health problem. Consumption of iodized salt was the most effective and the cheapest permanent solution. However, universal salt iodization must be monitored to ensure a normal iodine intake. States had an important role in ensuring sustained iodine intake through supervising the quality of iodized salt, promoting iodized salt consumption and periodically measuring its impact on the population. In order to avoid brain damage to a child, iodine intake was especially important during pregnancy and breastfeeding, when a mother's iodine requirement increased by 30%.

He supported the draft resolution, but with the fifth preambular paragraph amended to read: "Applauding the support of international and bilateral development agencies, especially WHO, UNICEF and WFP, and nongovernmental and private partners, including Kiwanis International, the International Council for the Control of Iodine Deficiency Disorders and the Network for Sustained Elimination of Iodine Deficiency;".

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, supported the Director-General's efforts to highlight the elimination of iodine deficiency disorders, which affected many people in his Region, in particular young children and pregnant women. Iodine deficiency was one of the main causes of mental retardation and preventable cognitive impairment in children, representing a threat to national, social and economic development in many countries.

Iodine deficiency disorders were often hidden, despite their impact on populations. The Region had coordinated efforts in alerting Member States to the public health implications and in building national capacities for identification and management of those disorders. WHO's recommendation of salt iodization as the most effective strategy to eliminate iodine deficiency disorders had been adopted by all Member States. The Regional Committee's resolution EM/RC49/R12, adopted in 2002, urged Member States to legislate for universal salt iodization at the safe level recommended by WHO, and to establish monitoring and evaluation. All Member States in the Region had undertaken to make iodized salt available to the general population. Insufficient production and inappropriate pricing of iodized salt limited its consumption. Inadequate laboratory facilities affected quality control of iodized salt and the determination of iodine status. The poor enforcement of legislation allowed non-iodized and poor-quality iodized salt to enter the market. WHO and its partners should provide support for evaluation of national programmes for the elimination of iodine deficiency disorders. Quality control and assurance, were needed. The Secretariat should support the technical capacities of national standards and quality control bodies in Member States.

Mr ZHOU Jun (China) supported the draft resolution. States must work together in order to achieve the sustainable elimination of iodine deficiency disorders.

Dr ASLANYAN (Canada) expressed concern that greater international efforts had not been directed to overcoming a problem that significantly affected health and economic development. He urged all Member States to reaffirm their commitment to the goals set out in resolution WHA58.24.

Canada had been part of an international partnership which, over a single decade, had increased the number of households consuming iodized salt from 20% to 66%, and since 1992 had supported salt iodization programmes in 43 countries. His country was working with WFP on a micronutrient initiative in order to reach the remaining 30% of households without iodized salt. He supported the draft resolution.

Dr DIAKHABY (Guinea), speaking on behalf of the 46 Member States of the African Region, supported the draft resolution. The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights recognized that food and nutrition were fundamental human rights. The Convention on the Rights of the Child recognized the right of children to the enjoyment of the highest attainable standard of health, and the obligations of States to fight illness and malnutrition. The United Nations General Assembly's special session on children had

renewed commitments to eliminating iodine deficiency disorders by 2005, primarily through universal salt iodization. Populations that engaged in subsistence farming often suffered iodine deficiency disorders as the soil lacked iodine; those disorders were the principal cause of cognitive impairment and frequently resulted in cerebral lesions, goitre, cretinism and miscarriages.

Since the World Summit for Children in 1990, Africa had progressed in making iodized salt available and 22 countries in the Region had raised their iodine intake to adequate levels. For instance, Nigeria had adopted a universal salt iodization strategy; more than 90% of all salt sold was iodized. Nevertheless, more than three million newborns every year, often in disadvantaged families, were at risk of iodine deficiency because their mothers did not consume iodine during pregnancy. Deficiency disorders could be combated by stronger political will, a better regulatory structure, the commitment of salt producers and importers and increased demand for iodized salt. Salt iodization, social mobilization within communities and the establishment of national and regional coalitions were essential strategies. Consumption of iodized salt was the sustainable solution to iodine deficiency disorders in Africa. Salt producers and importers should develop and follow a worldwide industrial code of conduct in order to ensure universal salt iodization, and small producers should be supported. All salt producers should guarantee a sustainable mechanism for the production of potassium iodate.

States should aim to achieve universal salt iodization in Africa by the end of 2007. Only iodized salt should be imported into the Region, and all communities and families should understand that iodized salt was beneficial for children's health and education.

Dr BURROW (International Council for Control of Iodine Deficiency Disorders), speaking at the invitation of the CHAIRMAN and on behalf also of the Network for Sustained Elimination of Iodine Deficiency, said that, despite progress, 2000 million people were still iodine deficient, mostly in economically disadvantaged areas, including 22 million newborns each year who might fail to reach their full intellectual potential. The use of iodized salt in an iodine-deficient population could increase the average IQ among children by as much as 13.5 points. Cognitive development and school performance would be enhanced, leading to greater economic productivity for the family, the community and the nation.

Universal salt iodization was a safe, cost-effective and sustainable strategy to ensure optimal iodine nutrition, and required commitment by Member States, salt producers and the public. WHO's Global Strategy on Diet, Physical Activity and Health could be adjusted for salt consumption. Iodine deficiency could be eliminated at very low daily cost. Guaranteeing access for 90% of households to iodized salt was commendable but not enough. Unless iodine nutrition was maintained, the symptoms and damage caused by deficiency would soon recur. The elimination of iodine deficiency disorders contributed to meeting many of the Millennium Development Goals, including poverty reduction, infant mortality reduction, maternal health and education for all. He urged Member States to fight iodine deficiency disorders, and to adopt the draft resolution. His organization was ready to lend technical assistance to United Nations agencies.

Dr DAYRIT (Secretary) recalled that an amendment had been proposed to the fifth preambular paragraph, which read: "Applauding the support of international and bilateral development agencies, especially WHO, UNICEF, WFP, and nongovernmental and private partners, including Kiwanis International, the International Council for Control of Iodine Deficiency Disorders and the Global Network for Sustained Elimination of Iodine Deficiency".

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's third report, and adopted as resolution WHA60.21.

A. Improving the containment of antimicrobial resistance (resolution WHA58.27)

Dr PHUSIT PRAKONGSAI (Thailand), noting that resolution WHA58.27 requested the Director-General to provide support for the generation of up-to-date information on antimicrobial resistance at regional and subregional levels and to make that information available to Member States and other parties, enquired about key activities conducted and progress made in generating such information. The resolution further requested the Director-General to provide support for gathering and sharing evidence on cost-effective interventions for prevention and control of antimicrobial resistance at national and local levels. So far there had been no evidence of any activities initiated by WHO either at headquarters or in regional offices; what had actually been undertaken and what was preventing WHO from fulfilling that task? He also requested information on the plan for improving the containment of antimicrobial resistance at global and regional levels in the biennium 2008–2009.

Mr JØRGENSEN (Denmark), speaking on behalf of the five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), said that containment of antimicrobial resistance was urgent; as indicated in the report, progress in combating the problem had been very limited. As the impact of antimicrobial resistance continued to grow, the lack of global leadership on the matter had potentially devastating consequences. A globally coordinated response was needed, and WHO's leadership in multisectoral efforts was of paramount importance.

The rational use of medicines was just one measure needed to contain antimicrobial resistance, yet it remained the essential focus of WHO's work. Antimicrobial resistance should also be placed at the core of the communicable diseases agenda. Ways needed to be found of measuring the global burden of disease caused by antimicrobial resistance.

He called on the Secretariat to report to the Sixty-second World Health Assembly on the implementation of resolution WHA58.27, clearly reflecting WHO's broad multisectoral leadership role.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that antimicrobial resistance was a growing problem, yet not enough was being done to tackle it effectively. Containment of antimicrobial resistance should form part of wider efforts to contain irrational use of medicines. Thus, the intersectoral national task force to coordinate containment of antimicrobial resistance should be a subgroup of the overall national body on rational use of medicines.

In most developing countries, including those in his Region, despite regulations to the contrary, some specialized medicines, including antibiotics, continued to be widely available without prescription. Surveillance systems were weak in many of the countries, so that it was difficult to gauge the extent of inappropriate use of antibiotics. Those countries that were not monitoring the prevalence of resistance were the ones most likely to be least able to contain it.

Antibiotic resistance was a complex issue, with links to infection control, rational use of medicines and development of new replacement antibiotics. Progress was slow in all those areas. Where second-generation antibiotics were available, they were generally beyond the reach of those who needed them most.

Ms IMAI (Japan) said that antimicrobial resistance should be tackled urgently and globally, because of the risk of a possible spread across borders and the difficulty of treatment. Japan had been taking comprehensive measures including promotion of rational use of medicines; post-marketing surveillance of antibiotics use; surveillance of drug-resistant bacteria; and providing guidance on prevention of infection within medical institutions. Japan looked forward to WHO's enhanced activities.

Mr ABDOO (United States of America) supported the statements made by the Nordic group and by Japan.

Dr ALA (Philippines) said that in her country the Antimicrobial Resistance Surveillance Reference Laboratory coordinated surveillance of antimicrobial resistance in common bacterial pathogens. Its data were used in the preparation of standard treatment guidelines for various infectious diseases and as criteria for inclusion of antimicrobial agents in the country's essential medicines list. Treatment algorithms had been drawn up for appropriate use of antibiotics. Compliance with guidelines for community-acquired pneumonia and tuberculosis was promoted by the "No compliance, no reimbursement" policy of the National Social Health Insurance Programme.

Dr ZUCKER (Assistant Director-General) agreed with the delegate of the Islamic Republic of Iran that it was difficult to gauge the full extent of the problem. Responding to the questions from the delegate of Thailand, he confirmed that antimicrobial resistance was linked to the rational use of medicines. The Secretariat was taking a cross-cutting approach to both those issues, involving Member States and other organizations of the United Nations system, including FAO, in particular. The subjects were also covered by appropriations in the budget for the biennium 2008–2009.

B. Implementation by WHO of the recommendations of the Global Task Team on Improving AIDS Coordination among Multilateral Institutions and International Donors (resolution WHA59.12)

Dr MESSELE (Ethiopia) said that high-priority interventions against HIV/AIDS in Ethiopia covered the three pillars of prevention, treatment, and care and support for the infected and the affected. Health promotion and social mobilization were enhancing community participation and reducing stigmatization and discrimination. The Ethiopian Millennium AIDS Campaign, launched in November 2006, had resulted in the testing of more than 600 000 people in two months, nearly double the planned target. The number of facilities providing voluntary counselling and testing had reached 926, and antiretroviral therapy was provided at 260 sites. The number of people taking free antiretroviral therapy had increased from 900 to 63 000 over three years.

A harmonized code of conduct had been signed in September 2005 between the Government and health partners. Development partners must align their strategies with country-led responses to HIV/AIDS and reduce administrative burdens.

Ms DE HOZ (Argentina) said that the global efforts to halt the HIV/AIDS pandemic were inadequate. One concern was the poor access of infected people to antiretroviral treatment. Antiretroviral therapy reduced mortality and increased years of healthy life. The global strategy of "3 by 5" had provided a large number of people with access to antiretroviral therapy, but much remained to be done. Her Government had a policy on antiretroviral medicines designed to prevent monopolies by admitting original product manufacturers to the market. It also covered the full cost of antiretroviral therapy, treatment for opportunistic infections and testing.

Ms PRANGTIP KANCHANAHATTAKIJ (Thailand), noting WHO's contribution to the recommendations of the Global Task Team, said that Thailand attached importance to strengthening national ownership and leadership. Support from multilateral agencies and other partners should be in line with national priorities, plans and strategies.

Mr RAMOTSOARI (Lesotho), speaking on behalf of the 46 Member States of the African Region, said that they faced major challenges in their efforts to mitigate the impact of HIV and AIDS. Already suffering from poverty and weakened social support services, younger generations were increasingly vulnerable. The older generation, mostly grandmothers, were taking on the responsibility of raising increased numbers of orphans, with meagre resources.

Coordinated national responses were essential. Most African countries had set up national HIV and AIDS coordination mechanisms, often answerable to the highest office of State. Such structures had facilitated national policy-making and strategy formulation, resource mobilization, monitoring and evaluation, in line with the "Three Ones" principle. Benefits in the form of HIV/AIDS containment

and impact mitigation would accrue from efficient coordination, harmonization and leadership. The national coordinating structures mobilized financial and technical resources from all stakeholders. The Region was grateful to WHO and other aid partners for their support.

Published frameworks for coordination, monitoring and evaluation had reduced duplication of effort. Prevention was a priority and countries were expanding access to counselling and testing in innovative ways such as the Know Your Status campaign in Lesotho. New approaches to protection and impact mitigation for the most vulnerable members of society were facilitating access to basic education, health care and other basic services; protective laws were being enacted for women and children.

However, the African States still faced challenges in coordination, including the reluctance of some partners to adhere to agreed priorities. He commended WHO for its role of advocacy and partnership with the African countries.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland), speaking also on behalf of Denmark, France, Italy, the Netherlands and Norway, welcomed the progress report and the remarks made by the delegate of Lesotho, which had put a human face on the need for enhanced coordination. Although the number of countries with joint teams was increasing, the number of teams with joint programmes was still low. Greater reorientation of agencies' programmatic focus around national priorities was needed, as was increased accountability of the joint United Nations teams to country governments.

An independent review of implementation of the Global Task Team's recommendations would be presented to the UNAIDS Programme Coordinating Board in June 2007. He requested a detailed response on how WHO would act on the recommendations, and explicit ideas from WHO about its responsibilities as a UNAIDS cosponsor. The European Union statement on the Medium-term strategic plan had expressed disappointment at the plan's silence on the Global Task Team and its minimal references to UNAIDS and division of labour issues. He also requested a substantive discussion on the findings of the independent review by the Executive Board at its session in January 2008.

Dr XUNDU (South Africa), commending the progress made, said that, in line with the "Three Ones" approach, South Africa had adopted a multisectoral strategic plan for HIV/AIDS and sexually transmitted infections for the period 2007–2011. All Government departments and sectors of civil society were expected to use it as a framework for the development of their own plans. The coordinating mechanism, South Africa's National AIDS Council, had been restructured.

She was pleased to note that WHO was taking action to broaden application of the Global Task Team's recommendations to include other international donors. Interaction should cover technical support, alignment with national policies, financial management systems, programmes and funding. The Global Task Team could support countries in minimizing ineffective use of aid from private philanthropic foundations. Developing local skills and expertise should be encouraged. Demonstrable skills transfer should be an integral part of technical assistance.

Dr MAZHANI (Botswana) said that HIV/AIDS remained a major challenge in Botswana, which had participated in the continental consultation on universal access and endorsed the actions proposed in the Brazzaville Commitment. Results had been analysed in four workshops, and a road map for moving towards universal access had been developed. But human resource capacity, infrastructure and financial resources remained a challenge. Botswana applied the "Three Ones" principle, and was reviewing its national HIV/AIDS strategic framework. The country coordinating mechanism was being restructured for improved governance of funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria and other sources. Other forums included the Botswana HIV/AIDS Partnership Forum and the Donors Forum, chaired by the Ministry of Finance.

Dr OKEYO (Kenya) said that UNAIDS had recently commissioned a study in order to assess the implementation of the Global Task Team's recommendations. The growing number of new

initiatives at country level had rendered coordination more complex; progress towards implementation of the recommendations was slow, with considerable strain placed on the health system. The Secretariat should use the findings in order to report on the implementation of resolution WHA59.12.

Ms MULLER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation had formed a global alliance on HIV and AIDS, supporting country programmes. It involved regional networks, and funding and operating partners supporting community actions. In the 10 southern African countries, it had developed a five-year programme, aimed at reaching 10% of the population with prevention information, providing care, treatment and support for 250 000 people living with HIV and AIDS, and assisting 460 000 orphans. Similar programmes were being developed in other regions.

The key to success lay at the community level. The Federation, in collaboration with WHO and Southern Africa HIV and AIDS Information Dissemination Service, had developed a training package on all components of HIV and AIDS interventions, including treatment literacy, community mobilization and treatment preparedness, and promotion of adherence to treatment. The package for community volunteers could be used by all organizations and had been widely distributed.

The Memorandum of Understanding between the Federation and the Regional Office for Africa signed 10 days previously was a milestone.

C. *World report on violence and health: implementation of recommendations*

Ms GARGOMI (Jordan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that violence affected all countries of the Region, in all areas – streets, homes, schools, workplaces and institutions. But it was commonly viewed as an issue of law and order, the role of health professionals being limited to dealing with its consequences. A change in attitude was occurring, however, encouraged by the launch of the *World report on violence and health*. The burden that violence placed on health institutions gave the health sector both a special interest in prevention and a key role. Raising awareness about prevention was only the first step. The Region was going through a difficult phase of political turbulence, involving all forms of violence, and the Member States concerned requested the Health Assembly and the Director-General to give special attention to capacity building, programme planning and resource mobilization in the Region. They noted with satisfaction that the injury prevention and control curriculum was one of the best capacity-building tools.

Mrs THOMAS (Sierra Leone), speaking on behalf of the Member States of the African Region, said that the recommendations made in the *World report on violence and health* complemented the action areas of the United Nations Declaration and Programme of Action on a culture of peace. The global campaign for violence prevention, launched in 2002, provided for violence prevention and advocacy. In 2003, the Regional Committee for Africa, in resolution AFR/RC53/R3, had urged countries to advocate nonviolent resolution of conflicts; raise awareness of the public-health impact of violence and injury; implement prevention programmes; develop information systems for prevention; and encourage research. In 2004, the Regional Committee, in resolution AFR/RC54/R6, had called for multisectoral and coordinated responses for the prevention, care and management of child abuse. Heads of State and Government of the African Union had endorsed the recommendations of the *World report on violence and health* and requested Member States to develop plans of action for violence prevention and systems for data collection on violence; they had also requested Member States to declare 2005 the African year of prevention of violence. That year had seen raised awareness, and had mobilized political will and resources for violence prevention. WHO was working very closely with the African Union to that end.

In response to demand for assistance in implementing the report's recommendations, WHO had developed several tools, which had been disseminated as part of WHO's global campaign for violence prevention. Projects to document violence prevention had been carried out in Mozambique and South

Africa and should be replicated elsewhere in the Region. In addition, independent research into violence-related disease had been carried out in South Africa.

Gender-based violence against women was a major public health and human rights problem throughout the world. Multicountry studies on women's health and domestic violence had been carried out, and other countries were seeking to replicate the methodology. The services available to deal with sexual violence were inadequate; care workers often lacked the necessary training. The 2003 guidelines for medico-legal care for victims of sexual violence should therefore be disseminated more widely in the African Region.

WHO should work with other partners in devising a public health and human rights approach to violence prevention, and should disseminate the comprehensive injury prevention and control curriculum it had developed, for use in training medical personnel in Member States.

Ms KONGSVIK (Norway) drew attention to a United Nations study, inspired by WHO's 2002 study, on violence against children. WHO needed to be fully involved in the follow-up, in the context of the system-wide United Nations approach to that multisectoral problem.

Dr LE GALÈS-CAMUS (Assistant Director-General) affirmed that WHO was working closely with UNICEF in order to develop a follow-up plan, and would remain actively involved with the report.

D. Promotion of road safety and traffic injury prevention (resolution WHA57.10)

Ms GARGOMI (Jordan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that adoption of resolution WHA57.10 on road safety and health, the dedication of the World Health Day 2004 to road safety and production of the *World report on road traffic injury prevention* had been strategies to prevent road traffic injuries. The United Nations had adopted similar resolutions and the G8 countries had commissioned an examination of support for low- and middle-income countries in their road-safety efforts. Following the recommendations made by that survey, the World Bank had created a facility in order to provide support to such countries. The recent First United Nations Global Road Safety Week was further proof of the international community's success in putting road safety high on the political agenda.

She recognized that such a broad issue required the engagement of many governmental and nongovernmental sectors, as well as civil society, in order to reduce the rising number of deaths and disabilities resulting from road traffic crashes in the Region. About 1.2 million lives were lost annually owing to predictable and preventable causes, a huge loss that compromised development and economic growth. Unless the subject was part of Member States' overall development agenda, deaths and disabilities due to road traffic crashes would continue to rise in the countries of the Region and many others.

Ms MAROUN (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that her organization, as a member of WHO's Road Safety Collaboration, had been able to bring community priorities into the discussions leading to the First United Nations Global Road Safety Week, thus optimizing the contributions of the Federation's volunteer base. It had published, jointly with the Global Road Safety Partnership, a practical guide on road safety for national Societies, in order to help the latter set up road safety programmes, design advocacy campaigns and form stronger relationships with their governments.

Youth vulnerability was of concern to her organization, which welcomed WHO's convening of the World Youth Assembly immediately before Global Road Safety Week. More than 1000 people aged under 25 were killed on the world's roads every day. The practical guide contained 20 key recommendations addressed to national Societies; but at least half were the responsibility of governments. There were excellent examples of work in the fields of public awareness, education and first-aid training from countries as diverse as Austria, Bulgaria, Cambodia, Cameroon, Lebanon, Peru, and the United Arab Emirates. The Societies would be inspired by the declaration adopted at the

World Youth Assembly that it was time for governments to acknowledge road traffic injuries as a major public health and development problem.

E. Disability, including prevention, management and rehabilitation (resolution WHA58.23)

Dr NETO DE MIRANDA (Angola), speaking on behalf of the Member States of the African Region, said that disability was a major public health problem in Africa, as a result of poverty, war injuries, landmines, HIV/AIDS, communicable diseases, poor perinatal care, malnutrition, road traffic injuries, and chronic somatic and mental conditions.

Since the period 1999–2009 had been declared the African Decade of Disabled Persons, African Heads of State and Government had adopted a plan of action. Projects and initiatives had been developed. National coordinating bodies had been created to rehabilitate disabled people. A series of country studies on the situation of disabled people had been initiated. Between 70% and 85% of disabled people in the Region lived in rural areas, where prevention and rehabilitation services were limited or unavailable. Achieving the Millennium Development Goals would be difficult unless disabled people were brought into the development process. Disability and poverty went together, and dealing with disability was a key to tackling poverty.

Most development programmes that dealt with disability were limited. Current challenges were: including disabled people in poverty alleviation initiatives; the inadequacy of human and financial resources; the lack of effective national rehabilitation programmes; difficulties of integration, stigmatization and discrimination; and availability of information on disability and poverty. She requested continued technical support in order to strengthen policies and programmes for the prevention of physical and sensory disability and to develop capacity for disability management. She also urged WHO to organize a regional meeting of experts in order to review the needs of people with disabilities, and to support the African States in collecting reliable data on disability, and in assessing the cost-effectiveness of interventions.

Africa continued to face challenges in putting into effect the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities, and needed support in that regard. She welcomed the Convention on the Rights of Persons with Disabilities, looked forward to guidance from WHO on its implementation, and acknowledged the start of work on a world report on disability and rehabilitation.

Dr AL RASHIDI (Oman), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that disability was a neglected area within health systems worldwide, although it affected 10% of the world's population. Many of the disabilities in the Region were caused by natural and man-made disasters. The dominant approach in health systems appeared to be mortality reduction; the mobilization of resources for the prevention of disability should be a high priority.

Community rehabilitation programmes were appropriate, especially for developing countries, but they currently had poor coverage and needed to include activities to protect the dignity and rights of disabled people. Highlighting the prevention of violence and injuries should not mean ignoring the rehabilitation and empowerment of people with disabilities: a reasonable balance must be struck between the two approaches. Emphasis should be placed on mobilizing resources for prevention and rehabilitation and on supporting and scaling up the coverage of community-based rehabilitation programmes.

F. Cancer prevention and control (resolution WHA58.22): cervical cancer

Dr OPIO (Uganda), speaking on behalf of the Member States of the African Region, noted the substantial achievements made in fighting cervical cancer, which included: drawing up an action plan and the ongoing collaborative partnership between WHO and stakeholders to promote that plan; recommending prevention and control strategies; investigating and introducing alternative screening techniques that were more suitable for low-resource countries; and promoting applied research on vaccines against the disease.

Challenges that remained included: attaining universal and equitable access to cervical cancer prevention, screening, treatment and palliative care services, and meeting the high costs of delivering human papillomavirus vaccines. The decision as to whether and when to introduce those vaccines would be made at national level, based on the burden of cervical cancer and the risk of exposure to the virus in each country.

He requested the Secretariat to work with the African Member States to strengthen their capacity to implement cancer control programmes; to mobilize resources in order to implement cancer prevention and control programmes; and to promote further research on new diagnostic technologies, and research and development for cancer medicines.

Dr AL AJMI (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that cervical cancer was the second most common cancer among women in the Region. Although it was among the most preventable and treatable forms of cancer if detected early and managed effectively, patients in many countries were presenting late with advanced tumours, by which time treatment was difficult or impossible. Most women in the Region still did not have access to cervical cancer prevention programmes or adequate care; there was also a stigma associated with the disease, even among the health community. All women had the right to accessible, affordable and effective services for early detection of breast and cervical cancer; such services should be delivered as part of a comprehensive programme within an effective primary care system. A coordinated effort must be made to increase community awareness about ways of ensuring early detection of breast and cervical cancer. An integrated public health approach towards primary prevention of cervical cancer must be one of the modalities for health promotion in the Region. Additional funds and technical support must be mobilized in order to introduce national control programmes for breast and cervical cancer in the countries of the Region.

Dr VIOLAKI-PARASKEVA (Greece) expressed concern that it would take 10 to 30 years after a human papillomavirus vaccine was introduced for any reduction in cancer incidence and mortality to be measurable. In particular, countries would be unable to judge whether including the vaccine in their immunization programmes would be cost effective; any adverse reaction to the vaccine might go undetected; and the lack of adequate statistics on cervical cancer would make it impossible for many countries to measure the effectiveness of any immunization programme.

Mr MACPHEE (Canada) recognized the health risks and consequences of human papillomavirus infection and advocated strong immunization programmes and related health systems. He welcomed the comprehensive action plan and delivery strategies that integrated human papillomavirus vaccine into existing immunization programmes.

Dr EMAFO (United Nations International Narcotics Control Board) said that one objective of the United Nations drug control conventions was to ensure that drugs were available for medical purposes. Narcotic drugs were indispensable for the management of moderate to severe pain, and yet remained underused or unavailable in sufficient quantities, especially in developing countries. WHO and the International Narcotics Control Board had cooperated on raising awareness about the use of opioids in pain management and, recently, on implementing resolution WHA58.22. He advocated adoption of the framework for the Access to Controlled Medications Programme that had been jointly prepared by the Control Board and WHO. He urged all governments to examine the extent to which their laws and regulations permitted the use of opioids for medical purposes, to identify impediments, and to develop long-term strategies for pain management.

WHO should continue to work with relevant organizations in order to combat activities that undermined the rational use of medicines, including the counterfeiting of medicines and their distribution through unlicensed channels such as unregulated markets and Internet pharmacies.

Ms MAZZANTI (International Atomic Energy Agency) said that the Agency's Programme of Action for Cancer Therapy sought to raise awareness and increase financial resources in order to

establish model demonstration sites in six countries that were strengthening cancer control plans and coordinating mechanisms. The approach, centred on the work of national cancer control committees, would promote the use of standardized methods and tools for the development of plans for national cancer control. Through the model demonstration sites, the Programme would pay special attention to cervical screening and related diagnostic activities and promote awareness of such programmes in mortality prevention.

H. Strengthening active and healthy ageing (resolution WHA58.16)

Mr ABDON (United States of America) welcomed the progress report and noted in particular the “age-friendly cities” project and the focus on adapting primary health-care capacity in order to meet the needs of older persons. He urged the Director-General to strengthen work on active, healthy ageing, as was called for in resolution WHA58.16.

Dr SHANGULA (Namibia), speaking on behalf of the Member States of the African Region, said that, in African countries, older persons were traditionally respected and their health and social well-being taken care of by their children and extended family members, their role being that of advisor and leader. The time had come to recognize the contribution made by older persons at many levels. Platforms were needed that would enable older persons to exchange views and share experiences.

In the African Region, certain governments had adopted laws and developed strategies in order to tackle the health and social well-being of older persons. Some countries had provided for the payment of social grants or monthly allowances aimed at improving the quality of life of retired older persons. Other programmes included the provision of social safety nets, subsidies on basic services and funeral benefits. Nevertheless, further work was needed.

Families were being encouraged to care for older persons within their communities. The implementation of the Madrid International Plan of Action on Ageing, 2002, which had been adopted by the African Union, should help to improve the quality of life of older persons. A strategy should be put in place and technical support and increased financial resources provided to African governments. Member States should also develop national plans with a gender focus for older persons, including those with disabilities.

Mr M'BAYE (Senegal) said that many older people in the African Region were not covered by social security and found themselves in great difficulty when they became ill, as was the case for 70% of older persons in Senegal. In September 2006 his Government had introduced free health care, from diagnosis to treatment, for persons of 60 years and over. Nevertheless, there were difficulties in implementation because of the people concerned and the illnesses suffered. He invited WHO and all its partners to support such initiatives.

Mr CHAOUKI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that resolution WHA58.16, in conjunction with the Regional Committee's resolution EM/RC50/R.10, provided a framework for implementing the regional plan and the revised strategy for active, healthy ageing and old age care.

Increasingly, programmes to promote the health of older persons were being developed. There were also opportunities for authorities, institutions, nongovernmental organizations, experts and individuals to share experiences relating to ageing populations and care in old age; good examples were the Doha International Conference on Ageing (Doha, 4–6 April 2005) and the International Day of Older Persons. Active ageing programmes and the integration of geriatric health services into primary health care systems were core strategies. Many challenges remained, including raising awareness, mobilizing resources, training and motivating qualified staff, institutionalizing old age services into primary health-care systems, and integrating work on healthy ageing in related programmes. Using the life-course approach within a healthy promotion framework was the best way of ensuring active and healthy ageing.

I. Emergency preparedness and response (resolution WHA59.22)

Dr KEBELA ILUNGA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, said that, in certain regions of the world, tragic situations were caused not only by natural disasters, but also by armed conflicts, which provoked mass internal displacements of populations and movements of refugees. Member States, with partners, donors and international organizations, needed to respond rapidly to situations caused by adverse weather conditions or armed hostilities. Prompt aid enabled the suffering of communities to be alleviated, but Africa lacked early-warning systems and specialized medical centres.

He welcomed WHO's normative work to provide countries with instruments for national rapid response and health interventions in emergencies, and also its identification of four priority areas. Emphasis should be on support to community initiatives, so that local structures could take over relief work. Implementation of the three-year programme launched in 2004 to deal with emergencies had built up WHO's response capabilities. Unfortunately, the programme would end in 2007 without having achieved all its goals. Staff training had progressed but not the creation of health centres adapted to function in emergencies, or the establishment of hospital protection systems. Member States in the African Region therefore wished the Secretariat to submit to the Sixty-first World Health Assembly the mid-term evaluation of the Health Cluster approach that was being applied in certain countries. They also wished to see regional emergency funds extended to other vulnerable and less affluent regions, modelled on the South-East Asia regional fund.

Although appreciative of WHO's normative work, he argued for equal effort at operational level. WHO should continue its work to alleviate the suffering of victims of emergencies and collaborate with development agencies in order to ensure effective health interventions during the post-crisis period. WHO should be involved in the medical aspects of nutrition, water, sanitation and care provided for victims; complete the listing of national and international health-care staff qualified to respond in emergency situations; build institutional capacities, at national and international levels; monitor, through the regional offices, implementation of the provisions of resolution WHA59.22; and assist in developing national programmes.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that in the Region natural disasters included earthquakes, landslides and floods. The recent conflict in Lebanon, with nearly one million internally displaced persons, had demonstrated the importance of health care. Cluster bombs and restricted access of the health workforce in southern Lebanon posed an immediate threat to public health and safety. Much work lay ahead to ensure that the health infrastructure was prepared for future emergencies.

Security, shelter, food, water and health were all essential in an emergency. Building national and local capacity would ensure that methods of coping were developed and sustained. It was important to invest more in disaster preparedness and risk reduction measures. Immediate steps could be taken to mitigate the impact of some disasters on the health sector: for example, making major hospitals resilient to disasters. Lessons from previous natural disasters and their impact could be applied in order to assess the risks and ensure best practices. The Organization and donor countries should ensure that technical and financial resources were made available in order to develop capacities for risk reduction and emergency response.

Mr MACPHEE (Canada) welcomed WHO's engagement in the humanitarian reform process and its leadership of the Global Health Cluster. His country sought to ensure better harmonization of health standards and encouraged WHO to work further with UNICEF in order to promote common standards in health and nutrition. The Health and Nutrition Tracking Service could improve the performance of humanitarian activities and he looked forward to its continued implementation. He was interested in the applicability of the Safe Hospitals Initiative, in particular with regard to Africa, and the indicators that would be used to measure hospital safety. He encouraged the Secretariat to ensure clear lines of responsibility between headquarters and regional offices in order to establish best practices for emergency preparedness and response.

Dr MAZHANI (Botswana) welcomed the initiatives aimed at placing more emphasis on risk reduction. His Government recognized the need to make measures for disaster preparedness and response an integral part of its development agenda. It had adopted a sectoral approach in planning under the auspices of the National Disaster Management Committee; a national multisectoral plan for disaster management had been developed.

Botswana had been facing several disasters, including droughts, floods, malaria epidemics, animal diseases and an HIV/AIDS epidemic, but it had allocated funds and other resources to respond to them. It had strengthened epidemiological monitoring of communicable diseases, which would facilitate rapid detection and reporting of outbreaks and a proactive response. He commended WHO's guidance on response to disasters worldwide.

Ms HELA (South Africa) said that her country's capacities for disaster management had increased. Nevertheless, there was still concern that no mechanism coordinated Member States' responses during disasters. WHO should play a leading role and act as the focal point for all health-related humanitarian actions. It should work with the United Nations Office for the Coordination of Humanitarian Affairs, and Member States too should play a key role in that work.

Ms MULLER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that Red Cross and Red Crescent societies were on the front line when emergencies arose. Preparedness for their essential work at local level was supported by the Federation through emergency response teams, technical guidance and community tools. Pandemic preparedness brought home the limitations of health systems and the need to integrate civil society into those systems. Some issues were becoming more serious because of extreme weather events and conditions, population growth, urbanization and ageing, whose humanitarian consequences would be discussed at the 30th International Conference of the Red Cross and Red Crescent (Geneva, 26–30 November 2007). Part of that discussion would enable those concerned with public health to consider the importance of strengthening the community base, including the volunteer component. The brain drain of health professionals from developing countries and a widening service gap were all the more challenging in the most vulnerable countries. Governments and international organizations had to show respect for volunteers and provide an environment for volunteerism in emergency preparedness and response.

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

The meeting rose at 17:30.

EIGHTH MEETING

Tuesday, 22 May 2007, at 10:00

Chairman: Mr T. ZELTNER (Switzerland)

1. THIRD REPORT OF COMMITTEE B (Document A60/60)

Mr AL-FAKHERI (Saudi Arabia), Rapporteur, read out the draft third report of Committee B.

The report was adopted.¹

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

Progress reports on technical and health matters: Item 12.21 of the Agenda (Document A60/28)
(continued from the seventh meeting)

J. Reducing global measles mortality

Dr SUGIURA (Japan) stated that his country had established a collaborative partnership with China and the Republic of Korea on infectious diseases research and control in 2006; in addition, it was engaged in bilateral cooperation with China on vaccine-preventable diseases, including measles and poliomyelitis; and with Viet Nam on measles vaccine production, in order to ensure a stable supply of vaccine. His country remained committed to the elimination of measles in the Western Pacific Region and welcomed the progress of the measles programme; however, he was concerned about the disposal of used syringes.

Dr SADRIZADEH (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that routine immunization coverage was still low in some countries; such campaigns were important to maintain the successes already achieved. In 1997, the Regional Committee for the Eastern Mediterranean had adopted a resolution to eliminate measles by 2010,² and measles mortality had declined; however, it would be challenging to sustain the high population-based immunity required to achieve that goal, particularly in countries with low routine vaccination coverage. Those countries required periodic catch-up immunization campaigns. Adopting a global target of reducing measles mortality by 90% by 2010 would secure the continued commitment of countries and of the partners providing financial and technical support. That would contribute to achieving the regional target of eliminating measles by 2010 and to the Millennium Development Goal of reducing by two thirds the mortality rate among children under five by 2015. He urged Member States to call for a resolution on reducing measles mortality by 90% by 2010.

¹ See page 314.

² Resolution EM/RC44/R.6.

Dr SÁ NOGUEIRA (Guinea-Bissau), speaking on behalf of the 46 Member States of the African Region, highlighted the considerable progress made: the routine immunization coverage rate at regional level had risen to 75% in 2006, while the mortality rate at the end of 2005 had fallen by 75% compared with five years earlier – well in excess of the projected 50% reduction. However, mass vaccination campaigns had not prevented outbreaks of measles, even in those countries with high coverage. The main challenges were to maintain those achievements and to improve rates of routine immunization coverage under the Extended Programme on Immunization, in order to reduce measles incidence to a minimum. Existing levels of financing needed to be maintained in order to ensure continued immunization activities. Although the International Finance Facility for Immunization was providing financial support for 2007–2008, financing might be considerably lower after that period. Countries should work towards mobilizing resources internally in order to ensure continued funding of measles immunization. That would enable the regional strategic plan to be implemented until its end date of 2009 and the regional goal of a 90% reduction in measles mortality compared with 2000 to be reached by that date. Regional monitoring of measles had improved, but the system depended on the infrastructure for monitoring poliomyelitis and acute flaccid paralysis, and funding needed to be preserved in order to maintain the gains made in the fight against measles. He requested the Health Assembly to look at ways of maintaining financing levels, in order to reduce global measles mortality rates and safeguard the achievements of the previous five years.

Dr PHUSIT PRAKONGSAI (Thailand) applauded the progress made, but recalled that the number of children who had died from measles in 2005 was still high and measles vaccination coverage low. He supported the new goal of reducing global measles mortality by 90% by 2010 as compared to the baseline of 2000. Ensuring that at least 90% of each birth cohort was vaccinated against measles was not easy for developing countries; neither was ensuring strong political commitment from governments of countries with high disease burdens. In the South-East Asia Region, some 12.6 million children had not been vaccinated against measles in 2005, and a clear strategy to improve measles immunization coverage in that Region was urgently needed.

Dr DEMIRALP (Turkey) said that it was important to build on the progress reported and reduce measles mortality by 90% by 2010. Political commitment at country level to providing better access to routine childhood immunization should be sustained, intensified surveillance extended to all priority countries, and technical and financial support from partners continued.

In line with the European Region's goal, Turkey was working towards the elimination of measles by 2010. Between 2003 and 2005, all children aged nine months to 14 years had received a supplementary vaccination, whether they had been previously vaccinated or not; 96% immunization coverage had been achieved. Case-based and laboratory-confirmed surveillance had been launched, and the number of measles cases had decreased to 34 in 2006 from almost 9000 in 2004.

Dr SULEIMAN (Oman) thanked the Secretariat for its support to developing countries in reducing measles mortality and morbidity rates. As it was not possible to achieve 100% immunization coverage from one series of immunizations, he asked whether the pattern of elimination might be altered in order to cover two doses rather than one, with the proviso that countries first implemented the strategy for immunization catch-up, followed by the maintenance and follow-up strategies. Total immunization would then be higher, with coverage from the first dose at 85% to 90% and from the second dose at 100%.

Dr MTONGA (Zambia) said that the Zambian immunization programme, aimed at improving the availability, access and delivery of good-quality health-care services, was recognized for its high level of coverage. The Expanded Programme on Immunization aimed to achieve high coverage by immunizing children against vaccine-preventable communicable diseases, including tuberculosis, poliomyelitis, measles and diphtheria. Zambia appreciated the support given by the GAVI Alliance, and had achieved more than 95% measles vaccination coverage by means of a strategy aimed at

reaching every district. The remaining challenge was to strengthen health systems for vaccine delivery. Zambia supported the global strategy for elimination of measles.

Dr DAHL-REGIS (Bahamas) said that the Caribbean countries welcomed the progress made in reducing measles mortality. Gratitude was due to all partners in the global initiative, which was the best investment for achieving Millennium Development Goal 4. She supported the proposal to adopt a resolution setting a target of a 90% reduction in measles mortality by 2010. The region had become measles-free and that could set an example for the world.

Mr ROY (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, welcomed the continuing successes of the Measles Initiative globally, and in Africa in particular. The partnership with WHO, UNICEF and other organizations had led to the setting up of the Measles Initiative in 2000. Donor support had made possible a series of measles catch-up immunization programmes – essential for sustained mortality reduction. As in the case of the eradication of poliomyelitis and smallpox, civil society had demonstrated its powers of advocacy, fund-raising and provision of human resources in order to back up health delivery. Other disease-control interventions should be based on similar partnerships in innovative and cost-effective ways. The Measles Initiative had benefited other disease control programmes by, for example, integrating vitamin A supplementation, de-worming medicine or poliomyelitis vaccination into its interventions. With continuing support, the remarkable progress made by the Measles Initiative partnership and health ministries would be continued until 2010 and possibly 2015. The goal of a 90% reduction in measles mortality by 2010 was achievable. A strong resolution by the Health Assembly to that end would be welcomed by donors and other partners.

The Federation's many volunteers were ready to support community-level education and behaviour change, which were essential to high vaccination coverage and best delivered through a network of community volunteers. If all partners worked together for humanity, a huge contribution could be made to achievement of the Millennium Development Goal of reducing child mortality.

Dr SINGAY (Bhutan) said that Bhutan remained committed to eliminating measles by 2010, a goal it had almost reached; however, it needed WHO's help to strengthen surveillance and the necessary laboratory facilities. He supported WHO's strategy to eliminate the disease.

Ms MAFUBELU (Assistant Director-General) congratulated Member States for their outstanding achievement in reducing global measles mortality. Indeed, the African Region had exceeded the target by reducing mortality by 75%. WHO welcomed the support it had received in the Measles Initiative partnership and looked forward to working with all partners towards the next goal, a reduction of 90% in measles mortality by 2010 which would be attained if the present trend continued and if Africa continued to lead the way; indeed, a 100% reduction by 2010 might be possible. She had taken note of the desire of some Member States for a resolution on the goal of 90% reduction by 2010. In reply to the delegate of Japan, she said that it was the policy of WHO and UNICEF to supply disposable syringes for each vaccination dose. The Secretariat provided technical assistance to ensure environmentally friendly disposal. She assured the delegate of Thailand that the South-East Asia Region was covered in the second phase of the Measles Initiative; planning had started in some countries with good progress being made, and work was also being done on an original approach to facilitate attainment of a 90% reduction in that Region by 2010.

K. Health Metrics Network

Dr FAIHUN (Benin), speaking on behalf of the 46 Member States of the African Region, said that health information was little used for decision-making in Africa because it was delivered late and lacked analysis. Health statistics were unreliable, owing to limited resources: decision-makers were unable to define problems, monitor progress, assess the impact of their actions or take evidence-based decisions in health policy, programme design and resource allocation.

In Africa, the production of indicators raised complex problems, requiring statistical knowledge and skills for each disease or programme. Information was demanded by funding bodies or international initiatives, thus putting further pressure on the systems. Good standardized health information was vital to the operation of health systems, and the African Region was committed to setting up a global framework of national and global partnerships in order to improve health information.

The Health Metrics Network was filling a gap. Several countries, including Benin, had started to use the Network as a tool suited to the needs of health information systems in Africa. Once stakeholders had been identified and the questionnaire completed, the problems facing a national health information system emerged clearly. Bringing together health experts and statisticians would channel investment and technical assistance into building health information systems. All parties could analyse the weaknesses of a national health information system and be directly involved in finding solutions. The normative framework for performance evaluation was clearly linked to the assessment, planning and implementation of solutions agreed by all.

The strengthening of systems required resources for the design and use of health indicators. Each country would have to mobilize partners, donors and technical agencies within a development plan that avoided duplication. However, not all development partners accepted that view in the short term. Awareness-raising would therefore continue at national level, in order to mobilize further investment in health information systems.

He fully endorsed the need to build up health information capacities through development plans; to set up or strengthen processes for the production, analysis, dissemination and use of health information; and to establish mechanisms for monitoring progress, so that such systems could adapt to national and global changes. The Health Metrics Network and its partners should resolutely support the 10 countries in the “first wave” in drawing up development plans for national health information and subsequently extend the experiment to other countries.

He endorsed the strategic approaches proposed and supported the draft resolution contained in resolution EB118.R4.

Dr PHUSIT PRAKONGSAI (Thailand) welcomed the Health Metrics Network initiative. However, the Network should be extended to bridge two gaps: first, in building capacity in order to produce policy analysts who were capable of converting the data generated by a health information system into knowledge; and second, in strengthening the weak link between knowledge and policy formulation.

Mr RAMOTSOARI (Lesotho) reported that Lesotho had been reorganizing its health management information system, with the technical assistance of Health Metrics Network partners and with financial support from development partners. The previous year’s assessment of the country’s system against the Health Metrics Network’s objective standards had yielded an average score of 60%. Further support would be required to underpin a government investment plan designed to deal with the system’s weaknesses and to continue building on the strengths identified.

Dr MAKUBALO (South Africa) stressed the importance of health information, which provided the baseline data for policy formulation, programme implementation and monitoring progress towards the attainment of health goals. South Africa agreed on the need to elaborate further the architecture of a sound health information system. Mapping and understanding such a system’s complex institutional and policy frameworks at country level would help to strengthen the activities of the Health Metrics Network, enhance statistical comparisons between countries, and contribute to the generation and sharing of knowledge.

Dr MAZHANI (Botswana) said that a weak, fragmented, understaffed and underfunded health information system undermined the capacity of developing countries such as Botswana to engage in evidence-based decision-making for health policy and to monitor progress towards national and international health targets. He therefore welcomed the potential of the Health Metrics Network. The

Director-General should support countries in the preparation of Network grant proposals and in reviewing the funding criteria so as to allow middle-income countries, such as Botswana, to benefit from assistance as well.

Mr MACPHEE (Canada) regarded the Health Metrics Network as a core element for making progress towards the overall objective of strengthening health systems. Canada's funding of health systems in Africa, Can\$ 450 million over the coming decade, would proceed in parallel with the development of baseline statistics to measure the progress made. He requested more statistical detail on the initiative and an example of success, such as one of the 40 countries that had already received grants, to serve as a model. He asked whether the goal of having the Network's framework universally accepted as the global standard for health information by 2011 remained achievable with current and forecast resources.

The CHAIRMAN said that, in the absence of further comments, he took it that the Committee noted the reports.

The Committee noted the progress reports.

Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group: Item 12.20 of the Agenda (Document A60/27) (continued from the sixth meeting, section 2)

The CHAIRMAN recalled that the delegation of Brazil had proposed a draft resolution and that a drafting group had been set up. The drafting group had met the previous evening; he invited the chairman of the drafting group to report to the Committee on progress.

Dr SHANGULA (Namibia), speaking as chairman of the drafting group, said that agreement had been reached on revised versions of two of the 12 preambular paragraphs and two of the four operative paragraphs. In order to maintain the momentum of the discussions, he proposed that, since Committee B was approaching the end of its work, the drafting group should meet immediately after the current meeting, rather than later in the day, as had been planned in the programme of work.

After a procedural discussion in which Ms BLACKWOOD (United States of America), Mr SCHRÖER (Germany, on behalf of the European Union), Ms PODESTA (Australia), Mr ANDREWS (United Kingdom of Great Britain and Northern Ireland), Mr BEYER (Switzerland), Dr SHANGULA (Namibia), Ms KONGSVIK (Norway), Mr BENTO ALCÁZAR (Brazil) and Mr MSELEKU (South Africa) participated, the CHAIRMAN took it that the Committee could agree to the proposal for the drafting group to meet forthwith and for the Committee to finish its work later that afternoon.

It was so decided.

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

The meeting rose at 11:30.

NINTH MEETING

Tuesday, 22 May 2007, at 15:00

Chairman: Mr T. ZELTNER (Switzerland)

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

Health technologies: Item 12.19 of the Agenda (continued from the sixth meeting, section 2) (Documents EB119/2006–EB120/2007/REC/1, resolution EB120.R21, A60/26 and A60/26 Add.1)

The CHAIRMAN drew attention to the following revised draft resolution, which incorporated the proposed amendments:

Health technologies¹

The Sixtieth World Health Assembly,

Having considered the report on health technologies;²

Recognizing that ~~health technologies~~ **medical devices [Netherlands]** equip health-care providers with tools that are indispensable for effective and efficient prevention, diagnosis, treatment and rehabilitation and attainment of internationally agreed health-related development goals, including those contained in the Millennium Declaration;

Understanding that ~~health technologies~~ **medical devices [Netherlands]** represent an economic as well as a technical challenge to the health systems of many Member States, and concerned about the waste of resources resulting from inappropriate investments in ~~health technologies~~ **medical devices [Netherlands]** that do not meet high-priority needs, are incompatible with existing infrastructures, are irrationally or incorrectly used, or do not function efficiently;

Acknowledging the need for Member States and donors to contain burgeoning costs by establishing priorities in the selection and acquisition of ~~health technologies~~ **medical devices [Netherlands]** on the basis of their impact on the burden of disease, and to ensure the effective use of resources through proper planning, assessment, acquisition and management;

Noting the needs to expand expertise in the field of ~~health technologies~~ medical devices [Netherlands],

1. URGES Member States:

(1) to collect, verify, update and exchange information on ~~health technologies~~ **medical devices [Netherlands]** as an aid to their prioritization of needs and allocation of resources;

(2) to formulate as appropriate national strategies and plans for the establishment of systems for the assessment, **planning, [Mexico]** procurement and management of ~~health~~

¹ The term “health technologies refers to the application of organized knowledge and skills in the form of devices, medicines, vaccines, procedures and systems developed to solve a health problem and improve quality of lives” [Kenya and Afghanistan].

² Document A60/26.

~~health technologies~~ **medical devices [Netherlands], in collaboration with personnel involved in health-technology assessment and biomedical engineering [Mexico];**

(3) to draw up national **or regional [Netherlands]** guidelines for good manufacturing and regulatory practices, to establish surveillance systems and other measures to ensure the quality, safety and efficacy of medical devices **and to participate in the harmonization of international good-manufacturing practices [Mexico];**

(4) to establish where necessary regional and national institutes of health technology, and to collaborate and build partnerships with health-care providers, industry, patients' associations and professional, scientific and technical organizations;

(5) to collect information that interrelates medical devices [Netherlands] which are considered indispensable in dealing with priority public-health conditions at different levels of care and in various settings and environments, with the required infrastructure, procedures and reference tools [Afghanistan];

2. REQUESTS the Director-General:

(1) to work with interested Member States and WHO collaborating centres on the development, in a transparent and evidence-based way, of guidelines and tools, including norms, standards **and a standardized glossary of definitions [Netherlands]** relating to ~~health technologies~~ **medical devices [Netherlands];**

(2) to provide support to Member States where necessary in establishing mechanisms to assess national needs for ~~health technologies~~ **medical devices [Netherlands]** and to assure their availability and use;

(3) to develop methodological tools to support Member States in analysing their [health technology] needs and health-system prerequisites [Afghanistan];

~~(4)~~ to provide technical guidance and support to Member States where necessary in implementing ~~policies on health technologies~~ **medical devices [Netherlands], in particular for priority diseases, according to different levels of care in developing countries [Thailand];**

~~(5)~~ to work jointly with other organizations of the United Nations system, international organizations, academic institutions and professional bodies in order to provide support to Member States in the prioritization, selection and use of ~~health technologies~~ **medical devices [Netherlands];**

(6) to establish and update regularly an evidence and web-based [health technologies] database which will provide guidance on appropriate medical devices according to levels of care, setting, environment, and intended health intervention, tailored to the specific needs of country or region [Kenya];

(7) to set up a clearing house or repository or integrated system on medical devices related to clinical procedures at different levels of care [Mexico];

(8) to provide support to Member States with vulnerable health-care systems so as to identify and put in place appropriate [health technology] that facilitates access to quality services in primary health care [Kenya];

~~(9)~~ to report on implementation of this resolution to the Sixty-second World Health Assembly.

Dr PHUSIT PRAKONGSAI (Thailand), supported by Dr SALEHI (Afghanistan), speaking on behalf of the countries of the Eastern Mediterranean Region, said that he appreciated the definition of health technologies given in the the footnote. "Health technologies" was broader in content than the term "medical devices" proposed by the Netherlands, and should therefore be used instead throughout the draft resolution.

Ms VELÁZQUEZ BERUMEN (Mexico), recalling that Mexico had proposed the draft resolution a year earlier, suggested some amendments. The definition of health technologies should appear not in a footnote but in the first preambular paragraph, and thereafter the short term "health

technologies” should be used only in the second preambular paragraph, as a general definition, while the rest of the document should refer to “health technologies, in particular medical devices”.

The last part of paragraph 1(3) should be amended to read: “and, where appropriate, to participate in international harmonization”. In paragraph 1(4), “institutes” should be replaced by “institutions”. In paragraph 1(5), the words “which are considered indispensable” should be deleted. In the Spanish text of paragraph 2(5), formerly paragraph 2(4), the word “*consuno*” should be replaced by “*conjunto*”. In the same paragraph, “*órganos*” should be replaced by “*organismos*”. In paragraph 2(6), the words “in the form of a clearinghouse,” should be inserted after “database” and paragraph 2(7) should be deleted.

Mr HOHMAN (United States of America) expressed some concern about a definition of health technologies that would include medicines and vaccines. He asked the Secretariat to explain the source of the definition, to indicate whether the work of the department responsible for health technologies did in fact cover medicines and vaccines, and to provide a definition of medical devices.

Mr WIJNBERG (Netherlands) said that the report in document A60/26 referred to medical devices as “a major subset of health technologies”. It also stated that medical devices could be broadly defined as “diagnostic and therapeutic equipment, instruments and supplies and ancillary equipment”. His delegation had attempted to translate the content of the report into language suitable for a resolution. The original draft had addressed the broader topic of health technologies, whereas the Executive Board had wanted to restrict the topic to the product component of medical technologies.

He did not object to the preambular paragraphs using language such as “health technologies, in particular medical devices” in order to make the transition from the title of the document to its intended content, provided that the operative paragraphs referred to “medical devices” as defined in the report.

Mr MARTIN (Switzerland) supported the call by the United States of America for clarity of definition. With regard to the use of “*dispositifs*” for devices in the French text, he suggested that “*équipements*” would be more appropriate, since “*dispositifs*” could also cover procedures or software.

Dr ZUCKER (Assistant Director-General), replying to the delegate of the United States of America, said that the work of the cluster for health technology and pharmaceuticals covered medicines, but not vaccines, which were dealt with by another cluster. The phrase “health technologies, in particular medical devices” gave an overall picture of the subject area, but the cluster’s work focused on medical devices.

Dr GROTH (Essential health technologies) said that the Executive Board, at its 120th session, had convened a group of experts for a consultative meeting in order to discuss the scope and definition of health technologies. As a preparatory step, a consultant from Mexico had made a comprehensive review of the definitions of health technologies used in WHO and elsewhere. The experts had reached agreement on a definition which had been included in the text of the draft resolution at the request of the delegations of Afghanistan and Kenya.

Dr ZUCKER (Assistant Director-General) said that the Secretariat recognized that the definition given was a comprehensive one which might touch on areas that were not necessarily covered by the cluster for health technology and pharmaceuticals.

Dr DAYRIT (Secretary) said that the Mexican proposal to add the text of footnote 1 to the first preambular paragraph had been withdrawn at the request of the United States of America.

In addition to the other proposed amendments, the square brackets should be removed from “health technology” in paragraphs 2(3) and 2(8) and from “health technologies” in paragraph 2(6). Further, at the request of the United States of America, the words “which are considered indispensable in dealing” in paragraph 1(5) should be replaced by “which deal”.

Switzerland had proposed a subamendment to the amendment to paragraph 2(6) proposed by Mexico, whereby the words “in the form of” would be replaced by “to serve as”.

Lastly, the United States of America had proposed that paragraph 2(9) should be amended to indicate that implementation of the resolution would be reported through the Executive Board to the Sixty-second World Health Assembly.

The draft resolution, as amended, was approved.¹

The meeting was suspended at 15:40 and resumed at 18:00.

Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group: Item 12.20 of the Agenda (Document A60/27) (continued from the eighth meeting, section 2)

Dr SHANGULA (Namibia), speaking in his capacity as chairman of the drafting group, reported that the drafting group had reached agreement on the operative part of the draft resolution. The group had not yet been able to consider the preambular paragraphs, but he was confident that, if allowed to continue its discussions that evening, it would be able to agree a draft text for submission to the Committee the following morning.

The CHAIRMAN suggested that the Committee should close its ninth meeting in order to allow the drafting group time to complete its work. Consideration of the agenda item would be resumed the following morning.

It was so agreed.

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

The meeting rose at 18:10.

¹ Transmitted by the Health Assembly in the Committee’s fourth report and adopted as resolution WHA60.29.

TENTH MEETING

Wednesday, 23 May 2007, at 09:20

Chairman: Mr T. ZELTNER (Switzerland)

1. FOURTH REPORT OF COMMITTEE B (Document A60/62)

Mr BIN AL-FAKHERI (Saudi Arabia), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.¹

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

Public health, innovation and intellectual property: progress made by the Intergovernmental Working Group: Item 12.20 of the Agenda (Document A60/27) (continued from the ninth meeting)

Dr SHANGULA (Namibia), speaking in his capacity as chairman of the drafting group, reported that, after four meetings lasting a total of nearly 10 hours, the group had agreed on the following draft resolution:

The Sixtieth World Health Assembly,

Recalling resolution WHA59.24, creating an intergovernmental working group with the purpose of elaborating a draft global strategy and plan of action to provide a medium-term framework based on the recommendations of the Commission on Intellectual Property, Innovation and Public Health, and to secure, inter alia, an enhanced and sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries, proposing clear objectives and priorities for research and development, and estimating funding needs in this area;

Concerned that communicable diseases account for approximately 50% of the burden of disease in developing countries, and that access to medicines, vaccines and diagnostic tools is hampered by, inter alia, inadequate health-care systems, lack of resources and prices that are beyond the reach of many in the developing world;

Conscious of the growing burden of disease and conditions that disproportionately affect developing countries, particularly those affecting women and children, including an upsurge in noncommunicable diseases;

Noting that the Doha Ministerial Declaration on the TRIPS Agreement and Public Health confirms that the Agreement does not and should not prevent Members from taking measures to protect public health;

Noting that intellectual property rights are an important incentive for the development of new health-care products;

¹ See page 314.

Welcoming with enthusiasm the commitment of the Director-General to the process spearheaded by the Intergovernmental Working Group on Public Health, Innovation and Intellectual Property,

1. EXPRESSES appreciation to the Director-General for her commitment and encourages her to guide the process to draw up a global strategy and plan of action that will provide a medium-term framework for needs-driven essential health research and development;
2. URGES Member States to support fully and actively the Intergovernmental Working Group process and provide adequate resources to WHO;
3. REQUESTS the Director-General:
 - (1) to ensure technical and financial support to the Intergovernmental Working Group in order to facilitate completion of its tasks in time for its report to the Sixty-first World Health Assembly;
 - (2) to provide as appropriate, upon request, in collaboration with other competent international organizations, technical and policy support to countries that intend to make use of the flexibilities contained in the agreement on Trade-Related Aspects of Intellectual Property Rights and other international agreements in order to promote access to pharmaceutical products,¹ and to implement the Doha Ministerial Declaration on the TRIPS Agreement and Public Health and other WTO instruments;
 - (3) to provide technical and financial support for regional consultative meetings in order to set regional priorities that will inform the work of the Intergovernmental Working Group;
 - (4) to encourage the development of proposals for health-needs driven research and development for discussion at the Intergovernmental Working Group that includes a range of incentive mechanisms [including those that separate paying for the cost of research and development from the price of medicines, vaccines, diagnostic tools and other health-care products] and a method for tailoring the optimal mix of incentives to a particular condition or product, with the objective of addressing diseases that disproportionately affect developing countries;
 - (5) to prepare background documents on each of the eight proposed elements of the plan of action, as identified by the Intergovernmental Working Group, including:
 - a matrix on ongoing activities and current gaps;
 - a matrix on current proposals referring to key stakeholders;
 - the financial implications of those proposals.

He thanked the delegations involved in producing the draft resolution for their cooperation and constructive contributions to what had not been an easy process.

The CHAIRMAN paid tribute to the leadership of the delegate of Namibia. Drawing attention to the brackets remaining in paragraph 3(4), he opened the floor for comments on the draft resolution.

Mr ABDOO (United States of America), acknowledging the substantial progress made by the drafting group, said that his delegation was ready to make considerable compromises in order to move towards a consensus, albeit with a number of editorial changes designed to improve its flow and content. First, in the second line of preambular paragraph 2, “diagnostic tools” should be changed to

¹ “Pharmaceutical product” means any patented product, or products manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems (WTO General Council (30 August 2003) on Implementation of paragraph 6 of the Doha Ministerial Declaration on the TRIPS Agreement and Public Health).

“diagnostic kits” in order to keep the language consistent with that of the TRIPS agreement. Second, in the second line of paragraph 2, the words “continue to” should be inserted before “provide adequate resources to WHO”. Third, paragraph 3(2) should be redrafted to read as follows: “To provide, as appropriate, technical and policy assistance to Member States, at their request and in collaboration with competent international organizations, that have considered and desire to make use of the flexibilities in the TRIPS agreement to promote access to pharmaceutical products in accordance with the Doha Ministerial Declaration on the TRIPS Agreement and Public Health”. Regarding footnote 1, he preferred to use the official text: “‘Pharmaceutical product’ means any patented product, or products manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration (WT/MIN(01)/DEC/2)”. Finally, in paragraph 3(4), the entire bracketed section and the 16 words following it should be deleted, so that the paragraph would read “... a range of incentive mechanisms, with the objective of addressing diseases that disproportionately affect developing countries”.

Mr BENTO ALCÁZAR (Brazil) applauded the efforts of the chairman of the drafting group and said that reopening the negotiations merely to make the draft more readable would undermine the work done to finalize such an important and complex text. Only those present throughout the previous day’s discussions were in a position to amend it. As the delegation of the United States of America had left the room during the afternoon session, he requested its delegate to withdraw his suggested amendments so as to allow the Committee to move on and approve the text as it stood.

Mr SANTA CRUZ (Chile), endorsing the comments of the delegate of Brazil, said that the amendments suggested by the delegate of the United States of America were not editorial but substantive changes that had been discussed at length the previous day.

Ms IMAI (Japan) said that the wording of the bracketed part of paragraph 3(4) was too vague and expressed support for the proposals put forward by the delegate of the United States of America.

Dr NYIKAL (Kenya), speaking on behalf of the Member States of the African Region, also considered that the amendments proposed by the delegate of the United States of America changed the substance of the text and raised points that had already been discussed during the absence of the delegation of that country from the previous day’s meeting. Members attending that meeting had worked hard to shift from entrenched positions to a common ground, and it would be unfair to have to go through the process again. Moreover, it would be tantamount to turning Committee B into a drafting group. He therefore called for the draft resolution to be adopted as presented.

Dr PONGSADHORN POKPERMDEE (Thailand) said that the draft resolution in its current form was sound; his delegation did not accept the proposed changes. He strongly supported the comments of the delegates of Brazil and Kenya.

Ms PODESTA (Australia) said that the bracketed text in paragraph 3(4) needed to be dealt with before a decision could be reached, and requested clarification on the source of the definition of pharmaceutical products presented in the footnote.

Mr SILBERSCHMIDT (Switzerland), supported by the delegates of Germany, speaking on behalf of the European Union, and Brazil, agreed that the negotiations should not be reopened fully but suggested that, in a spirit of compromise, the text in square brackets should be amended to read “also addressing the linkage between the cost of research and development and the price of medicines, vaccines, diagnostic tools and other health-care products”.

The CHAIRMAN said that there seemed to be endorsement of Switzerland's proposal.

Ms PODESTA (Australia) supported the proposal of Switzerland, and also the proposal by the United States of America to change "diagnostic tools" to "diagnostic kits", which would be consistent with the TRIPS agreement.

Ms IMAI (Japan) said that, with regard to paragraph 3(4), Japan had supported the proposal of the United States of America, but could accept that of Switzerland.

Dr DAYRIT (Secretary) confirmed that the footnote was slightly different from the one used in the resolution on malaria, and read out the latter note.

Ms PODESTA (Australia) suggested that the footnote from the resolution on malaria should be retained in the present resolution.

Mr ABDOO (United States of America) asked the Secretariat to clarify what the "flexibilities in other international agreements" were.

Mr SANTA CRUZ (Chile) said that the range of flexibilities granted to a country was given not only by the TRIPS agreement but also by other multilateral or bilateral agreements. Therefore, if a country was seeking technical assistance from WHO, WIPO, or WTO, there would be no point in asking for guidance on flexibility within the TRIPS agreement if the country had already agreed to restrict it. That was what "other international agreements" meant.

Dr NYIKAL (Kenya), speaking on behalf of the African Region, supported the proposal of Switzerland for the bracketed text in paragraph 3(4), and that of Australia with regard to the footnote. Referring to the question of the delegate of the United States of America on paragraph 3(2), he said that any continued search for nuances of meaning would be tantamount to turning the entire Committee into a drafting group and inviting all delegations to return to their original national positions rather than supporting the consensus that had been reached.

Ms KONGSVIK (Norway) suggested inserting "relevant" before "international agreements".

Mr BENTO ALCÁZAR (Brazil) said that he was concerned about the course the process was taking. The day before, the group had agreed to leave one portion of text in brackets, since no decision had yet been reached on that wording. The content of the footnote had also been agreed the day before, although some minor unintentional errors of wording had been made. The redrafting process should stop there. Of course the text could be improved, but the intention had not been that the Committee should become a drafting group. The text that the group had managed to agree the previous day was an approved text, at least informally. There had been no objection to it, and the time had come to adopt it.

Dr SHANGULA (Namibia) said that in his view it was acceptable to introduce minimal changes for the sake of improving the text. The change from "tools" to "kits" was acceptable, in the interests of consistency, and the same applied to the footnote. The proposal by the delegate of Switzerland would make it possible to eliminate the brackets in paragraph 3(4). With those minor amendments, he earnestly urged that the spirit of the negotiations the day before should again prevail, and that the Committee should move on to approve the whole text.

The CHAIRMAN read out paragraph 3(4), as amended by the proposal of Switzerland, noting that that was the only amendment on which there was agreement.

Mr ABDOO (United States of America) said that his delegation dissociated itself from the consensus and reserved the right to take a different position in plenary.

Ms PODESTA (Australia) recalled that in paragraph 3(4) there had been agreement to change “diagnostic tools” to “diagnostic kits”.

Ms WISEMAN (Canada) supported by the delegate of Kenya, said that she had understood that the Swiss proposal had been to say “including also addressing the linkage ...”.

The CHAIRMAN said that in the written text before him, “including” had been deleted. However, he could see the delegate of Switzerland indicating that it could be retained. He noted that there was general agreement to change “tools” to “kits”.

The draft resolution, as amended, was approved.¹

The meeting was suspended at 10:15 and resumed at 10:20.

3. FIFTH REPORT OF COMMITTEE B (Document A60/64)

Mr BIN AL-FAKHERI (Saudi Arabia), Rapporteur, read out the draft fifth report of Committee B.

The report was adopted.²

4. CLOSURE

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

The meeting rose at 10:20.

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA60.30.

² See page 314.