



WORLD HEALTH ORGANIZATION

SIXTY-THIRD WORLD HEALTH ASSEMBLY

GENEVA, 17–21 MAY 2010

**SUMMARY RECORDS OF COMMITTEES
REPORTS OF COMMITTEES**

GENEVA
2010

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	OIE	– <i>Office International des Epizooties</i>
ASEAN	– Association of Southeast Asian Nations	PAHO	– Pan American Health Organization
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CIOMS	– Council for International Organizations of Medical Sciences	UNCTAD	– United Nations Conference on Trade and Development
FAO	– Food and Agriculture Organization of the United Nations	UNDCP	– United Nations International Drug Control Programme
IAEA	– International Atomic Energy Agency	UNDP	– United Nations Development Programme
IARC	– International Agency for Research on Cancer	UNEP	– United Nations Environment Programme
ICAO	– International Civil Aviation Organization	UNESCO	– United Nations Educational, Scientific and Cultural Organization
IFAD	– International Fund for Agricultural Development	UNFPA	– United Nations Population Fund
ILO	– International Labour Organization (Office)	UNHCR	– Office of the United Nations High Commissioner for Refugees
IMF	– International Monetary Fund	UNICEF	– United Nations Children’s Fund
IMO	– International Maritime Organization	UNIDO	– United Nations Industrial Development Organization
INCB	– International Narcotics Control Board	UNRWA	– United Nations Relief and Works Agency for Palestine Refugees in the Near East
ITU	– International Telecommunication Union	WFP	– World Food Programme
OECD	– Organisation for Economic Co-operation and Development	WIPO	– World Intellectual Property Organization
		WMO	– World Meteorological Organization
		WTO	– World Trade Organization

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The Sixty-third World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 21 May 2010, in accordance with the decision of the Executive Board at its 126th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA63/2010/REC/1

Verbatim records of plenary meetings, list of participants – document WHA63/2010/REC/2

Summary records of committees, reports of committees – document WHA63/2010/REC/3

CONTENTS

	Page
Abbreviations	ii
Preface.....	iii
Officers of the Health Assembly and membership of its committees	xi
Agenda	xiii
List of documents	xvii

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

First meeting.....	3
Second meeting	7

COMMITTEE A

First meeting

1. Opening of the Committee.....	9
2. Organization of work	9
3. Technical and health matters	
Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits.....	10
International recruitment of health personnel: draft global code of practice.....	18
Implementation of the International Health Regulations (2005)	19

Second meeting

1. First report of Committee A.....	25
2. Technical and health matters (continued)	
Public health, innovation and intellectual property: global strategy and plan of action.....	25
Monitoring of the achievement of the health-related Millennium Development Goals	37

	Page
Third meeting	
Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan	44
Fourth meeting	
1. Technical and health matters (continued)	
Monitoring of the achievement of the health-related Millennium Development Goals (continued).....	58
2. Organization of work	70
Fifth meeting	
1. Second report of Committee A.....	72
2. Technical and health matters (continued)	
Infant and young child nutrition.....	72
Birth defects	84
Sixth meeting	
1. Organization of work	86
2. Technical and health matters (continued)	
Counterfeit medical products	86
Seventh meeting	
1. Technical and health matters (continued)	
Birth defects (continued).....	104
2. Organization of work	107
3. Technical and health matters (resumed)	
Food safety	108
Prevention and control of noncommunicable diseases: implementation of the global strategy.....	112
Eighth meeting	
1. Third report of Committee A	118
2. Technical and health matters (continued)	
Strategies to reduce the harmful use of alcohol	118
Counterfeit medical products (continued).....	127
Prevention and control of noncommunicable diseases: implementation of the global strategy (continued).....	127
Ninth meeting	
Technical and health matters (continued)	
Prevention and control of noncommunicable diseases: implementation of the global strategy (continued).....	133
Counterfeit medical products (continued).....	140
Tuberculosis control: progress and long-term planning; prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis.....	141
Counterfeit medical products (resumed).....	142

	Page
Tenth meeting	
Technical and health matters (continued)	
Tuberculosis control: progress and long-term planning; prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (continued).....	144
International recruitment of health personnel: draft global code of practice (continued).....	150
Viral hepatitis	157
Monitoring of the achievement of the health-related Millennium Development Goals (continued)	162
Eleventh meeting	
1. Technical and health matters (continued)	
Counterfeit medical products (continued)	171
Infant and young child nutrition (continued).....	173
Monitoring of the achievement of the health-related Millennium Development Goals (continued).....	177
Birth defects (continued)	177
Viral hepatitis (continued)	180
2. Organization of work	183
3. Technical and health matters (resumed)	
Chagas disease: control and elimination (continued)	183
WHO's role and responsibilities in health research.....	186
Human organ and tissue transplantation.....	189
4. Organization of work (resumed).....	193
Twelfth meeting	
1. Technical and health matters (continued)	
Infant and young child nutrition (continued).....	194
Treatment and prevention of pneumonia.....	197
Counterfeit medical products (continued)	201
2. Fourth report of Committee A	202
3. Technical and health matters (resumed)	
Strategic Approach to International Chemicals Management	203
Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services.....	209
Public health, innovation and intellectual property: global strategy and plan of action (continued)	211
4. Fifth report of Committee A.....	214
5. Closure	214

COMMITTEE B

First meeting

1.	Opening of the Committee	215
2.	Organization of work	215
3.	Programme and budget matters	
	Programme budget 2008–2009: performance assessment	215
	Eleventh General Programme of Work, 2006–2015	218
4.	Financial matters	
	Financial report and audited financial statements for the period 1 January 2008–31 December 2009	219
	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	220
	Scale of assessments 2010–2011	221
	Amendments to the Financial Regulations and Financial Rules	221
	Safety and security of staff and premises and the Capital Master Plan	221
5.	Audit and oversight matters	
	Report of the External Auditor to the Health Assembly	223
	Report of the Internal Auditor	226
6.	Staffing matters	
	The election of the Director-General of the World Health Organization	227

Second meeting

1.	Staffing matters	
	Human resources: annual report	229
	Report of the International Civil Service Commission	230
	Amendments to the Staff Regulations and Staff Rules	231
	Appointment of representatives to the WHO Staff Pension Committee	231
2.	Management and legal matters	
	Partnerships	231
	Method of work of the governing bodies	233
	Agreements with intergovernmental organizations	234
3.	Collaboration within the United Nations system and with other intergovernmental organizations	234
4.	Technical and health matters	
	Leishmaniasis control	235
5.	Organization of work	236
6.	Technical and health matters (resumed)	
	Chagas disease: control and elimination	236
	Global eradication of measles	238

Third meeting

	Staffing matters (continued)	
	The election of the Director-General of the World Health Organization (continued)	240

	Page
Fourth meeting	
Technical and health matters (continued)	
Chagas disease: control and elimination (continued)	248
Global eradication of measles (continued)	251
Smallpox eradication: destruction of variola virus stocks	255
Availability, safety and quality of blood products.....	258
Fifth meeting	
Staffing matters (continued)	
The election of the Director-General of the World Health Organization (continued).....	263
Sixth meeting	
Staffing matters (continued)	
The election of the Director-General of the World Health Organization (continued).....	274
Seventh meeting	
1. First report of Committee B	283
2. Staffing matters (continued)	
The election of the Director-General of the World Health Organization (continued).....	283
Eighth meeting	
1. Technical and health matters (continued)	
Availability, safety and quality of blood products (continued)	291
Progress reports	
A. Poliomyelitis: mechanism for management of potential risks to eradication...	293
B. Control of human African trypanosomiasis	300
C. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets	301
D. Rapid scaling up of health workforce production	303
E. Strengthening nursing and midwifery	305
F. Sustaining the elimination of iodine deficiency disorders.....	308
G. Multilingualism: implementation of action plan	310
H. Health of migrants	311
I. Climate change and health	312
J. Primary health care, including health system strengthening	314
2. Second report of Committee B	316
3. Closure	316

PART II

REPORTS OF COMMITTEES

Committee on Credentials	319
General Committee	320
Committee A	321
Committee B	323



OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Mr M. ZENAIDI (Tunisia)

Vice-Presidents

Dra M.I. RODRÍGUEZ (El Salvador)
Dr R. SEZIBERA (Rwanda)
Professor R. AKDGAĞ (Turkey)
Mrs G.A.GIDLOW (Samoa)
Professor MYA OO (Myanmar)

Secretary

Dr M. CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Angola, Austria, Bangladesh, Eritrea, Israel, Nauru, Nicaragua, Oman, Singapore, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, and Zambia.

Chairman: Dr B. BLAHA (Austria)

Vice-Chairman: Mr S. ALTAF ALI
(Bangladesh)

Secretary: Mr X. DANNEY, Senior Legal
Officer

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Burkia Faso, Cape Verde, Chad, Chile, China, Cuba, Democratic Republic of the Congo, Estonia, France, Jamaica, Jordan, Libyan Arab Jamahiriya, Russian Federation, Spain, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, and United States of America.

Chairman: Mr M. ZENAIDI (Tunisia)

Secretary: Dr M. CHAN, Director-General

MAIN COMMITTEES

Under Rule 33 of the Rules of Procedure of the World Health Assembly, each delegation is entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr M. MUGITANI (Japan)

Vice-Chairmen: Mr U. SCHOLTEN
(Germany) and Dr D. CHIRIBOGA
(Ecuador)

Rapporteur: Dr P. MISHRA (Nepal)

Secretary: Dr Q.M. ISLAM, Director, Making
Pregnancy Safer

Committee B

Chairman: Dr W. JAYANTHA (Sri Lanka)

Vice-Chairmen: Dr G.J. KOMBA-KONO
(Sierra Leone) and Dr N. EL SAYED
(Egypt)

Rapporteur: Dr A.-P. SANNE (Norway)

Secretary: Dr M. DAYRIT, Director, Human
Resources for Health

AGENDA¹

PLENARY

- 1. Opening of the Health Assembly**
 - 1.1 Appointment of the Committee on Credentials
 - 1.2 Election of the President
 - 1.3 Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee
 - 1.4 Adoption of the agenda and allocation of items to the main committees
- 2. Report of the Executive Board on its 125th and 126th sessions**
- 3. Address by Dr Margaret Chan, Director-General**
- 4. Invited speaker**
- 5. [deleted]**
- 6. Executive Board: election**
- 7. Awards**
- 8. Reports of the main committees**
- 9. Closure of the Health Assembly**

COMMITTEE A

- 10. Opening of the Committee²**
- 11. Technical and health matters**
 - 11.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits

¹ Adopted at the second plenary meeting.

² Including election of Vice-Chairmen and Rapporteur.

- 11.2 Implementation of the International Health Regulations (2005)
- 11.3 Public health, innovation and intellectual property: global strategy and plan of action
- 11.4 Monitoring of the achievement of the health-related Millennium Development Goals
- 11.5 International recruitment of health personnel: draft global code of practice
- 11.6 Infant and young child nutrition
- 11.7 Birth defects
- 11.8 Food safety
- 11.9 Prevention and control of noncommunicable diseases: implementation of the global strategy
- 11.10 Strategies to reduce the harmful use of alcohol
- 11.11 Tuberculosis control
 - Progress and long-term planning
 - Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis
- 11.12 Viral hepatitis
- 11.13 Leishmaniasis control
- 11.14 Chagas disease: control and elimination
- 11.15 Global eradication of measles
- 11.16 Smallpox eradication: destruction of variola virus stocks
- 11.17 Availability, safety and quality of blood products
- 11.18 Strategic Approach to International Chemicals Management
- 11.19 WHO's role and responsibilities in health research
- 11.20 Counterfeit medical products
- 11.21 Human organ and tissue transplantation
- 11.22 Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services
- 11.23 Treatment and prevention of pneumonia

11.24 Progress reports

- A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)
- B. Control of human African trypanosomiasis (resolution WHA57.2)
- C. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)
- D. Rapid scaling up of health workforce production (resolution WHA59.23)
- E. Strengthening nursing and midwifery (resolution WHA59.27)
- F. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)
- G. Multilingualism: implementation of action plan (resolution WHA61.12)
- H. Health of migrants (resolution WHA61.17)
- I. Climate change and health (resolution WHA61.19)
- J. Primary health care, including health system strengthening (resolution WHA62.12)

13. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

COMMITTEE B

12. Opening of the Committee¹

13. [transferred to Committee A]

14. Programme and budget matters

14.1 Programme budget 2008–2009: performance assessment

14.2 Eleventh General Programme of Work, 2006–2015

15. Financial matters

15.1 Financial report and audited financial statements for the period
1 January 2008 – 31 December 2009

¹ Including election of Vice-Chairmen and Rapporteur.

- 15.2 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
- 15.3 [deleted]
- 15.4 Scale of assessments 2010–2011
- 15.5 [deleted]
- 15.6 Amendments to the Financial Regulations and Financial Rules
- 15.7 Safety and security of staff and premises and the Capital Master Plan

16. Audit and oversight matters

- 16.1 Report of the External Auditor
- 16.2 Report of the Internal Auditor

17. Staffing matters

- 17.1 The election of the Director-General of the World Health Organization
- 17.2 Human resources: annual report
- 17.3 Report of the International Civil Service Commission
- 17.4 Amendments to the Staff Regulations and Staff Rules
- 17.5 [deleted]
- 17.6 Appointment of representatives to the WHO Staff Pension Committee

18. Management and legal matters

- 18.1 Partnerships
- 18.2 Method of work of the governing bodies
- 18.3 Agreements with intergovernmental organizations

19. Collaboration within the United Nations system and with other intergovernmental organizations

LIST OF DOCUMENTS

A63/1 Rev.1	Agenda ¹
A63/2	Report of the Executive Board on its 125th and 126th sessions
A63/3	Address by Dr Margaret Chan, Director-General to the Sixty-third World Health Assembly
A63/4	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A63/5 and A63/5 Add.1	Implementation of the International Health Regulations (2005)
A63/6, A63/6 Add.1 and A63/6 Add.2	Public health, innovation and intellectual property: global strategy and plan of action. Report of the Expert Working Group on Research and Development Financing ²
A63/7	Monitoring of the achievement of the health-related Millennium Development Goals
A63/8	International recruitment of health personnel: draft global code of practice ³
A63/9	Infant and young child nutrition
A63/10	Birth defects ⁴
A63/11	Food safety
A63/12	Prevention and control of noncommunicable diseases: implementation of the global strategy ⁵
A63/13	Strategies to reduce the harmful use of alcohol: draft global strategy ⁶
A63/14	Tuberculosis control

¹ See page xiii.

² See Annex 9.

³ See Annex 5.

⁴ See Annex 6.

⁵ See Annexes 4 and 9.

⁶ See Annex 3.

A63/15	Viral hepatitis
A63/16	Leishmaniasis control
A63/17	Chagas disease: control and elimination
A63/17 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/18	Global eradication of measles
A63/19	Smallpox eradication: destruction of variola virus stocks
A63/20	Availability, safety and quality of blood products
A63/21	Strategic Approach to International Chemicals Management
A63/22	WHO's role and responsibilities in health research ¹
A63/22 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/23	Counterfeit medical products
A63/24	Human organ and tissue transplantation ²
A63/24 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/25 and A63/25 Corr.	Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services
A63/25 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/26	Treatment and prevention of pneumonia
A63/27	Progress reports
A63/28	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan ¹

¹ See Annex 7.

² See Annex 8.

LIST OF DOCUMENTS

A63/29	Programme budget 2008–2009: performance assessment
A63/30	Eleventh General Programme of Work, 2006–2015
A63/31	Scale of assessments 2010–2011
A63/32	Financial Report and Audited Financial Statements for the period 1 January 2008 – 31 December 2009
A63/33	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
A63/34	Amendments to the Financial Regulations
A63/35	Safety and security of staff and premises and the Capital Master Plan: Safety and security of staff
A63/36	Safety and security of staff and premises and the Capital Master Plan: The Capital Master Plan
A63/37	Report of the External Auditor to the Health Assembly
A63/38	Report of the Internal Auditor
A63/39	The election of the Director-General of the World Health Organization
A63/40	Human resources: annual report
A63/41	Report of the International Civil Service Commission
A63/42	Amendments to the Staff Regulations and Staff Rules
A63/43	Appointment of representatives to the WHO Pension Committee
A63/44 and A63/44 Corr.1	Partnerships ²
A63/44 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/45	Method of work of the governing bodies
A63/46	Agreements with intergovernmental organizations ³

¹ See Annex 9.

² See Annex 1.

³ See Annex 2.

A63/47	Collaboration within the United Nations system and with other intergovernmental organizations
A63/48	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A63/48 Add.1	Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly
A63/49	Programme budget 2008–2009: performance assessment. First report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-third World Health Assembly
A63/61	Election of Members entitled to designate a person to serve on the Executive Board
A63/62	First report of Committee B
A63/63	Third report of Committee A
A63/64	Fourth report of Committee A
A63/65	Second report of Committee B
A63/66	Fifth report of Committee A

Information documents

A63/INF.DOC./1	Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits
A63/INF.DOC./2	International recruitment of health personnel: draft global code of practice
A63/INF.DOC./3	Counterfeit medical products
A63/INF.DOC./4	Voluntary contributions by fund and by donor for the financial period 2008–2009
A63/INF.DOC./5	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A63/INF.DOC./6	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A63/INF.DOC./7	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan
A63/INF.DOC./8	Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan

LIST OF DOCUMENTS

Diverse

A63/DIV/1 Rev.1	List of delegates and other participants
A63/DIV/2	Guide for delegates to the World Health Assembly
A63/DIV/3	Decisions and list of resolutions
A63/DIV/4	List of documents
A63/DIV/5	Address by Mrs Ellen Johnson Sirleaf, President of the Republic of Liberia to the Sixty-third World Health Assembly
A63/DIV/6	Address by Mr Ray Chambers, United Nations Secretary-General's Special Envoy for Malaria to the Sixty-third World Health Assembly

PART I

**SUMMARY RECORDS OF MEETINGS
OF COMMITTEES**

GENERAL COMMITTEE

FIRST MEETING

Monday, 17 May 2010, at 10:40

Chairman: Mr M. ZENAI (Tunisia)
President of the Health Assembly

1. ADOPTION OF THE AGENDA (Document A63/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 31 of the Rules of Procedure of the World Health Assembly, its first task was to consider the adoption of the agenda and allocation of items to the main committees. Four agenda items were being proposed for deletion from the provisional agenda contained in document A63/1, namely item 5 (Admission of new Members and Associate Members) as no new applications had been received; item 15.3 (Special arrangements for settlement of arrears) as no request had been made for any such arrangement; item 15.5 (Assessment of new Members and Associate Members); and item 17.5 (Report of the United Nations Joint Staff Pension Board).

In the absence of any objection, he would take it that the Committee wished to recommend to the Health Assembly the deletion of those items from the provisional agenda.

It was so agreed.

The CHAIRMAN said that he took it that the Committee wished to recommend to the Health Assembly that it should adopt the revised provisional agenda, as amended.

It was so agreed.

2. ALLOCATION OF ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY (Documents A63/1 and A63/GC/1)

The CHAIRMAN said that he would transmit the General Committee's recommendations on the adoption of the agenda to the Health Assembly at its second plenary meeting. Items 2–4 and 6–9 would also be taken up in plenary.

The observer of ISRAEL¹ said that, as a Jewish holiday during which no work was permitted, fell on Wednesday, 19 May, he requested that agenda item 13 on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, which was due to be discussed by Committee B on that day, be taken up on Thursday, 20 May.

¹ Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

The delegate of the LIBYAN ARAB JAMAHIRYA, supported by the delegate of JORDAN, said that the Arab health ministers considered that there was no logical reason for the postponement of the discussion; the matter should be taken up as originally scheduled.

The delegate of FRANCE said that the task of the General Committee was to facilitate the work of the Health Assembly. In order to ensure a high quality and effective debate, all interested parties should be able to participate in the discussion. Accordingly, he would have no difficulty with the request made by the observer of Israel.

The delegate of the UNITED STATES OF AMERICA, endorsing the views of the previous speaker, said that the General Committee should demonstrate flexibility. He sought clarification from the Legal Counsel as to whether a precedent existed for the deferral of items in such cases.

The LEGAL COUNSEL said that, pursuant to Rule 31 of the Rules of Procedure of the World Health Assembly, the General Committee discussed the allocation and order of items for discussion and made recommendations in that regard. The main committees could themselves decide on the order in which they wished to discuss the items.

The delegate of the LIBYAN ARAB JAMAHIRYA said that, as there was no logical or legal reason for deferring the discussion of agenda item 13, he could only assume that the suggestion had been made for political reasons. He cautioned against politicizing the work of WHO, and reiterated that the item should be taken up on Wednesday, 19 May.

The delegate of the UNITED STATES OF AMERICA agreed that political issues should not be brought into the work of the Health Assembly. The request for postponement was perfectly reasonable, particularly since Israel was one of the parties concerned in the discussions and likely to be referred to in the draft resolution that he understood was to be produced. He requested clarification as to whether the main committees themselves could discuss further the order of items.

The LEGAL COUNSEL said that, while the main committees generally respected the recommendations of the General Committee, they did sometimes change the order of items.

The observer of ISRAEL¹ said that his request had not been motivated by political reasons. The simple fact was that Wednesday, 19 May was a Jewish holiday when no work was permitted. He pointed out that there were certain religious holidays on which Muslims did not work.

The DIRECTOR-GENERAL outlined two possible solutions: the General Committee could take a vote on the request made by the observer of Israel, or the request could be referred to Committee B, which could vote on it if no agreement was forthcoming.

The delegate of the UNITED STATES OF AMERICA said that the matter should be decided by the General Committee. Any vote taken should be by roll call.

The delegate of the LIBYAN ARAB JAMAHIRYA countered that the result of any vote would be a foregone conclusion.

The delegate of JORDAN endorsed the comments of the previous speaker, and suggested that agenda item 13 might be taken up on Tuesday, 18 May.

The CHAIRMAN pointed out that Committee B did not begin its work until Wednesday morning.

The delegate of the LIBYAN ARAB JAMAHIRYA supported the suggestion of the delegate of Jordan, and suggested that item 13 might be allocated to Committee A in order to allow for discussion on Tuesday, 18 May.

The delegate of the UNITED STATES OF AMERICA said that he could support the suggestion to allocate item 13 to Committee A on the understanding that no precedent would be set, and that the item would be taken up on Tuesday, 18 May.

The DIRECTOR-GENERAL said that, as sufficient time had to be allowed to enable any draft resolution that might be submitted on item 13 to be translated into the six official languages, the item was likely to be taken up by Committee A on the afternoon of Tuesday.

The delegate of the LIBYAN ARAB JAMAHIRYA said that the General Committee should specify in its recommendation to the Health Assembly when item 13 was to be taken up by Committee A.

The delegate of FRANCE said that it was important not to rush into the discussion. In order to ensure a high quality and effective debate, the principle of multilingualism should be respected and the relevant documents must be available in all six languages.

The delegate of CHAD supported the comments of the delegate of the United States of America, as did the delegate of BURKINA FASO.

The delegate of SPAIN said that discussion of the item on Tuesday rather than Wednesday would give the European Union less time to consult with the Palestinian delegation in order to develop a more consensual version of a draft resolution.

The delegate of ESTONIA endorsed that view.

The delegate of TURKEY said that he would welcome discussion of agenda item 13 on Tuesday, 18 May.

The delegate of the DEMOCRATIC REPUBLIC OF THE CONGO expressed concern that the allocation of the item to Committee A might prevent the Committee from considering other important items on its agenda.

The LEGAL COUNSEL said that there appeared to be support for the proposal to move the item to Committee A for consideration on Tuesday afternoon, but some reservations had been expressed. However, he had heard no formal objection to the proposal to allocate the item to Committee A in light of the very special circumstances at that session of the Health Assembly.

The CHAIRMAN, responding to a question from the delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, said that Committee B could begin its work on Tuesday, 18 May if the plenary had completed the debate on agenda item 3.

The CHAIRMAN said that he would take it that the Committee wished to approve the proposed allocation of items to Committees A and B. He also took it that the General Committee decided to recommend to the plenary that agenda item 13 on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, which was normally allocated to Committee B, be exceptionally allocated to Committee A and taken up during the afternoon of Tuesday, 18 May. That recommendation was premised on the following: that the change was without precedent to the future allocation and scheduling of that item; that the proposed draft resolution would

be available in all languages as soon as possible in advance of Tuesday afternoon; and that Committee A would take into account the need for coordination among and between regional groups and other groups, and the need to ensure sufficient time to discuss the other items allocated to it.

It was so agreed.

In relation to the programme of work for the Health Assembly, the CHAIRMAN drew attention to the proposed revised preliminary daily timetable, set out in the annex to document A63/GC/1. A second meeting of the General Committee was scheduled for Wednesday, 19 May to consider proposals for the election of Members entitled to designate a person to serve on the Executive Board and to consider any change in the programme of work of the Health Assembly.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 19 May.

The CHAIRMAN drew attention to decision EB126(3), whereby the Executive Board had decided that the Sixty-third World Health Assembly should close no later than Friday, 21 May 2010. He took it that the proposal was acceptable.

It was so agreed.

Referring to the list of speakers for the debate on agenda item 3, he proposed that, as on previous occasions, the order of the list of speakers be strictly adhered to and that further inscriptions be taken in the order in which they were made. Those inscriptions should be handed into the Office of the Assistant to the Secretary of the Health Assembly, or during the plenary to the officer responsible for the list of speakers, on the rostrum. He further proposed that the list of speakers should be closed the following day at 10:00. In the absence of any objection, he would inform the Health Assembly of those arrangements at its second plenary meeting.

It was so agreed.

In response to the statement by the delegate of FRANCE that he had issues to raise concerning translation, Dr YOUNES (Governing Bodies) said that any such comments could be made either orally or in writing.

He also announced that Committee A stood ready to establish a working group on the draft global code of practice on international recruitment of health personnel at any time.

The meeting rose at 11:40.

SECOND MEETING**Wednesday, 19 May 2010, at 17:40****Chairman:** Mr M. ZENAI (Tunisia)
President of the Health Assembly**1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A63/GC/2)**

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and Rule 100 of the Rules of Procedure of the World Health Assembly. In accordance with these provisions the Committee needed to nominate 12 new Member States for that purpose.

To help the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Sixty-third World Health Assembly and which had to be replaced. The second (document A63/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies, by region, were: Africa, 2; the Americas, 3; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion was made by the General Committee, the CHAIRMAN noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval. There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 100 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board: Armenia, Barbados, China, Ecuador, Mongolia, Morocco, Mozambique, Norway, Seychelles, Timor-Leste, United States of America and Yemen.

It was so agreed.

Despite the provisions of Rule 100 on the timing of submission of the list to the World Health Assembly, he proposed, in view of the Executive Board's decision to shorten the duration of the current Health Assembly, that the Committee recommend the Health Assembly to elect the Members in the next day's plenary.

It was so decided.**2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY**

Dr MUGITANI (Japan), Chairman of Committee A, reported on the progress of work in that committee. Dr JAYANTHA (Sri Lanka) reported on the progress of the work of Committee B.

The CHAIRMAN said that after consultation with the two chairmen, it had been decided to transfer the following agenda items from Committee A to Committee B: items 11.13, Leishmaniasis control, 11.14, Chagas disease: control and elimination, 11.15, Global eradication of measles, 11.16, Smallpox eradication: destruction of variola virus stocks, 11.17, Availability, safety and quality of blood products, 11.18, Strategic Approach to International Chemicals Management, 11.19, WHO's role and responsibilities in health research, 11.21, Human organ and tissue transplantation, 11.22, Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services, 11.23, Treatment and prevention of pneumonia, and 11.24, Progress reports.

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

It was so agreed.

The General Committee then drew up the programme of work of the Health Assembly for Thursday, 20 May and Friday, 21 May.

The meeting rose at 17:50.

COMMITTEE A

FIRST MEETING

Monday, 17 May 2010, at 15:30

Chairman: Dr M. MUGITANI (Japan)

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

The CHAIRMAN welcomed participants and introduced Dr Zaramba, Dr Sedyaningsih and Professor Sohn Myongsei, who would participate in the deliberations of the Committee as representatives of the Executive Board.¹ Accordingly, any views they expressed would be those of the Board, not of their respective governments.

He informed the Committee that Mr U. Scholten (Germany) and Dr D. Chiriboga (Ecuador) had been nominated as Vice-Chairmen and Dr P. Mishra (Nepal) as Rapporteur.

Decision: Committee A elected Mr U. Scholten (Germany) and Dr D. Chiriboga (Ecuador) as Vice-Chairmen, and Dr P. Mishra (Nepal) as Rapporteur.

2. ORGANIZATION OF WORK

The CHAIRMAN said that, in view of the full agenda, delegates should limit their statements to three minutes. If a delegate spoke on behalf of a group of countries, no other delegate from countries in that group should take the floor.

He proposed that agenda items 11.5 and 11.1 should be covered during the current meeting and that agenda item 13 should be moved from Committee B to Committee A.

It was so decided.

Mr HERNÁNDEZ AGUADO (Spain), speaking on behalf of the Member States of the European Union, recalled that following an agreement between WHO and the European Commission in 2000, the European Union had participated in the World Health Assembly as an observer. He requested that it should also be invited to participate as an observer, without vote, in meetings of subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Union.

It was so agreed.

¹ Participating by virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 11.1 of the Agenda (Documents A63/4, A63/INF.DOC./1, A63/48 and A63/48 Add.1)

Dr FADA (Senegal), speaking on behalf of the Member States of the African Region, said that the pandemic (H1N1) 2009 vaccine had been made available only to health-care personnel in most African countries and that only a few countries had benefited, owing to cumbersome procurement procedures. The response to the pandemic in Africa had highlighted many shortcomings, including lack of reliable data, insufficient diagnostic capabilities and limited access to drugs and vaccines. In June 2009, the Regional Committee for Africa had adopted a resolution¹ aimed at strengthening pandemic preparedness and response, which invited all Member States to continue integrated disease surveillance at all levels, implement the International Health Regulations (2005) and contribute to the African Public Health Emergency Fund. The Regional Committee had also urged Member States to vaccinate persons travelling to large international events.

Regarding pandemic influenza preparedness, he recalled the position of the African Region on the need for an equitable and transparent framework for ensuring access to vaccines and for building capacity and transferring technology and knowledge so that developing countries eventually would be able to produce their own vaccines. African States were obliged to share viruses, and it was unacceptable that they should then not have access to vaccines made from those viruses. He welcomed the progress towards consensus on the Pandemic Influenza Preparedness Framework for the sharing of influenza viruses and access to vaccines and other benefits, in particular the draft Standard Material Transfer Agreement.

Mr XIAO Donglou (China) also welcomed the consensus reached on virus and benefit sharing and the progress achieved in controlling pandemic (H1N1) 2009. The WHO Global Influenza Surveillance Network had rapidly provided virus samples and vaccines, enabling China to conduct surveillance and carry out research and development for the production of vaccines. His Government would continue to support and participate in the Network and in negotiations on the Pandemic Influenza Preparedness Framework. The Director-General should continue to play an active role in coordination and consultation with Member States so as to achieve consensus on the framework.

Dr MAGPANTAY (Philippines) said that the development of a Standard Material Transfer Agreement would formalize a transparent and reliable process for sharing biological materials for pandemic influenza preparedness within the WHO network of laboratories. He supported the adoption of guiding principles on benefit-sharing with influenza vaccine manufacturers in order to ensure the sharing of benefits, protect intellectual property rights and facilitate dispute resolution. WHO should be authorized to develop a binding statement that would allow any entity receiving pandemic influenza preparedness biological materials to pursue intellectual property rights in connection with the use of those materials and urge such entities to grant to WHO a non-exclusive, royalty-free, sub-licensable licence to those rights, subject to certain terms and conditions, including commitment, ability and readiness of a potential recipient to use the sub-licence to good effect. He appreciated the Secretariat's efforts to facilitate a transparent process for finalizing an agreement for consideration by the Health Assembly.

Mr HERNÁNDEZ AGUADO (Spain), speaking on behalf of the European Union, expressed appreciation of the efforts of the Open-Ended Working Group of Member States on Pandemic Preparedness to put in place a fair, transparent and efficient system for the sharing of influenza viruses and access to vaccines and other benefits. The Working Group's meeting in May 2010 had marked a

¹ Resolution AFR/RC59/R5.

great step forward. Some important issues remained unresolved, however, and he encouraged Member States to continue to cooperate constructively in order to achieve a sustainable system. Such a system would help to bring about a full and transparent exchange of surveillance information and virus samples; a commitment on the part of all stakeholders to ensure equitable and timely access to vaccines, antiviral agents and other benefits; improved global surveillance, laboratory capacity, production of vaccines and transfer of knowledge to developing countries; promotion of vaccine research and development; and better deployment of vaccines. The European Union supported the draft resolution proposed by the Open-Ended Working Group¹ and looked forward to the finalization of an agreement before the Sixty-fourth World Health Assembly.

Mr SALMAN AL-SAYYAD (Bahrain) recognized the need for a well-structured mechanism that would ensure better sharing of viruses and benefits than under the current temporary arrangements. There should be a unified agreement regarding circulation of biological materials. The focus should not be on intellectual property matters at present, especially in relation to the pandemic influenza A (H1N1) 2009 virus. He expressed appreciation for the efforts made in sharing knowledge and building capacity in order to address the pandemic. Although his Government supported WHO's efforts with regard to the pandemic, the Organization's management of the pandemic had been criticized by some, which had harmed its credibility and that of the health ministries of Member States and affected public acceptance of the vaccine. As a result, WHO had had to launch a campaign to counter the criticism. There were lessons to be learnt from that experience.

Mr EL MENZHI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that coordinated emergency measures were essential in order to minimize the threat to global health security posed by pandemic influenza. Measures taken at the domestic level in response to pandemic (H1N1) 2009 had clearly demonstrated the existence of extraordinary capacity for dealing with public health emergencies in the manner prescribed under the International Health Regulations (2005).

The exchange of clinical specimens and virus isolates with WHO Collaborating Centres had been crucial to pandemic forecasting and to the development of the vaccine against the pandemic virus. Ensuring equitable and affordable access to pandemic vaccines was of major concern to his Region, as was ensuring equitable benefit sharing. A set proportion of vaccines produced for pandemic strains should be allocated to each region on the basis of its population, with particular attention to countries with limited resources or special needs. Under no circumstances should intellectual property rights be a primary consideration when dealing with an influenza pandemic that directly affected all human beings. He supported the development of the Standard Material Transfer Agreement as a means of ensuring equitable and rapid access for all countries to pandemic influenza vaccines through, for example, an international stockpile.

Dr WIBISONO (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, expressed appreciation for the work of the Open-Ended Working Group, which had laid a sound foundation for future negotiations, thanks to the open and transparent way in which it had dealt with sensitive issues. In his view, the two Standard Material Transfer Agreements proposed by Brazil, India and Indonesia should govern the transfer and use of pandemic influenza preparedness biological materials and products and any processes developed using those materials. The sharing of influenza viruses with human pandemic potential on the one hand and access to vaccines and other benefits on the other should be reflected on an equal footing in the agreement eventually adopted, and the agreement should apply to all providers and recipients of biological materials, both within and outside the WHO Global Influenza Surveillance Network.

¹ Contained in document A63/48.

The solution to the challenges of pandemic influenza rested on the implementation of multiple, interlinked tools, including a Standard Material Transfer Agreement, sustainable financing and solidarity mechanisms, strengthened support for the Global Action Plan to Increase Supply of Pandemic Influenza Vaccines and enhanced surveillance capacity under the International Health Regulations (2005). He supported the draft resolution put forward by the Open-Ended Working Group and thanked the Director-General for her continued support in the process of negotiating the Pandemic Influenza Preparedness Framework.

Dr KESKİNKILIÇ (Turkey) said that important lessons were to be learnt from pandemic (H1N1) 2009. The fact that it had been less severe than expected had led to conspiracy theories and engendered mistrust of protection measures such as vaccination, which could ultimately cause a resurgence of diseases that had been virtually eliminated, placing an unexpected burden on health systems. Indeed, outbreaks of poliomyelitis and measles had recently occurred in some parts of the European Region.

A method for joint procurement of vaccines was needed as not all countries were able to buy sufficient quantities, while others were left with unused stockpiles. It was to be hoped that the Open-Ended Working Group could address that problem. National pandemic preparedness plans should be revised and legislation on the International Health Regulations (2005) enhanced in the light of the knowledge and experience gained in the course of the pandemic. WHO had a critical leadership role to play in that regard.

Mr AL-TAAE (Iraq) said that WHO should reassess its pandemic influenza preparedness and response measures with a view to incorporating more authenticated and pragmatic approaches. It should also exert greater pressure to ensure that companies were not able to dictate conditions in relation to such matters as the production, shipment, distribution and return of medicines, vaccines, laboratory kits and other supplies. WHO should furthermore promote research in anticipation of a possible second wave of pandemic (H1N1) 2009 virus, with particular attention to genotyping and potential mutations, and it should channel more support into human and institutional capacity building. In addition, the Organization should enhance its surveillance network by increasing the number of sentinel sites and strengthening intercountry and interregional collaboration. It was essential to strengthen activities aimed at combating seasonal influenza.

Dr NORHIZAN ISMAIL (Malaysia) said that timely sharing of influenza viruses with pandemic potential was a crucial part of influenza preparedness. The two WHO National Influenza Centres in his country continued to support the WHO Global Influenza Surveillance Network by sending representative isolates to WHO Collaborating Centres for reference and research on influenza. Such isolates were used as the basis for WHO's annual recommendations on the composition of influenza vaccines for the northern and southern hemispheres. Like other developing countries that contributed to the network, Malaysia was concerned about fair and equitable benefit sharing and therefore supported the establishment of a framework that would be more sustainable, predictable and structured than the current ad hoc arrangement for the sharing of viruses and benefits and would ensure timely access to adequate and affordable vaccines, diagnostics and other medical products required in the event of a pandemic. In the development of that framework, commercial interests and profits should not take precedence over public health; instead, global needs and interests should be prioritized.

Dr AL NASSER (Kuwait) said that, from the start of the public health emergency declared by WHO in 2009, his country's Ministry of Health had fully harnessed its technical and material resources in order to combat pandemic (H1N1) 2009, to which end it had implemented various measures in the context of an emergency plan. It had formed a committee to put the plan into effect, including by circulating it to all concerned parties and providing them with the requisite training. All suspected cases of influenza had been monitored and the spread of the virus had been successfully

contained as a result of the preventive measures taken. Laboratories had been specially equipped to identify the virus and new laboratories opened in order to speed up diagnosis. Infected persons had received appropriate medical treatments in hospital quarantine wards and a widespread media campaign had been launched to disseminate information on the disease and its prevention. Talks on the subject had also been given in schools. The Ministry of Health had participated in meetings held on the subject by WHO and the States of the Gulf Cooperation Council with a view to strengthening solidarity in the face of the pandemic.

Dr HARVEY (Jamaica) acknowledged WHO's work in making the pandemic influenza virus available to vaccine-producing countries and in ensuring the availability of vaccines to non-vaccine-producing countries in the developing world. Ensuring timely and equitable access to medicines and vaccines remained a critical concern, however, especially for non-producing countries. The proposed arrival time of vaccines in Jamaica, for instance, had been long after the peak incidence of acute respiratory illnesses. He urged the Open-Ended Working Group to complete its work on the remaining elements of the framework as quickly as possible in order to ensure the equitable distribution of cost-effective vaccines, especially to developing countries.

The pandemic had afforded his Government the opportunity to test its response capacity and identify gaps, and it had learnt the value of a robust surveillance system, strong laboratory capacity and the availability of a preparedness plan. It continued to strengthen intersectoral collaboration in order to mitigate the potential impact of pandemic (H1N1) 2009 and was conducting educational campaigns and establishing a communication network, which would promote continued preparedness and heighten surveillance in order to ensure early detection of subsequent outbreaks.

Ms JONES (United States of America) said that the worldwide distribution of vaccines and other medical supplies in response to pandemic (H1N1) 2009 had been relatively successful but not prompt enough. The rapid and transparent sharing of influenza viruses with pandemic potential remained critical to global preparedness and response efforts. The United States had been at the forefront of the international response by providing vaccines, medications, supplies and expert personnel to countries across the globe. Her Government supported the draft resolution proposed by the Open-Ended Working Group, and welcomed the notable progress made by the Working Group in its recent discussion of difficult issues. It also supported the Secretariat's efforts to conduct technical consultations and studies in advance of the Working Group's next meeting, to which industry input should be viewed as essential. Since 2006, her Government had contributed some US\$ 35 million to the WHO Global Action Plan to Increase Supply of Pandemic Influenza Vaccines in order to boost influenza vaccine manufacturing capacity in developing countries, and in January 2010 it had hosted an international workshop to delineate various options for doing so, a key outcome of which had been recognition of the need for a new comprehensive framework and strategic plan for building vaccine-manufacturing capacity. WHO was already working to develop such a framework and her Government was committed to supporting that effort. It commended WHO's timely efforts under the International Health Regulations (2005) to detect, assess and support information-sharing in relation to pandemic (H1N1) 2009 virus and to develop and implement evidence-based health measures and guidelines in support of surveillance, clinical and pharmacological management, infection control and individual and community measures. It supported WHO's efforts to examine the response to the pandemic and looked forward to the report on the matter.

Mrs CHISTYAKOVA (Russian Federation) supported the leading role of WHO in establishing a series of international measures to contain and reduce the effects of pandemic (H1N1) 2009. Her Government's prioritization of the production of four types of monovalent vaccines had enabled it to vaccinate more than 15% of vulnerable individuals. She commended the open discussion on access to vaccines and other benefits and also welcomed the progress achieved by the Open-Ended Working Group on that subject. Her Government had established measures to ensure such access, in particular through technology transfer for vaccine production and strengthening of epidemiological surveillance

and laboratories. It stood ready to continue cooperating constructively in the work of the Working Group.

Mr KÜMMEL (Germany) commended the progress made by the Open-Ended Working Group and welcomed further consultations and studies aimed at finalizing the Pandemic Influenza Preparedness Framework before the next Health Assembly. His Government had contributed more than €25 million in support of pandemic influenza preparedness in low-income countries. Of that amount, more than €15 million had been provided directly to WHO for its Global Response Plan and for vaccine deployment in developing countries. The remainder had been allocated to bilateral support for the development and implementation of national pandemic preparedness plans.

Ms EPHREM (Canada) said that pandemic (H1N1) 2009 had underscored the importance of advancing efforts towards a sustainable, predictable and systematic approach to influenza virus sharing and access to benefits, including vaccines, as a means of safeguarding global public health and supporting pandemic influenza preparedness and response. Her Government was encouraged by the progress made during the recent meeting of the Open-Ended Working Group and was committed to working with other Member States to achieve a successful outcome. To that end, she supported the draft resolution proposed by the Working Group.

Mrs BONNIN (France) affirmed that pandemic (H1N1) 2009 had demonstrated the effectiveness of the WHO Global Influenza Surveillance Network and the virus sharing system. Thanks to the Network a vaccine had been developed before the second wave of the pandemic. The sharing of viruses through the Network should be voluntary but systematic, without preconditions. She did not oppose the draft resolution proposed by the Open-Ended Working Group, but questioned the feasibility and operational consequences of creating a dual system for materials transfer. Access to vaccines should be improved in the short term through emergency support measures coordinated by WHO and in the long term by increasing vaccine production capacity in countries. She commended WHO's Global Action Plan to Increase Supply of Pandemic Influenza Vaccines, which had helped a number of countries to enhance their production capacity. That initiative showed that it was possible to create sustainable systems for increasing vaccine production capacity worldwide. Affected countries must have equitable and speedy access to pandemic vaccines as soon as they became available. The experience of the past year had shown that it was difficult to predict which virus strain might cause a pandemic and where it might first appear. In the light of that experience, it was essential to reassess the pandemic preparedness strategies applied in recent years and to bear in mind the need for continued surveillance of influenza H5N1 in disease-endemic areas.

Dr MAKABI (Japan) expressed the hope that an expert consultation would move forward to close the gap in access to vaccines noted by the Open-Ended Working Group. He expressed appreciation of the donations of pandemic (H1N1) 2009 vaccine provided by governments and vaccine manufacturers. Such support was essential in order to improve access to vaccines. The WHO Global Influenza Surveillance Network had functioned well for the past 50 years and the current framework for sharing specimens should be maintained. It was important also to establish a system for the sharing of benefits. Sub-licensing should be regarded as part of benefit sharing. Intellectual property rights should be protected in the development of vaccines and medical products, as such protection could encourage innovation.

Dr NAKORN PREMSRI (Thailand) said that prolongation of the negotiations on a Pandemic Influenza Preparedness Framework posed a risk to human security. It was disappointing that consensus had not yet been reached on a Standard Material Transfer Agreement and a system for equitable benefit sharing, despite the efforts of the Open-Ended Working Group. He requested the Secretariat to identify three strengths and three weaknesses of the recent meeting of the Working Group with a view to accelerating further negotiations. The important role of industry should be

recognized and it should be invited to participate in the Working Group's next meeting. In principle, his Government favoured the establishment of a global financial mechanism to provide sustainable and predictable resources for implementing benefit sharing; however, such a mechanism should not replace benefit sharing per se.

With support from WHO and technology transfer from the Russian Federation, Thailand had developed a pandemic influenza vaccine, which would be licensed in August 2010 if the current clinical trial was successful, thus demonstrating the feasibility of building vaccine-manufacturing capacity in developing countries. He called for continuing WHO support for that purpose and urged Member States to reach consensus at the earliest possible opportunity on all issues relating to the Pandemic Influenza Preparedness Framework.

Dr FERDINAND (Barbados) thanked WHO for its support and advice, which had enabled her Government to control pandemic (H1N1) 2009. Barbados had recently completed a vaccine campaign for at-risk groups and strengthened its influenza surveillance and laboratory capacity. She supported the sharing of influenza viruses and efforts to make vaccines available to all, and therefore also supported the draft resolution proposed by the Open-Ended Working Group.

Dr ANIBUEZE (Nigeria) also thanked WHO and donor countries for their help in containing pandemic (H1N1) 2009 in his country. His Government had enhanced surveillance activities and strengthened public awareness campaigns. Under its pandemic vaccine deployment plan, it planned to vaccinate health workers and essential service providers once it had received donated vaccine from WHO. He called for further support in capacity building for surveillance and in the assessment of core capacities under the International Health Regulations (2005).

Dr MESELE (Ethiopia) said that her country had demonstrated its commitment to safeguarding global public health by contributing viruses to the Global Influenza Surveillance Network. Her Government endorsed the Standard Material Transfer Agreement, which enshrined the principle of provider countries sharing with recipient parties the benefits derived from the use of their biological resources. She recognized the need to protect intellectual property rights in order not to thwart innovation, but that need must be balanced against the need to provide affordable access to vaccines and medicines. Her Government supported the principle of granting access to intellectual property rights on inventions derived from the use of biological materials, and also endorsed the proposal that the holder of such rights should agree to grant a non-exclusive, royalty-free, sub-licensable licence to WHO with respect to such rights.

Dr MUKABI (Kenya), underlining the vulnerability of the African Region to pandemic influenza, urged the Open-Ended Working Group to reach agreement quickly on the remaining elements of the Pandemic Influenza Preparedness Framework and expressed support for the two Standard Material Transfer Agreements proposed by Brazil, India and Indonesia. He also supported the draft resolution put forward by the Working Group.

Mr MENESES GONZÁLEZ (Mexico) said that his country's success in controlling the influenza pandemic was reflected in the figures currently being reported to WHO. Mexico had provided WHO with the pandemic virus strain in order to support the development of a vaccine, thereby responding to the request to share viruses with pandemic potential as called for by resolution WHA60.28. His Government supported the draft resolution proposed by the Open-Ended Working Group and urged the early conclusion of its work.

Mr DE ALMEIDA CARDOSO (Brazil) observed that pandemic (H1N1) 2009 had tested the current system, and, whereas viruses had been shared quickly and steadily, vaccines had not been made available in the same manner. In order to be prepared for a potentially devastating pandemic, it was essential to correct the shortcomings of the existing system. A more effective mechanism was

needed that would enhance international cooperation and improve pandemic preparedness, particularly in developing countries. Most developing countries did not have the means either to produce vaccines and antiviral agents or to purchase them in the global market. Unless steps were taken, most of the world's populations would continue to lack access to vaccines, which would be catastrophic in the context of a severe influenza pandemic.

The sharing of viruses must be matched by an equal obligation to share benefits and an agreement formalizing that obligation should be concluded without delay. The Standard Material Transfer Agreement should cover the following elements: donation of vaccines and antiviral agents; establishment of tiered-pricing mechanisms; transfer of technology, skills and know-how to developing countries; and granting to WHO of non-exclusive, royalty-free licences which could be sub-licensed to developing countries for pandemic influenza preparedness purposes. The vaccines and other products produced under the agreement should only be used by national public health systems.

Dr MOREIRA (Ecuador) said that consensus must be reached on the Standard Material Transfer Agreement. The role of industry should be recognized, but so should the contribution made by countries that shared their biological materials.

Mr ELIRA DOKEKIAS (Congo) said that, thanks to WHO's support, his Government had been able to control the pandemic and to exchange virus isolates with European countries and countries within the African Region. However, it had not had access to the vaccine during the most acute phase of the pandemic. The vaccine had become available only in February 2010, by which time the pandemic was waning, and its supply had been subject to unacceptable conditions. He called on WHO and the international community to ensure that African countries had access to vaccines and antiviral agents at affordable prices so that they would be equipped to deal with future epidemic outbreaks.

Mr NABEEL (Pakistan) said that his Government was striving to hone its response capacity to the desired international level. It had taken several measures to curb the spread of the pandemic, including enhanced surveillance at entry points and distribution of information on infection control to medical professionals and the general public. He expressed confidence that the Open-Ended Working Group would reach consensus on the Standard Material Transfer Agreement.

Mr SEADAT (Islamic Republic of Iran) said that his delegation had participated actively in the deliberations of the Open-Ended Working Group and was committed to achieving its objectives. The H1N1 pandemic had proved that the existing system for the sharing of viruses exacerbated inequities in the health domain. Developing countries were required to share their biological materials, but there was not a corresponding requirement regarding sharing of benefits. A legally binding system had to be created that required both providers and recipients to fulfil their commitments in the areas of access to vaccines and benefit sharing. Accordingly, he supported continuation of the work of the Open-Ended Working Group.

Ms MORALES (Bolivarian Republic of Venezuela) said that additional technical studies were needed in order to resolve issues relating to access to pandemic vaccines and ethical considerations in the marketing of vaccines, and her delegation therefore supported the Open-Ended Working Group's proposal for continued work on the matter.

Dr ABUDHER (Libyan Arab Jamahariya) said that the measures taken to curb the pandemic at the international level, such as awareness-raising and surveillance at entry points, had been adopted in his country. Medication had also been made available. The distribution of vaccines and the sharing of benefits should be equitable.

Mrs EL-HALABI (Botswana) expressed support for the proposed Standard Material Transfer Agreement and urged further clarification of benefit-sharing principles and issues of intellectual

property rights. Botswana had strengthened its structures at the national and district levels in order to improve coordination for pandemic preparedness and response and had set up a multisectoral pandemic influenza national task force. Laboratory diagnosis remained a challenge. Virus specimens from Botswana were currently sent to South Africa for testing, which prolonged the time required to obtain results. Efforts were in hand to develop in-country laboratory testing capacity.

Her Government had submitted an influenza A (H1N1) 2009 vaccine deployment plan to WHO and was awaiting approval of a donation to cover 10% of its vaccine requirement, although that would not be enough to vaccinate all priority groups. She appealed to the Director-General to increase the donation and requested that its delivery be expedited. She also suggested stockpiling at regional levels in order to facilitate access to vaccines and ensure timely distribution.

Professor Shan-chwen CHANG (Chinese Taipei), said that in response to the 2009 influenza pandemic, Chinese Taipei had implemented both non-pharmaceutical interventions, such as contact tracing and quarantine, and pharmaceutical approaches, such as stockpiling of antiviral agents and purchase of 15 million doses of pandemic (H1N1) vaccine. The mortality rate had thus been limited to 1.8 per million population and the pandemic had been successfully controlled.

Chinese Taipei had obtained H1N1 vaccine strains quickly from WHO and other sources and its only local vaccine manufacturer had thus been able to deliver 10 million doses of vaccine. If its regulatory authority were able to participate in the WHO vaccine prequalification programme, Chinese Taipei could contribute more vaccines against pandemic (H1N1) 2009 virus, influenza A (H5N1) virus or other viruses with pandemic potential. He applauded WHO's work in establishing an international stockpile of antiviral agents, pandemic vaccine and syringes and distributing those materials to countries in need. Chinese Taipei would be pleased to contribute vaccines and antiviral agents to the international stockpile or directly to countries.

Dr FUKUDA (Special Adviser on Pandemic Influenza) said that the Secretariat was committed to learning from the experience of the pandemic and applying the lessons learnt in order to improve its performance. The response to the pandemic was being examined in conjunction with a review of the implementation of the International Health Regulations (2005), which the Committee would be discussing subsequently. With regard to the strengths and weaknesses of the current system for sharing viruses and benefits, virus sharing during the pandemic had been successful, albeit with some shortcomings and difficulties in delivering resources in a timely manner. The Secretariat was committed to resolving those difficulties and would continue to provide support in order to ensure that vaccines, antiviral agents and other critical materials would be available when needed.

The DIRECTOR-GENERAL said that the strengths and weaknesses of the Organization's performance would be evaluated by the Review Committee on the functioning of the International Health Regulations (2005), which would issue a report in due course.

Dr NAKORN PREMSRI (Thailand) repeated his keenness to identify the strengths and weaknesses of the process under way within the Open-Ended Working Group. The ability to see those strengths and weaknesses would enable Member States to improve the process and resolve the remaining issues. He reiterated that industry should be invited to participate in the Working Group's deliberations.

The DIRECTOR-GENERAL said that she was reluctant to critique a process led by Member States' governments. She would leave the identification of weaknesses to the governments, but she could identify several strengths of the Working Group. One was the quality of its co-chairs. Another was the frank and open discussion of difficult issues, the understanding of which was key to the achievement of consensus. A third was the participation of many senior technical and political personnel in the Working Group, which was important because the issues under discussion were both technical and political.

The CHAIRMAN took it that the Committee was prepared to approve the draft resolution contained in the report of the Open-Ended Working Group.

The draft resolution was approved.¹

International recruitment of health personnel: draft global code of practice: Item 11.5 of the Agenda (Documents A63/8 and A63/INF.DOC./2)

Mr INFANTE CAMPOS (Spain), speaking on behalf of the European Union, proposed that a drafting group should be established to work on the draft global code of practice on international recruitment of health personnel and that the Committee should defer consideration of the item until later in the session. If established, the drafting group would begin its work immediately.

Mr AL-TAAE (Iraq) said that his delegation wished to join the drafting group.

Mr SEADAT (Islamic Republic of Iran) did not oppose the establishment of the drafting group, but said that he would have preferred that the Committee follow the normal procedure of introducing and discussing the agenda item before considering whether to set up the group.

Mr ELIRA DOKEKIAS (Congo) concurred with the delegate of Iran. A drafting group should be established only if, after discussion, the Committee decided that the draft code required amendment.

The DIRECTOR-GENERAL said that, as the item was open, the Committee could discuss the draft code if it so chose. Alternatively, it could suspend consideration of the item and resume it later, after receiving the report of the drafting group.

Mr LARSEN (Norway) pointed out that the Executive Board had already dealt twice with the issue of international recruitment of health personnel and that there had been an extensive consultation process in which all countries had had the opportunity to provide input on the draft code of practice. It would doubtless take time to come to agreement on the final code and, therefore, regardless of whether the Committee decided to establish a drafting group, the item should be discussed at an early point in the agenda.

Ms WISEMAN (Canada) said that it was her impression that, following consultations and the submission of comments on the draft code at the regional level, everybody wished to see the code adopted during the current Health Assembly. To that end, she supported the establishment of a drafting group.

The CHAIRMAN took it that the Committee wished to establish the drafting group and to suspend consideration of the item and resume it at a later time, as suggested by the Director-General. The drafting group would begin its work immediately under the chairmanship of Dr Viroj Tangcharoensathien (Thailand). He clarified that only Member States could participate in the group's work.

It was so decided.

(For continuation of the discussion and adoption of the WHO Global Code of Practice on the International Recruitment of Health Personnel, see the summary record of the tenth meeting.)

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.1.

Implementation of the International Health Regulations (2005): Item 11.2 of the Agenda (Documents A63/5 and A63/5 Add.1)

The CHAIRMAN announced that the Chairman of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009 would be available at the end of the meeting to respond to Member States' questions regarding the Review Committee's report.¹

Dr AL-SAYYAD (Bahrain) observed that increased international travel had led to increased public health risks. Bahrain had been selected from among the Member States of the Eastern Mediterranean Region to review the questionnaire prepared by the Secretariat regarding implementation of the International Health Regulations (2005) and had participated in a regional workshop to review the Regulations and a meeting to discuss their implementation at national level. His Government was committed to the full implementation of the Regulations.

Dr KESKİNKILIÇ (Turkey) commended the effective work of the WHO Office for National Epidemic Preparedness and Response in Lyon, in particular its training activities and production of educational materials. Access to training activities on the Regulations, which were an important component in strengthening national capacity, should be facilitated. Member States should be informed of such activities both through formal communication processes and national focal points. Educational materials should be accessible on the Internet and translated into the official languages of WHO and into other languages of Member States. Possibilities for distance learning should also be explored. Cooperation between countries was crucial to the successful implementation of the Regulations: experience should be shared, regional workshops should be organized and the measures taken by Member States to implement the Regulations should be compiled in a database. The WHO regional offices should focus on countries that required financial and other support in order to achieve the implementation targets. It was essential to improve early warning and response systems in order to control the threat of new and emerging diseases.

Dr MOHAMMAD (Kuwait) said that his Government had begun implementing the Regulations in June 2007. It had established a national focal point, appointed contact points to liaise with the Secretariat and the Regional Office for the Eastern Mediterranean, implemented the Regulations concerning all points of entry and provided training for personnel in those areas, and revised legislation to bring it into line with the Regulations. A computer network was being developed to link all points of entry.

Dr LEE Han-sung (Republic of Korea) commended WHO's efforts to tackle pandemic (H1N1) 2009 within the framework of the Regulations. Useful lessons had been learnt which would help with the challenges that lay ahead. The experience of the pandemic had underlined the importance of strengthening national capacity to implement the Regulations, especially in the least developed countries, and of bringing national legislation into conformity with the Regulations. It had also shown the need to incorporate measures into the Regulations to ensure adequate supplies of medicines, especially antiviral agents, which had been crucial in dealing with the pandemic, especially in the period before the vaccine had become available. The Secretariat should provide technical, financial and legal support to help to reduce implementation gaps among Member States.

Dr RAHMAH (Brunei Darussalam) said that the experience of the influenza pandemic had proved invaluable in testing and assessing the Regulations and in identifying key enabling factors such as use of existing reporting systems, identification of resources and the existence of effective, timely

¹ Document A63/5 Add.1.

communication networks. The questionnaire prepared by the Secretariat had been useful for assessing the status of implementation and addressing gaps and challenges in her country, and her Government was grateful for WHO's support and technical advice.

Mr PARRONDO (Spain), speaking on behalf of the European Union, welcomed the establishment of the Review Committee. The current pandemic had demonstrated the importance of the role played by the Director-General under the Regulations in managing international public health emergencies and had provided an opportunity for the Secretariat and Member States to assess the strengths and weaknesses of the global response to the situation. The work of the Review Committee and the experience gained in dealing with the pandemic would improve the global response to future public health emergencies. He commended the Director-General and Chairman of the Review Committee for the transparency of the review process. The discussions in the media and among politicians in the wake of the pandemic had shown the importance of such transparency. Member States should be encouraged to put forward the names of experts to be included in the Roster of Experts from which Review Committee members had been drawn and to continue providing information to assist the Committee in evaluating the response to the pandemic.

He stressed the importance of communication strategies. The information provided to the media should be assessed. The Event Management System was working well, but could be improved, notably through the creation of a special web page containing information on current emergencies. The European Union looked forward to the assessment of additional measures taken by Member States to address the pandemic's impact on public health and on international travel and trade, and it supported the strengthening of links with other international and intergovernmental organizations, as such coordination would enhance the response to future public health emergencies.

Dr NAKORN PREMSRI (Thailand) expressed gratitude to Mexico for having reported the first case of influenza A (H1N1) infection in a timely and open manner. Such reporting was crucial to maintaining an effective response system. He welcomed the establishment of the Review Committee and encouraged it to review all types of communications, including those between countries in the same region, regional offices and other partners. The Review Committee should also examine the benefits of parallel communications among national focal points, neighbouring countries and countries of origin and destination. He noted with concern that only 119 Member States had completed the questionnaire on the implementation of the Regulations, which would appear to indicate a slow rate of implementation. The Secretariat should strive to accelerate implementation. He requested an update on development of a web-based system for the reporting of progress in implementation of the Regulations and affirmed his Government's commitment to full implementation.

Dr BALUMA (Philippines) said that the questionnaire had enabled Member States to assess their progress in meeting core capacity requirements and implementing the Regulations. Pandemic (H1N1) 2009 had provided opportunities to improve core capacities and reassess surveillance systems. He welcomed initiatives to identify technical and financial resources to enable Member States to sustain their implementation efforts.

Timely communication had facilitated information-sharing among Member States on the evolving status of the pandemic and other health events. He commended efforts to encourage the notification of health threats associated with chemical, radiological and biological events. Member States should consider establishing event-based surveillance systems as his country had already done.

Ms JONES (United States of America) said that Member States should openly and transparently share information concerning disease outbreaks, as required by the Regulations. Her Government was ensuring that public health events were rapidly assessed and reported to WHO. She encouraged the Secretariat to engage other sectors in implementation of the Regulations. Intersectoral coordination was crucial given the broad scope of the Regulations. The Secretariat should continue to support

Member States in strengthening their core capacities and facilitate collaboration between States Parties in identifying and addressing areas of need in resource-constrained countries.

Pandemic (H1N1) 2009 had tested all aspects of the Regulations and exposed the weaknesses, gaps and challenges that should be addressed in order to ensure better preparedness. Her Government supported the work of the Review Committee and endorsed efforts to identify practical solutions to enhance response capacities and strengthen implementation of the Regulations.

Mr AL-TAAE (Iraq) said that, following ratification of the Regulations, his Government had established a committee to engage all related ministries, bodies and departments of health. The main implementation challenges in Iraq were collaborative capacity building involving all stakeholders and practical application of the Regulations. Controlling communicable diseases and combating pandemic influenza were two such applications.

Mr HAGE CARMO (Brazil) praised the transparent work of the Review Committee. The questionnaire on implementation of the Regulations would serve as an important tool for identifying gaps and assessing progress in implementation. The South American countries had developed their own questionnaire for evaluating their capacities. That exercise had strengthened cooperation among Member States in the region. He thanked WHO and PAHO for organizing a conference in Ecuador to facilitate the exchange of experiences in relation to the Regulations. Additional gatherings should be convened to focus on issues such as emergency communications between countries and WHO and legal aspects of implementation of the Regulations.

Dr PHILLIPS (Trinidad and Tobago) said that his Government had joined other Member States in fostering global partnerships through the sharing of information and expertise in dealing with public health emergencies of international concern. PAHO had played an active role in supporting the mobilization of resources for effective implementation of the Regulations in Trinidad and Tobago. Measures had been taken to develop and strengthen national capacity with regard to the detection and response to public health emergencies occurring at national and subnational levels, and particular progress had been made at points of entry. Work was under way to address challenges in the areas of documentation, legislation and human resource expansion.

Dr MELNIKOVA (Russian Federation) said that the Regulations were crucial to the organization of effective, internationally coordinated measures to prevent the spread of infectious diseases, including pandemic influenza. Information received through the framework of the Regulations had enabled her Government to put in place measures to forestall the pandemic. A flexible system, adapted to the requirements and capacities of Member States, was needed in order to respond to public health emergencies of international concern. The conclusions and recommendations of the Review Committee would highlight the corrections and additions needed to enhance the current system.

She welcomed the Secretariat's efforts to provide technical support to States in relation to infectious disease monitoring, laboratory strengthening and biosecurity. Those efforts should focus in particular on strengthening national capacities. She also welcomed the Secretariat's work to develop global partnerships with various international and intergovernmental organizations, especially in relation to transport. Further health protection measures should be developed within the framework of the Regulations, particularly in respect of international travel and transport. The Secretariat should step up work to develop a system of certification for transport companies and establish international and intergovernmental standards for ship sanitation control.

Dr ABUDHER (Libyan Arab Jamahiriya) said that his Government was firmly committed to implementation of the Regulations, the usefulness of which had been demonstrated by pandemic (H1N1) 2009. He thanked WHO for the concerted efforts made to facilitate implementation of the Regulations in order to protect international public health in the face of new pandemics.

Dr LIANG Wannian (China) expressed appreciation of the Secretariat's work on implementation of the Regulations. China had continued to strengthen its response capacity, for example by improving interdepartmental coordination, perfecting its health emergency alert system and working actively to prevent the spread of the pandemic (H1N1) 2009 virus. He suggested that all the health emergencies that had occurred since the introduction of the Regulations should be evaluated in order that the lessons learnt might inform the development of guidelines to enable more effective prevention and response.

He expressed his Government's profound thanks for the technical support provided by the Secretariat and the international community following the earthquake in Qinghai province in April 2010.

Dr GAMARRA (Paraguay) said that implementation of the Regulations had been crucial in helping countries to identify gaps at the national, subnational and regional levels, which in turn had encouraged training and the development of integrated national information systems. Strengthening of national information systems was critical for better and more timely application of the Regulations and emphasis should therefore be placed on developing such systems.

Paraguay was implementing the Regulations with the support of WHO and PAHO. An evaluation in 2009 of core capacities for detection and response to public health emergencies of international concern had led to the development of a national capacity-building plan for 2009–2012.

Dr SIMON (New Zealand) said that his Government strongly supported the Regulations and expected to be fully compliant with them by 2012. The Regulations had provided the main framework for the international response to the influenza pandemic in 2009. The designation of national focal points had facilitated effective communication between countries and with WHO as envisaged under the Regulations. The pandemic had highlighted the vital importance of national public health surveillance and response systems, and had demonstrated how such systems contributed to WHO's global surveillance and response coordination activities. New Zealand had fully discharged its obligations with respect to rapid reporting of cases of pandemic influenza and had made ample use of the secure Event Information Site.

He welcomed the Secretariat's efforts to strengthen global implementation of the Regulations. However, his Government had found the 2009 implementation questionnaire overly complex and excessively long; a review of its design might encourage full responses from Member States to future questionnaires. He acknowledged the constraints faced by small countries in meeting their obligations under the Regulations and urged the Secretariat to ensure that they received the support they needed.

Dr MOREIRA (Ecuador) affirmed his country's commitment to implementing the Regulations. In 2009, the Central and South American countries including Ecuador had used an instrument designed by MERCOSUR to assess core capacities at national and local level. That instrument had included 27 evaluation indicators, some of which had differed from the indicators in the WHO questionnaire. He suggested that the indicators to be included in future surveys be agreed with Member States and formulated so as to enable comparison with the 2009 evaluation. It would thus be clear where progress had been made.

Mr TOBAR (Argentina) said that MERCOSUR had set up an intergovernmental commission for the implementation of the International Health Regulations (2005) and had designed various instruments for assessing core capacities, including at subnational levels. Those instruments might be useful to countries in other regions. He underlined the importance of ensuring intersectoral coordination in the application of the Regulations and of maintaining open channels of communication between national focal points.

Mrs TOLSTOI (France) expressed her Government's strong support for implementation of the Regulations and welcomed the initiative taken by the Director-General in convening the Review

Committee. Pandemic (H1N1) 2009 had highlighted the urgent need to continue strengthening national capacities, including diagnostic capacity, and to enhance the effectiveness of national focal points. It was also vital to ensure that public health measures were undertaken in a coordinated manner in order to check the spread of epidemics. WHO had a key role to play in that regard. The pandemic had clearly demonstrated the difficulties States faced in mounting a rapid response to international public health emergencies once WHO had raised the alarm. Her Government supported application of the provisions of Article 11 of the Regulations, which allowed early sharing of information on events still being investigated. Such information could help national focal points to accelerate the response to events that were eventually determined to be public health emergencies of international concern.

She welcomed the establishment of an expert group to finalize the list of countries where WHO might recommend disinsection for departing conveyances. The approach taken should be based not on countries but on points of entry. The Secretariat should undertake an examination of the methods and products used for disinsection of aircraft, focusing in particular on their safety and effectiveness, and should provide technical guidelines on matters relating to implementation of the Regulations, such as the criteria for imposition of quarantines.

Dr TAKEI (Japan) said that strengthening of core capacities was essential for further implementation of the Regulations. Greater coordination between organizations was required in order to enhance information-sharing and a communication strategy was needed that included infectious disease, chemical and food safety threats. With regard to Annex 2 of the Regulations, he noted wide variation in the quality of data reported by Member States and suggested that the Secretariat could improve the quality by providing technical support to countries or by using less-complex indicators for assessing the timely reporting of emergency situations. Responses to the H1N1 pandemic should be evaluated in order to provide guiding principles for use in respect of future pandemics. His Government was reviewing its own experiences in relation to the pandemic and would be pleased to share the results with other countries.

Dr BOUARE (Mali), speaking on behalf of the Member States of the African Region, said that all of them had undertaken to implement the Regulations by June 2012. To date, 17 African countries, including his own, had revised their national guidelines on integrated disease surveillance and response. A total of 85 laboratories in the Region were participating in external quality assurance programmes. All 46 African Member States had designated national focal points and were committed to ensuring that those centres operated 24 hours a day, seven days a week. Steps were being taken in countries across the Region to strengthen channels of communication with WHO and with other sectors. Thirty-one African countries had identified the national body responsible for implementation of the Regulations and 17 had designated at least one expert for inclusion on the Roster of Experts. Twenty-six countries had identified the competent authority at points of entry and 10 had submitted a list of ports authorized to issue ship sanitation control certificates and ship sanitation control exemption certificates. In 2009, 36 countries had submitted annual reports on implementation of the Regulations to WHO.

In order to meet the 2012 implementation deadline, the African States would need to take several measures, including mobilization of resources, revision of national technical tools and guidelines in order to bring them into line with the Regulations, assessment and development of national capacity for surveillance and response, strengthening of collaboration between the health sector and other sectors and enhancement of national, regional and international cooperation for information-sharing, strengthening of mechanisms to ensure equitable access to vaccines and medicines, and revision and adoption of regulatory and legislative measures. The Member States of the African Region looked to WHO for support in surmounting those challenges.

Professor Shan-Chwen CHANG (Chinese Taipei), said that Chinese Taipei had been dutifully fulfilling its obligations under the Regulations since January 2009. A contact point had been designated for communications with WHO under the Regulations and core capacities for surveillance

and response had been assessed and improved. Efforts had focused in particular on designated points of entry. A major obstacle to the development of core capacities was lack of experience, and Chinese Taipei would welcome support from Member States that had such experience and from the Secretariat. He expressed appreciation of the WHO Event Information Site, which made it possible to obtain timely information about public health emergencies and respond to them more rapidly. Chinese Taipei would continue to cooperate with Member States and with the Secretariat in the implementation of the Regulations.

Dr FINEBERG (Chairman, Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009) said that the Review Committee had drawn enormous benefit from input from States Parties and from various international organizations and would welcome continued advice and guidance, particularly in relation to the management of pandemic (H1N1) 2009. The discussion had highlighted the importance of strengthening national capacity, of communication, of flexibility in the response to international public health emergencies and of intersectoral coordination. Those were important considerations for the Review Committee to bear in mind, as were the lessons learnt from national reviews. The Committee would do its utmost to provide the Director-General with an independent and honest assessment of how well the Regulations were functioning and to do so in a manner that was open and available for scrutiny by Member States and other interested parties.

Dr FUKUDA (Special Adviser on Pandemic Influenza) pointed out that the Review Committee would also be looking at aspects of implementation of the Regulations not related to the pandemic. He had noted a high degree of consensus on the importance of the Regulations in coordination of the response to public health events of international concern. He had also noted the emphasis placed on importance of developing national capacities to implement the Regulations. He could not give a precise date for the launch of the web-based tool, but the target date was August or September 2010. To date, 101 responses had been received to the questionnaire. The information gathered thereby at the international level could be usefully augmented by input from regional instruments, such as the MERCOSUR questionnaire; however, questionnaires would need to be harmonized in order to avoid imposing an additional reporting burden on countries. The Secretariat would endeavour to ensure consistency of indicators and to reduce the length of the questionnaire. Concerning the comments on disinsection, he reported that a consultation on the matter was currently under way. As to Article 11 of the Regulations, information was made available on the secure portion of the Event Information Site about health events that had not been formally identified as public health emergencies of international concern.

The CHAIRMAN took it that the Committee wished to note the report.

It was so agreed.

The meeting rose at 19:15.

SECOND MEETING

Tuesday, 18 May 2010, at 09:15

Chairman: Dr M. MUGITANI (Japan)

1. FIRST REPORT OF COMMITTEE A: (Document A63/58)

Dr MISHRA (Nepal), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

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

Public health, innovation and intellectual property: global strategy and plan of action:
Item 11.3 of the Agenda (Documents A63/6, A63/6 Add.1 and A63/6 Add.2)

The CHAIRMAN introduced the item and drew attention to a draft resolution proposed by Ecuador on behalf of the Union of South American Nations (UNASUR), which read:

The Sixty-third World Health Assembly,

PP1 Having considered the reports on public health, innovation and intellectual property: global strategy and plan of action;²

PP2 Considering resolution WHA61.21 which requests the Director-General “to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consideration of proposals from Member States, and to submit a progress report to the Sixty-second World Health Assembly and the final report to the Sixty-third World Health Assembly through the Executive Board”;

PP3 Bearing in mind that the Expert Working Group on Research and Development: Coordination and Financing did not explore the intellectual property dimension, stating in the executive summary of its report³ that “the relevance of the integrity of intellectual property rights is well documented with respect to the need to foster and favour research and development”, a position that is at odds with the mandate established under resolution WHA61.21;

PP4 Emphasizing that the Expert Working Group on Research and Development: Coordination and Financing made some progress in analysis and proposals for coordination among research and development activities, as called for in resolution WHA61.21;

¹ See page 321.

² Documents A63/6, A63/6 Add.1 and A63/6 Add.2.

³ Document EB126/6 Add.1, Annex.

PP5 Noting that because, according to the executive summary report of the Expert Working Group on Research and Development: Coordination and Financing,¹ “the financing of research and development was examined, dividing diseases into the noncommunicable and the communicable groups for ease of analysis and because the data sources lent themselves to this analysis more readily than if the taxonomy of Types I, II and III had been used”, the Working Group failed to fulfil the mandate it had been given;

PP6 Considering that some of the proposals by the Expert Working Group on Research and Development: Coordination and Financing were discarded or were judged unsatisfactory, although the reasons for this conclusion were not stated in the report;

PP7 Further considering that, in its recommendations, the Expert Working Group on Research and Development: Coordination and Financing states the need to conduct an in-depth review of own proposals;¹

PP8 Observing that the Expert Working Group on Research and Development: Coordination and Financing failed to address the disconnection between the cost of research and development activities and the price of health products;

PP9 Emphasizing the importance of public funding of health research and development and the role of the State in regulating health research and development;

PP10 Affirming that, for the reasons stated, the Expert Working Group on Research and Development: Coordination and Financing has not fulfilled its mandate in respect of the principles and objectives contained in resolution WHA61.21, and that the requirements that the Group was supposed to satisfy still need to be addressed,

DECIDES that an intergovernmental group should immediately be constituted in order to make progress towards the development of innovative and sustainable financial mechanisms for research and development, in accordance with element 7 of the Global strategy on public health, innovation and intellectual property; that this group should be given a fixed-term mandate; and that it should inform the Executive Board at its 128th session of any progress made and submit its conclusions to the Sixty-fourth World Health Assembly.

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

1. Resolution Establishment of an intergovernmental working group to make progress in the development of innovative and sustainable funding mechanisms for research and development	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
11. To ensure improved access, quality and use of medical products and technologies.	11.1 Formulation and monitoring of comprehensive national policies on access, quality and use of essential medical products and technologies advocated and supported.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution has links with work to facilitate and implement activities for the global strategy and plan of action on public health, innovation and intellectual property.	

¹ Document EB126/6 Add.1, Annex.

<p>3. Budgetary implications</p> <p>(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).</p> <p>US\$ 3 million. This includes staff costs and the estimated cost of two meetings at headquarters over a duration of five working days per meeting. The costs concern travel, meeting rooms, translation and interpretation, security and general support.</p> <p>(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).</p> <p>US\$ 3 million. This includes the estimated cost of the two meetings at headquarters as mentioned in 3(a).</p> <p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</p> <p>No.</p>
<p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Through voluntary contributions provided by Member States.</p>
<p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>Implementation will take place at headquarters, however all levels of the Organization will be involved.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>No.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>One technical officer at P4 level and two administrative staff at G5 level.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>One year.</p>

Dr SULEIMAN (Oman), speaking as Chair of the Consultation on the Report of the Expert Working Group on Research and Development: Coordination and Financing, recalled that, in accordance with resolution WHA61.21, the Expert Working Group had been convened to study the existing financing and coordination mechanisms for research and development activities. It had submitted its report to the Executive Board at its 126th session. The Board had requested that the full report be made available in the six official languages and uploaded for a web-based consultation. The Board had further requested a one-day informal consultation, which had been held in Geneva on May 13. The consultations had dispelled misunderstandings that had arisen during the initial consideration of the report by the Board: in regard to, first, the inclusion of recommendations in the executive summary that did not appear in the full report and, secondly, the expectations that some Member States had held of broader terms of reference for the Expert Working Group.

Several areas required further analysis including feasibility and impact studies. He requested that two principal options for future progress be discussed by the Committee: the convening of a new expert working group or the establishment of an intergovernmental working group.

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the Member States of the European Union, expressed appreciation for the investigations of the Expert Working Group into new financial mechanisms and the transfer of pharmaceutical technologies to developing countries. Agreements had been signed between the European Commission, WHO and the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases in relation to elements 1, 3 and 4 of the global strategy and plan of action. He emphasized that the European Union funded national and regional networks. The main obstacles to technology transfer and local production in developing countries would be analysed further in collaboration with UNCTAD.

With regard to the Report of the Expert Working Group, he commended the Secretariat's organization of both the web-based consultation and the informal meeting of Member States which had led to important clarifications. The analysis contained in the Report should be understood within the context of activities made possible by WHO's mandate, capacity and expertise. It was important to find more efficient and transparent mechanisms for the collection and distribution of financial resources for research and development in the context of neglected diseases, as well as to ensure the judicious use of public funding. The consultations had made it possible to refine and develop the proposals contained in the report, which would allow the Executive Board to decide on the next steps at its 127th session. He did not agree with the proposal for an intergovernmental working group: continued exploration of the viability of existing proposals at national and regional levels would be preferable.

Dr MUKABI (Kenya), speaking on behalf of the Member States in the African Region, said that the delivery of quality health services, particularly in sub-Saharan Africa, was affected by both the burden of communicable and noncommunicable diseases and the very limited allocation of resources to research and development. He expressed appreciation for WHO's efforts to promote research, development and standards related to traditional medicine; the African Region, with its great potential in that area, should receive support for the implementation of the Beijing Declaration on Traditional Medicine (2008) from WHO's Quick Start Programme. However, the Region was still unable fully to use the flexibilities under the Agreement on Trade-Related Intellectual Property Rights (TRIPS) in order to improve access to essential medicines, and further support was required.

He commended WHO's support for the African Network for Drugs and Diagnostics Innovation; Kenya was preparing to host the third stakeholder meeting in October 2010. WHO should also work with partners such as the African Development Bank to establish an African innovation fund.

The Expert Working Group had in many respects fulfilled its mandate under resolution WHA61.21; however, its Report lacked in-depth analysis of the current financing and coordination of research and development in developing countries that would have formed a basis for assessment of proposals. He also expressed concern that the Report was overly representative of the developed world and did not take developing countries fully into account, notably in regard to de-linking the cost of research and development from the price of the final product in targeting diseases that disproportionately affected developing countries, and in the identification of alternatives to intellectual property as an incentive for research and development into public health goods.

He welcomed the actions taken by the Secretariat in response to concerns about the performance of the Expert Working Group and control of any conflict of interests among its members; he expressed support for the establishment of a new expert working group comprising representatives from all regions, with clear terms of reference and a time frame of at least two years.

Dr ALHAMER (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, recalled the provisions of the Doha Declaration on the TRIPS Agreement and Public Health, whereby countries, in response to issues that affected public health, could produce

pharmaceutical products without prior authorization of the patent holder or purchase medicines through parallel importation. Guidelines were needed on the extent to which countries could amend their legislation to handle situations calling for an emergency response, as was a definition of the term “emergency situation”. He expressed his support for the establishment of a new expert working group to consider that issue and the related questions of intellectual property. That solution would build on the progress achieved by the Expert Working Group and, taking account of previous decisions, would assist in finding coordination and financing mechanisms.

Mr PRASAD (India) commended the progress of WHO’s Quick Start Programme and expressed support for the mapping of global research and development activities, the setting of research priorities, and the setting of standards for traditional medicines in developing countries.

He welcomed the Report of the Expert Working Group. However, it had not dealt with many issues related to intellectual property, particularly in relation to the flexibilities provided by the TRIPS Agreement and TRIPS-plus measures, such as data exclusivity, extensions to patent terms and the enhanced scope of provisions for border enforcement. Implementation of those measures by developed countries obliged the adherence of developing countries through free-trade agreements or as part of financial aid packages. Another concern was the proposed anti-counterfeiting trade agreement, which would allow the seizure in transit of generic pharmaceutical products, thus making the trade in low-cost, generic products illegal.

Although the Report made reference to lack of access to knowledge, the proposed solution of buying out patents and compulsory licences, for example through patent pools, would be difficult owing to both the limited possibility of adequate financial grants from developing countries and the unwillingness of patent holders to sell the patents. Furthermore, the purchase of patents would not resolve the underlying issue of lack of knowledge related to the patented invention.

The Report had left too much for future work: having assessed proposals, it then failed to analyse the perceived combination of mechanisms that would deliver solutions for health; having established the benefits of cost-saving platforms for research and development, it failed to analyse how to increase investment in those for the needs of developing countries. He supported the creation of an intergovernmental working group to continue and build on the achievements of the Expert Working Group.

Dr SUNDORO (Indonesia) said that issues related to patents had long been a priority. The mandate of the Expert Working Group had been to consider the financing of research and development and report back to Member States. With regard to furthering progress, he favoured the creation of an intergovernmental working group.

Mr TOBAR (Argentina) said that the informal consultations had highlighted the weaknesses of the Report and the ambiguities in the mandate of the Expert Working Group. The Report contained many vague proposals, lacked in-depth analysis, and failed to explore several new funding mechanisms. The selection process of the experts concerned had lacked transparency. He therefore preferred the option of creating an intergovernmental working group in order to build on the activities of the Working Group.

Dr ALI (Bangladesh) said that, despite its limitations, the Report of the Expert Working Group could serve as a basis for future work. He called upon the Director-General to facilitate detailed consultations with Member States on the proposals made and other viable proposals that had not been fully analysed by the Working Group. A further expert working group could be established. The Secretariat should pursue the issue of de-linking the costs of research and development from the price of medical products, a key element in the global strategy and a high priority for many less developed countries. He looked forward to future reports on the impact of work to advance the global strategy and plan of action.

He welcomed the collaboration between WHO and other bodies, including WIPO and WTO, within the context of the global strategy. Excessive emphasis should not be placed on intellectual property enforcement and protection, in particular to the detriment of the least developed countries, and account should be taken of the flexibilities in place. He also welcomed the Quick Start Programme, and emphasized the need for regional mapping of research and innovation: projected work in the South-East Asia Region should take account of that proposal. He sought further information on the work done by entities outside WHO in pursuit of the priorities of the global strategy and plan of action.

Mr SILBERSCHMIDT (Switzerland) said that the Secretariat, Member States and partner institutes must coordinate their efforts to implement the eight elements of the global strategy and plan of action. In Switzerland, all activities associated with implementation of the plan of action were being evaluated, including those undertaken by the relevant ministries, by nongovernmental organizations, the pharmaceutical industry, public-private partnerships and in the scientific arena.

He commended the numerous initiatives contained in the report by the Secretariat. It would be useful to link each activity with an element of the global strategy. Particular attention should be paid to promoting implementation of the global strategy and plan of action in the African Region. He highlighted the initiative in the report concerning the framework designed to support countries in implementing the global strategy: the Netherlands and his country would be providing voluntary financial assistance, in collaboration with the New Partnership for Africa's Development, and he invited all interested delegations to a briefing session to be held on Wednesday, 19 May.

He welcomed the Report by the Expert Working Group, notably the recommendations concerning support for tracking resources and support for the creation of a global health research and innovation coordination and funding mechanism. Specific proposals for additional sources of funding for research and development should be discussed in greater detail, perhaps by an enlarged expert group. He strongly supported the proposal by the delegates of Kenya and Bahrain to establish a new expert working group, but only following discussion at the intergovernmental level.

Dr CHIRIBOGA (Ecuador) said that, at the recent meeting of health ministers of the Union of South American Nations held in his country, participants had concluded that access to medicines was a priority. The lack of research and development on medicines to treat diseases that were prevalent in many countries in the region had hampered access to medicines. One of the objectives of the global strategy and plan of action on public health, innovation and intellectual property was to increase efforts to promote access to medicines for diseases that disproportionately affected developing countries. The Expert Working Group had not fulfilled its mandate as its Report neither established nor identified specific financing alternatives to promote research and development and help to resolve the problem of access to medicines. Consequently, an intergovernmental working group should be set up to continue the work to identify innovative and sustainable funding mechanisms. That would call for a specific proposal for funding the intergovernmental working group. He urged Member States to support the draft resolution.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that the work of the Expert Working Group had not met the expectations of Member States: issues such as de-linking the cost of research and development from the price of health products, and the financing activities for Type I, II and III diseases had not been analysed in detail, nor had civil society been sufficiently involved in the consultations. He did not support the re-establishment of an expert working group of limited composition, but fully supported the proposal of the delegate of Ecuador, since governments must regain control and move the process forward.

Mr DE ALBUQUERQUE E SILVA (Brazil) affirmed WHO's central role as a provider of technical and political support to countries that intended to use the flexibilities provided for by the Doha Declaration on the TRIPS Agreement and Public Health. The global strategy and plan of action

had identified eight elements to be implemented to ensure access and innovation for needed health products and medical devices, with particular emphasis on the needs of developing countries. The Report of the Expert Working Group contributed to those objectives that were key issues in nearly all developing countries. However, the Report had flaws, which included: the separation of its conclusions from the indicators contained in the plan of action; the absence of critical analysis of the current system of stimulating innovation in the development of medical products, a system that was based exclusively on intellectual property rights; and it ignored the question of access to innovative treatments at fair prices for populations in developing countries. He supported the draft resolution; an intergovernmental working group with a fixed-term mandate would complement the work already undertaken by the Working Group.

Mr HOHMAN (United States of America) expressed regret that the extremely useful background information given by two members of the Expert Working Group at the informal consultations the previous week had not been included in the outcome report (document A63/6 Add.2). Although the mandate given to the Working Group by resolution WHA61.21 had been broad and open to interpretation, he saw no reason to criticize its method of work. The Working Group had made a wide range of proposals, and there was nothing to prevent Member States from proceeding with proposals that it had chosen to reject.

His Government did not support the proposal to establish an intergovernmental working group, which was likely to be a lengthy and costly exercise; he requested details of the financial implications of the draft resolution. Nor could his country support the establishment of another expert working group. However, a new group of experts might recommend to Member States ways of building on the proposals made by the Working Group, rather than consider new proposals linked to research and development for neglected diseases.

Dr TAKEI (Japan) said that factors such as the health system, the regulation system, quality assurance, appropriate use of medicines and the delivery system of medicines had a critical impact on the promotion of innovative research and development and on access to medicines and vaccines for diseases that disproportionately affected developing countries. Accordingly, he commended the Expert Working Group. He favoured expert consultations, rather than an intergovernmental process, as the option for clarifying certain elements of the Report, such as operational aspects. His Government had contributed to international activities through the provision of training workshops and research and development experts. WHO should continue to exercise leadership in the area of public health, innovation and intellectual property.

Dr THARNKAMOL CHANPRAPAPH (Thailand) said that the implementation of the global strategy and plan of action made great demands on Member States, and her Government was drafting a national plan of action. In response to the questions raised about the leakage of the preliminary report of the Expert Working Group, the investigation undertaken by WHO's Office of Internal Oversight Services had proven that the leak had not come from the Secretariat. By initiating the investigation, the Director-General had safeguarded the integrity of WHO. The incident should serve as a useful lesson.

The Report should be used as a basis for further work; however the methodology used by the Working Group had been limited in scope since innovations outside existing mechanisms had not been considered. The establishment of a new expert group was preferable to the convening of an open-ended intergovernmental working group, and the impartiality and independence of its members must be ensured.

Following the incorporation of TRIPS flexibilities into legislation by her country, access to seven essential medicines had increased more than ten-fold and costs had been reduced. Thailand was grateful to WHO for its support in that regard and would be pleased to share its experience with interested Member States.

Ms HAMILTON (Canada) welcomed the recent initiatives by the Secretariat concerning the global strategy and plan of action, including those to promote the transfer of technology, establish regional research and development networks, and to strengthen the WHO Prequalification of Medicines Programme.

She commended the Expert Working Group and welcomed the analysis in its Report, and the potential of practical initiatives for the financing of research and development. She agreed that it would have been useful for the Health Assembly to hear from members of the Working Group regarding the process and methods of work. Her Government would have difficulty in supporting the establishment of an intergovernmental working group and she suggested that WHO, in consultation with Member States, should determine how the next stage should be approached. A supplementary expert working group might be considered in order to undertake further analysis of the recommendations contained in the Report.

Dr LIU Dengfeng (China) welcomed WHO's encouragement of health-related innovation to meet the needs of developing countries and to ensure the availability of public health services and products. That included its work concerning research and development and its financing, and relevant incentive arrangements. The Report of the Expert Working Group aimed to ensure global health equity, particularly among poor and vulnerable groups in middle- and low-income countries.

WHO should establish an effective mechanism for allocation of financial and technological support from developed countries. Research and development should target diseases prevalent among poor populations in middle- to low-income countries; therefore the capacity for research and development and innovation within developing countries should be supported. New and innovative sources of financing should be considered within the specific context of the country concerned.

Mr AL-TAAE (Iraq) said that support for public health, innovation and intellectual property should be enhanced through better links between the Secretariat and Member States. Those should include the sharing of expertise; establishing standards for strengthening of public health, innovation and intellectual property; disseminating information by means of web sites and through conferences; and the inclusion of public health, innovation and intellectual property in WHO's biennial programmes.

Dr UGARTE UBILLUZ (Peru) said that the crux of the discussion was the existence of flexibilities under the TRIPS agreement as set out in the Doha Declaration. The Expert Working Group had been required to make proposals on innovative and sustainable financial mechanisms for research and development, which had raised the expectations of developing countries with respect to its outcome. However, one of the main conclusions of the Report concerned how developing countries financed or purchased patents, which was clearly not within the mandate of the Working Group. Other proposals for consideration, such as how to finance treatment for orphan and neglected diseases, for example Type II and III diseases, had been rejected. He questioned the need for a working group since countries were already negotiating with companies that produced and sold medicines to developing countries and should continue to do so. He agreed that the Working Group had not fulfilled its mandate, and supported the proposal to establish an intergovernmental group that would formulate innovative and sustainable financial mechanisms and submit its report to the Sixty-fourth World Health Assembly.

Dr LANDAETA (Bolivarian Republic of Venezuela), noting the Secretariat's efforts to implement the plan of action, said that the Report of the Expert Working Group had dealt only generally with how to provide incentives for research and development and contained proposals for financing mechanisms that placed the final responsibility on users, who were the very persons most affected by the diseases. Discussion of incentives for research and development should not be separated from discussions on intellectual property rights. He could not endorse a report containing so many inconsistencies, such as inclusion in the executive summary of recommendations that were not

in the report itself and with only a vague reference to de-linking. It supported the position adopted by the Union of South American Nations to establish an intergovernmental working group of short duration and report back in one year.

Mrs CHISTYAKOVA (Russian Federation) favoured continued international cooperation on science and innovation in order to help to achieve the health-related Millennium Development Goals, innovation and intellectual property rights. She also favoured developing a mechanism to coordinate research, particularly for Type II and III diseases, and to evaluate existing mechanisms in order to meet the expectations of Member States.

Dr SULEIMAN (Oman) expressed concern that certain diseases had been prevalent for nearly 60 years, especially in developing countries, and for which no cure or medicine had been developed. He urged the Secretariat to intensify its efforts in that regard. He supported the proposal of the delegate of Bahrain to set up a new expert working group to consider the proposals submitted.

Dr GAMARRA (Paraguay) supported the proposal by the delegate of Ecuador. Intellectual property was indeed a sensitive and complex issue in the context of health care and trade. She recalled the successful experience in negotiating the WHO Framework Convention on Tobacco Control, which had endowed the Organization with a legal instrument that was helping to save thousands of lives and had found a balance in dealing with trade issues thanks to a negotiated consensus. When deciding whether to establish an intergovernmental group, consideration for saving lives and improving the quality of life must be the Organization's first priority.

Mr CÓRDOVA VILLALOBOS (Mexico) noted with appreciation the progress made thanks to the efforts of the Expert Working Group, and which should continue until consensus was found among Member States. He suggested that a special group be established to consider proposals and work to a cost-efficient schedule.

Mr HOUSSIN (France) said that the Report of the Expert Working Group constituted an instrument that offered various approaches to implementation of elements 2 and 3 of the global strategy and plan of action and which should be applied as needed. Complementary studies should be undertaken on the feasibility and potential effectiveness of proposed solutions. As several delegates had emphasized, there was no need for a protracted intergovernmental negotiating process.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the issue of researching and implementing new mechanisms to de-link incentives for research from the cost of medical technology, in particular medicines, remained controversial. At the last meeting of the countries of the Non-Aligned Movement the problem of finding ways to provide incentives for research, particularly into diseases affecting developing countries, had been raised.

The Report of the Expert Working Group was required to provide Member States with guidance on the issues. However, many countries in the Region of the Americas had not been directly involved and considered that they had been left out of the process, without full access to available information. The report indicated that it had concentrated on public financing mechanisms because the relevance of intellectual property rights was well documented, particularly with respect to their perceived positive effect on promoting and improving research and development. That demonstrated the unchanged view held in many countries, particularly developed countries, that intellectual property rights did stimulate research and development. As the issue had not been thoroughly investigated, he supported the proposal to establish an intergovernmental group.

Mr CUERVO VALENCIA (Colombia) said that the right to health was fundamental and that access to medicines was recognized as a public good. Consequently, mechanisms to break the mould of the development and supply of new medicines to markets based on the ability to pay should be

strengthened. He supported the proposal to establish an intergovernmental group. Such a group might generate alternative forms of financing that would de-link the cost of research and development from the final cost of medicines and might clarify exactly how the TRIPS flexibilities could benefit countries by offering more reasonable prices for medicines and providing proper medical treatment of neglected diseases.

Professor KOUASSI (Côte d'Ivoire) said that, although the global strategy had been adopted at the Sixty-first World Health Assembly, consensus had not been reached on some points of the plan of action. At the Sixty-second World Health Assembly some follow-up on progress indicators agreed by Member States had been adopted in resolution WHA62.16. He commended the detailed report by the Secretariat.

Ms STEEN (Norway) said that the consultations held on 13 May 2010 and the comments made by Member States at the current meeting had highlighted some of the weaknesses of the Report by the Expert Working Group. The lack of specific terms of reference for the Working Group made it difficult to assess its compliance with its mandate. She was hesitant about establishing an intergovernmental working group without a specific mandate and requested the Director-General's interpretation and suggestions for how to progress further. She supported the proposal to establish another expert working group, but one with a clear mandate.

Professor Pei-Jer CHEN (Chinese Taipei), said that Chinese Taipei was in the process of amending its own Patent Act in order to ensure the efficient granting or extension of patents. Chinese Taipei continued to work on regulatory harmonization with its regional and international partners; it was keen to develop new diagnostics and vaccines against infectious diseases and would also like to participate in the global network and share its experience. It was committed to collaborating with international organizations on capacity building and training in intellectual property rights. However, the ultimate goal of the implementation of intellectual property rights was to improve public health, but emergencies called for a delicate balance between intellectual property rights and medical necessity.

Mr JAFRI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, agreed with the Expert Working Group that the two main barriers to the effective treatment of many patients were the lack of innovative therapies and the lack of access to already developed therapies. Thus his alliance supported an approach that balanced the need for access to affordable medicines and the development of safer and more effective medicines. It was regrettable that patients and their national and local groups had been neither encouraged to participate nor provided with the necessary support structures. He urged WHO and all stakeholders in the follow-up work of the Working Group to ensure that patients and patient groups were given a central role in the review of proposals.

Mr MBEWU (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, welcomed the Report of the Expert Working Group and the recommendations that WHO should support resource tracking and the creation of a global health research and innovation coordination and funding mechanism. An independent, neutral and sustainable mechanism to review all existing and newly proposed incentives for innovation should be established to address health needs of developing countries, a task consistent with the global strategy and plan of action. The Global Forum confirmed that it would be willing to coordinate those efforts. Member States should implement at least some of the promising schemes outlined in the Report. Her organization was also working with partners to assess donor options for grants to small- and medium-sized enterprises in developing countries, in line with funding approaches highlighted in the Report.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, urged Member States to sustain the momentum that had led to the adoption of the global strategy and plan of action, and to overcome the fundamental problems associated with a commercial research and development system driven by reward. Implementation of the strategy must be a priority, with the Secretariat's resources and expertise strengthened and sound engagement achieved with public interest groups.

The Report of the Expert Working Group had not paid sufficient attention to de-linking the cost of research and development from the price of health products. Innovation was meaningless without access. Funding mechanisms that allowed de-linkage, including push mechanisms such as product development partnerships and pull mechanisms such as prizes, should be designed to deliver products that met medical needs and ensured affordability. The process to be agreed by Member States should review current and proposed mechanisms to stimulate research and development. Individual initiatives, such as a prize fund for a tuberculosis diagnostic test at point-of-care, could be established quickly and tested; the UNITAID patent pools should be supported, and norms and principles should be elaborated by stakeholders to ensure equitable access to research and development for health products.

Mrs MATSOSO (Public Health, Innovation and Intellectual Property) observed the importance of the global strategy and plan of action, whose adoption was an expression of commitment by stakeholders at a global level, under the leadership of governments. She noted that the Chair of the Expert Working Group was present and could respond to comments on its work. She would comment on remarks about the Secretariat's work.

In response to the delegate of Kenya, she said that recognition had been given to the work carried out in relation to the eight elements of the global strategy and plan of action; the mapping of priorities in research and development; traditional medicine; and training and support on intellectual property and technology transfer. Further efforts would be made to provide support, particularly in Africa, as requested by the delegate of Switzerland. An innovative tool had been launched jointly with the African Union and The New Partnership for Africa's Development to assess the capacity of countries to undertake research and development work in Africa. As a next step Member States should allow that assessment to be made with the support of the Secretariat. Work had been carried out in the regions, particularly in the Region of the Americas and the South-East Asia Region, with initial support from the Secretariat.

The delegates of Bahrain and India had called for the development of guidelines, particularly with regard to flexibilities under the TRIPS agreement. The Secretariat had completed preliminary work with WIPO on a comprehensive assessment of national patent law. During the Secretariat's analysis of three TRIPS flexibilities, namely research exceptions, compulsory licensing and the Bolar provision, only 45 countries had responded. The Secretariat had provided support to Member States, particularly China and India and countries in the African Region, for assessing patentability criteria.

Responding to a point made by the delegate of Bangladesh, she said that WHO, WIPO and WTO were jointly providing support for activities relating to intellectual property including training programmes. Member States should determine what should be undertaken by the Secretariat in relation to element 5 of the global strategy. In response to the call by the delegate of Canada for a systematic reporting framework, she said that a framework had indeed been established and she urged Member States to read the online preliminary report on that matter. That report outlined further work with baseline data on technology transfer, initial data collected specifically on intellectual property, and mapping and prioritization concerning research and development.

The DIRECTOR-GENERAL, responding to the question by the delegate of the United States of America about the financial implications of the draft resolution, said that, if the Health Assembly decided to establish an intergovernmental working group, it would cost about US\$ 3 million to organize two meetings of about five days each.

Reaching agreement on the global strategy and plan of action had been a landmark for Member States, which had shown flexibility and awareness of the important links between public health, innovation and intellectual property. The subject area was complex, with numerous stakeholders and many different positions being held. In that connection, she had noted the views expressed also by observers and nongovernmental organizations in official relations with WHO. She commended the work of the Expert Working Group and thanked the experts who had participated in the informal consultation the previous week for amplifying their recommendations. She noted the remarks of the delegate of Norway about the scope of the mandate of the Working Group and the expectations of Member States. However, there appeared to be no disagreement that the Report was an important first step and the momentum it had created must not be lost.

In regard to the next step, some countries had expressed a preference for an intergovernmental working group, whereas others had proposed a new expert working group. Both options would, however, require additional resources. It had also been suggested that the Secretariat might ask the experts to carry out a more in-depth analysis and advise on progress. The delegate of Canada had suggested further consultation with Member States on how to proceed. However, in the absence of consensus, the Organization could not move ahead and she looked to the Member States for guidance. She emphasized her commitment and that of her staff to using the driving force created by Member States through adopting the global strategy and plan of action.

Ms ESCOREL DE MORAES (Brazil) suggested that various proposals might be combined. Brazil and the other members of the Union of South American Nations were not suggesting that a new intergovernmental working group should be established but rather an ad hoc intergovernmental group that would meet for a very limited time. It should examine proposals that had not been analysed by the Expert Working Group and evaluate the feasibility of existing proposals that had been ranked highly. It was important to maintain the momentum of progress in 2010.

With regard to resources, only 79% of the appropriation for strategic objective 11 under the Programme budget 2008–2009 appeared to have been expended, and thus WHO still had US\$ 49 million for that item. That amount would easily cover the projected cost of US\$ 3 million needed to hold two meetings of an intergovernmental group, the duration and format of which were open for discussion. She therefore asked Member States to reconsider the proposal put forward by the Union of South American Nations.

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the Member States of the European Union, said that he agreed with the delegate of Brazil that progress must be encouraged and he expressed appreciation for the efforts of the Director-General. However, the proposal to set up an intergovernmental group, even if it were an ad hoc group, was not the best idea and he suggested that an expert group should meet to further refine the existing text.

Mr SILBERSCHMIDT (Switzerland) asked the Legal Counsel whether the global strategy and plan of action could still move forward if no agreement was reached. He agreed with the delegate of Brazil on the need to make progress but was not in favour of establishing any kind of intergovernmental working group. Moreover, discussion of budgets was not appropriate at that point. The agenda item should be suspended and informal consultations held, with a view to reaching consensus on a proposal that could be introduced at a later stage.

Dr LEVENTHAL (Israel) said that, for the sake of efficiency and as the Health Assembly appeared unable to reach a consensus, the task of discussing possible ways to make progress should be delegated to the Executive Board.

Dr GAMARRA (Paraguay) supported the proposal to establish an intergovernmental group. Failure to reach consensus came with a price, which might be even higher if the follow-up to the

report was carried out solely by a group of experts. She was in favour of holding informal consultations in order to reach a decision on the matter.

Ms HAMILTON (Canada) echoed the comments made by many delegates that it was time to move forward. As she understood it, the delegate of Brazil was suggesting that an ad hoc group should be set up to look at both new proposals and proposals that had already been considered by the Expert Working Group. She recalled that, at the informal consultation held the previous week, the members of the Working Group had said that they had reviewed and rated many proposals, all on the basis of extensive criteria, before agreeing on the recommendations in the Report.

Dr SUWIT WIBULPOLPRASERT (Thailand) strongly supported the suggestion by the delegate of Switzerland to hold informal consultations and suggested that the same delegate should act as chairman. If an expert group or an intergovernmental working group were to meet in Thailand, his country would bear the local costs.

Dr ALI (Bangladesh), echoing the consensus to make progress, supported the suggestion by the delegate of Switzerland to hold open-ended discussions on how to proceed.

Dr MUKABI (Kenya) said that the African group had been sceptical about establishing an intergovernmental group mainly because of the prohibitive cost of fully participating in that type of meeting for some Member States. He was in favour of holding information consultations.

Mr MENESES GONZÁLEZ (Mexico) said that the Committee must move forward. He proposed that a working group comprised of government representatives and supporting experts should be set up to review the Report of the Expert Working Group.

Dr KHOUILLA (Gabon) said that, as he understood it, Member States had delegated to the Chairman the task of establishing some form of working group. Some delegates had suggested that the Expert Working Group should complete its work by reviewing the flaws that had been identified in its Report. Others had suggested that an intergovernmental group should be established. He endorsed the proposal by Mexico to combine the two solutions. He further suggested that those who benefited from the results of research and development should be given the opportunity to contribute to the proposed working group. The suggestion of the delegate of the United States that a group of experts be established to help countries to implement the approach outlined in the Report should also be given consideration.

The CHAIRMAN said that, if he heard no objection, he would take it that the Committee wished to suspend its consideration of item 11.3 and hold informal consultations, chaired by the delegate of Switzerland, the results of which would then be reported back to the Committee.

It was so agreed.

(For continuation of the discussion and approval of a draft resolution, see the summary record of the twelfth meeting, section 3.)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 11.4 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R4, and A63/7)

The CHAIRMAN drew attention to the resolution on the subject recommended by the Executive Board in resolution EB126.R4 and to a draft resolution on a WHO HIV/AIDS strategy for 2011–2015 proposed by the delegation of Brazil, which read:

The Sixty-third World Health Assembly,

PP1 Considering that the HIV epidemic still constitutes one of the foremost challenges to health and development, both in countries with generalized epidemics and in regions with concentrated epidemics affecting most at-risk groups, such as men who have sex with men, sex workers and injecting drug users;

PP2 Noting that globally HIV is the major cause of mortality among women of reproductive age and was responsible for the death of 280 000 children in 2008, thereby undermining efforts to achieve Millennium Development Goals 4 and 5;

PP3 Recognizing that the significant gains made in prevention and treatment of HIV/AIDS need to be protected and expanded for Millennium Development Goal 6 to be achieved, including the urgent need to strengthen targeted prevention measures and achieve universal access to antiretroviral treatment, within a framework of respect for human rights, gender equality, and the reduction of stigma and discrimination;

PP4 Recalling that WHO's work on HIV/AIDS has been guided by a series of strategies endorsed by several World Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

PP5 Considering that the WHO "3 by 5" strategy, launched in 2003, which focused on expanding access to antiretroviral treatment, was developed in the context of the Global Health Sector Strategy for HIV/AIDS (2003–2007), endorsed by the Fifty-sixth World Health Assembly (WHA56.30);

PP6 Recalling that in 2006 the United Nations adopted the target of Universal Access to HIV prevention, treatment and care by 2010, and WHO developed the Universal Access Plan 2006–2010, welcomed by the Fifty-ninth World Health Assembly, which has guided WHO's work since then;

PP7 Recognizing the need for countries to be supported in their efforts to expand the scope, improve the effectiveness and ensure the sustainability of their HIV responses so that they may achieve the Millennium Development Goals;

PP8 Noting that a sustainable HIV response requires robust health systems and for HIV to be integrated into other health services, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis prevention and control, harm reduction for drug users and primary health care, particularly in light of the global financial crisis;

1. URGES Member States:

(1) to reaffirm their commitment to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases and to the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development;

(2) to incorporate in their specific contexts the policies, strategies, programmes and tools recommended by WHO in order to implement HIV early diagnosis, prevention, treatment and care;

(3) to use existing administrative and legal means in order to promote access to treatment and diagnostic technologies;

(4) to integrate HIV into other key services, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis, harm reduction and primary health care, to ensure sustainability and maximize efficiencies and effectiveness;

2. REQUESTS the Director-General:

(1) to lead a broad consultative process to develop a WHO HIV/AIDS Strategy for 2011–2015 which will guide WHO's support to Member States, be aligned with broader

strategic frameworks, including the Millennium Development Goals, PHC and the UNAIDS Outcome Framework, and which builds on the five strategic directions of the Universal Access Plan, and takes into consideration the changing international public health architecture, and reflect the Paris Principles for Aid Effectiveness;

(2) to ensure that the knowledge arising from research be translated into efficient public health policies for HIV/AIDS, in accordance with the Global Strategy on Public Health, Innovation and Intellectual Property (WHA61.21);

(3) to submit to the Sixty-fourth World Health Assembly through the WHO Executive Board a WHO HIV/AIDS Strategy for 2011–2015 for its endorsement.

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

1. Resolution Strategy on HIV/AIDS for 2011–2015	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
2. To combat HIV/AIDS, tuberculosis and malaria.	2.1 Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution aims to strengthen activities linked with the following:	
<ul style="list-style-type: none"> • the development of a strategy on HIV/AIDS for 2011–2015 that will guide WHO's work on normative guidance, technical support to countries, strategic information and advocacy to promote the integration of work on HIV/AIDS into broader health and development programmes, with the aim of achieving the health-related Millennium Development Goals; • the provision of support to countries to scale up comprehensive and integrated HIV/AIDS programmes in order to achieve internationally agreed development goals. 	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
A maximum of US\$ 320 000, including:	
<ul style="list-style-type: none"> • six regional consultations with countries and other stakeholders, making use of already planned meetings and consultation mechanisms (at US\$ 150 000) • consultations with civil society (at US\$ 70 000) • consultation with the Strategic and Technical Advisory Committee on HIV/AIDS (at US\$ 70 000) • consultations with other strategic partners, including other organizations in the United Nations system, donors and development partners (at US\$ 30 000). 	
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
The full cost of US\$ 320 000 would be incurred during the biennium 2010–2011.	

<p>(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?</p> <p>Yes.</p>
<p>4. Financial implications</p> <p>How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?</p> <p>Additional funding is expected from voluntary contributions.</p>
<p>5. Administrative implications</p> <p>(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).</p> <p>WHO headquarters will lead the process of strategy development in association with all six regional offices.</p> <p>(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.</p> <p>Yes.</p> <p>(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).</p> <p>No additional staff are required.</p> <p>(d) Time frames (indicate broad time frames for implementation of activities).</p> <p>The broad consultation process will be completed by November 2010, in time for a draft strategy to be submitted for consideration by the Executive Board at its 128th session in January 2011.</p>

Professor SOHN Myongsei (representative of the Executive Board), introducing the item, reported that the Board at its 126th session in January 2010 had extensively discussed the item. It had welcomed the progress made in reducing rates of child mortality and improving the prevention and treatment of HIV/AIDS, tuberculosis and malaria, and had stressed the need to maintain those positive trends. It had, however, expressed concern at the continuing high levels of maternal mortality and the growing proportion of child deaths that occurred within the first month of life, which pointed to the need to remove obstacles to access to health care, including financial barriers, for mothers and their newborn infants.

Members of the Executive Board had also highlighted the importance to health of gender equality, education, nutrition, environmental sustainability, and access to safe water and sanitation. Challenges included the lack of domestic and international resources; the absence of political commitment; weak health and health information systems; inadequate capacity to deliver interventions; and the growing burden of noncommunicable diseases. Extreme poverty and complex emergencies were also affecting a number of countries. There was a need for continuing international support for multisectoral and multidisciplinary approaches; harmonized technical recommendations; stronger primary health care; and attention to human rights and equity. The Board had adopted resolution EB126.R4 which recommended to the Health Assembly a resolution for adoption.

Dr DIXON (Jamaica) said that Jamaica's Ministry of Health had made significant progress towards attaining the health-related Millennium Development Goals, as indicated in the report of the United Nations Economic and Social Council's 2009 Annual Ministerial Review. However, noncommunicable diseases currently accounted for more than 50% of fatal disease outcomes, and were a risk factor for maternal and child mortality. She therefore welcomed the recent adoption by the United Nations General Assembly of a resolution on the prevention and control of noncommunicable diseases (64/265). Jamaica had an efficient health system despite the relatively low per capita investment in health, as indicated by reduced maternal, infant and child mortality rates, declining

incidence of poverty and undernutrition, greater access to safe, piped drinking-water and good sanitation, and substantially increased skilled attendance at birth.

Achievement of the Millennium Development Goals required a coordinated, multisectoral response. Although Jamaica had embraced that strategy in individual sectoral strategic plans, there was no coordinating body to oversee implementation and monitor progress. Consideration should be given to a UNICEF/PAHO/WHO/UNDP/World Bank framework for the Caribbean for monitoring achievements towards the Goals, similar to that prepared for the African Union.

The Secretariat's report supported calls for provision of more development aid based on global partnerships, especially for low- and middle-income countries. However, it gave little detail on the links between the Goals and other sectors related to human development. High-level political commitment, sustained support from partners and an integrated approach were vital, especially at a time of economic recession. Verbal commitments made by the G8 and G20 nations at their summits, in 2005 and 2009 respectively, must be followed up by affirmative action, and WHO should work more closely with other organizations in the United Nations system to coordinate strategies for increasing development aid.

Turning to the resolution recommended by the Board, she proposed adding the words "taking into account leadership, public policy, universal coverage and service delivery reforms necessary for strengthening primary health care" to the end of subparagraph 1(3) and "and measles" to the end of subparagraph 1(10), and a new subparagraph to paragraph 2 to read: "to promote the development of robust and reliable health information systems to ensure the collection and compilation of quality data for accurate measurement and tracking of the Millennium Development Goals".

Dr KUNBOUR (Ghana), speaking on behalf of the Member States of the African Region, pointed out that attainment of the health-related Millennium Development Goals was a matter of human rights as well as development; healthy, active and productive populations were a prerequisite for socioeconomic development. The interventions to achieve the Goals were known and available, and urgent action was needed in the remaining five years before the 2015 target date. The African Heads of State and Government had signalled their commitment through the Abuja Declarations relating to Roll Back Malaria and control of HIV/AIDS, tuberculosis and other related infectious diseases in 2000 and 2001, respectively, the 2006 Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services in Africa by 2010, and the 2006

Continental Framework for Sexual and Reproductive Health and Rights and its Plan of Action. Current trends, however, suggested that many low-income countries, mostly in the African Region, would not meet Millennium Development Goal targets. Despite some encouraging results in relation to Goals 4 and 6, achievement of those Goals would require additional resources, strengthened health systems, equity in access to proven interventions, enhanced multisectoral responses and partnerships, greater priority for health in national policies, and exchange of good practices within the Region. Domestic resources would be insufficient to cover needs.

External aid must therefore be strengthened and aligned to country systems and effectively integrated with country budgets. Progress towards Goal 8 was disappointing. Global partnerships were critical to bridging financial gaps, in particular commitments to allocate 0.7% of gross national product to aid. Moreover, action to follow up the Paris Declaration on Aid Effectiveness appeared to have been reduced to alignment at country level, without harmonization at the global level.

The Member States of the African Region reaffirmed the principles and values of primary health care and strengthened health systems, and the need to adopt a multisectoral approach and to tackle health inequities. They were urged to make progress towards the target allocation of 15% of public expenditure to the health sector, as set by the Abuja Declaration, and to ensure an annual per capita health spending of at least US\$ 34 as recommended by the WHO Commission on Macroeconomics and Health.

The rising incidence and mortality of noncommunicable diseases was a major source of concern and threatened the progress made so far. He reinforced calls for targets related to noncommunicable diseases to be incorporated in the Millennium Development Goals, and welcomed the inclusion of the

Goals on the agenda of the next G8 summit and the United Nations General Assembly in September 2010. He supported the draft resolution recommended in resolution EB126.R4.

Dr MINNIS (Bahamas) said that the Bahamas was two thirds of the way to achieving the Goals, which were inextricably linked. However, the Bahamas and countries with similarly small populations faced challenges in relation to monitoring and evaluation of targets as a consequence of the mathematical models used to interpret data. Indicators that monitored proportional changes required relevant baseline data and reporting methods based on declining or changing rates should be examined. Quality and comparability of data should also be taken into account in order to avoid distortions in global interpretations.

At the 34th Annual Meeting of Commonwealth Health Ministers held on 16 May 2010, it was reported that 19 Commonwealth countries still had high maternal mortality ratios and that progress towards targets for skilled attendance at birth remained slow. Nevertheless there was optimism that most countries would meet the 2015 targets provided that concerted national, regional and global interventions were maintained. He supported the resolution recommended by the Board.

Professor JOOMA (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that maternal and neonatal mortality in the Region exacted a heavy toll in 2008: some 58 000 and 510 000 deaths, respectively. Some 50% of births still took place outside of health-care facilities, and 40% were not attended by skilled health personnel. Contraceptive use was low and fertility rates therefore remained high. Although child mortality rates had fallen in recent years, many other factors, including emergencies due to security concerns, inadequate human and financial resources, and health inequities within and between countries, jeopardized the achievement of Millennium Development Goal 4.

AIDS, tuberculosis and malaria accounted for more than 260 000 deaths annually and the HIV/AIDS epidemic would not be reversed unless prevention and treatment was provided to high-risk groups. Antiretroviral treatment was available in all countries in the Region, but many people living with HIV/AIDS were unaware of their infection and did not seek treatment. Availability of voluntary and confidential HIV testing and counselling was therefore a high priority. Malaria remained endemic in nine countries, three of which were targeting elimination. Ownership of insecticide-treated bed nets and access to effective treatment were increasing but coverage was far from universal. Tuberculosis prevalence and mortality in the Region had shown a steady decline since 1990, and all countries were making good progress in implementing the expanded Stop TB strategy. Low rates of case detection remained a problem, however, partly owing to limited collaboration between different providers of health care.

Appropriate solutions tailored to individual countries were needed. Poverty reduction and equitable access to primary health care services must be accelerated if low-income countries were to achieve the Goals. Health systems should be strengthened; innovative approaches to partnerships could reduce duplication of effort and improve use of resources; and monitoring and reporting mechanisms should be streamlined.

Dr ISA SABB (Bahrain), commending progress towards achieving the Millennium Development Goals, said that current strategies did not take into account challenges such as evolving disease patterns, climate change, environmental problems, demographic changes and behaviour damaging to health. The increasing burden of noncommunicable diseases was a particular concern, especially their impact on the health of young people.

Bahrain was committed to the achievement of the health-related Goals. It had a strong health infrastructure, which permitted the delivery of good-quality services for mothers and children through health-care facilities. Maternal and child mortality had been reduced substantially and, in 2006, 99% of births were attended by skilled health workers. Measles and rubella control programmes had increased their coverage. The cumulative total of cases of HIV infection since the first case in 1986 stood at 364 in 2009, of which 50 had received treatment and care. Mortality from malaria had been

reduced by two thirds between 1996 and 2006, and tuberculosis mortality had declined since the adoption of the directly observed treatment, short course (DOTS) strategy in 1999. She supported the resolution recommended by the Board.

Dr LIANG Wannian (China) endorsed the Secretariat's assessment of the current situation and supported the resolution recommended by the Board. He welcomed the attention being given to fair health outcomes and the values of primary health care and to changing disease patterns in developing countries. He hoped that the joint efforts of the Secretariat and Member States would lead to the prevention and control of noncommunicable diseases being incorporated in the framework of the Millennium Development Goals.

(For continuation of the discussion, see the summary record of the fourth meeting, section 1).

The meeting rose at 12.25.

THIRD MEETING

Tuesday, 18 May 2010, at 15:40

Chairman: Dr M. MUGITANI (Japan)

HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN: Item 13 of the Agenda (Documents A63/28, A63/INF.DOC./5, A63/INF.DOC./6, A63/INF.DOC./7 and A63/INF.DOC./8)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Algeria, Bahrain, Bangladesh, Cuba, Kuwait, Libyan Arab Jamahiriya, Nicaragua, Oman, Pakistan and the Bolivarian Republic of Venezuela, and informed the Committee that Argentina, Azerbaijan, Lebanon and Turkey wished to be added to the list of sponsors. The text read:

The Sixty-third World Health Assembly,

PP1 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;

PP2 Recalling all its previous resolutions on health conditions in the occupied Arab territories;

PP3 Recalling resolution EB124.R4, adopted by the Executive Board at its 124th session, on the grave health situation caused by Israeli military operations in the occupied Palestinian territory, particularly in the occupied Gaza Strip;

PP4 Taking note of the report of the Director-General on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;

PP5 Noting with deep concern the findings in the report of the Director-General on the specialized health mission to the Gaza Strip;

PP6 Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory, particularly in addressing the emergency needs in the Gaza Strip;

PP7 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;

PP8 Expressing its deep concern also at the health crisis and rising levels of food insecurity in the occupied Palestinian territory, particularly in the Gaza Strip;

PP9 Affirming the need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian territory;

PP10 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;

PP11 Affirming the right of Palestinian patients and medical staff to have access to the Palestinian health institutions in occupied east Jerusalem;

PP12 Deploring the incidents involving lack of respect and protection for Palestinian ambulances and medical personnel by the Israeli army, which have led to casualties among Palestinian medical personnel, as well as the restrictions on their movements imposed by Israel, the occupying power, in violation of international humanitarian law;

PP13 Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

PP14 Expressing deep concern at the grave implications of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

PP15 Expressing deep concern also at the serious implications for pregnant women and patients of restrictions on movement imposed by Israel on Palestinian ambulances and medical personnel,

1. DEMANDS that Israel, the occupying power:
 - (1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that are causing the serious shortage of medicines 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) abandon its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;
 - (3) 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 for the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;
 - (4) facilitate the access of Palestinian patients and medical staff to the Palestinian health institutions in occupied east Jerusalem and abroad;
 - (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, and demands that the occupying power, Israel, provide the detainees who are suffering from serious medical conditions worsening every day, with the necessary medical treatment;
 - (7) facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (8) assume its responsibility with regard to 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;
 - (10) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;
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 help meet urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;
 - (3) calls upon the international community to exert pressure on the government of Israel, to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein, and to help lift the restrictions and obstacles imposed on the Palestinian people including the free movement of people and

medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities, and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;

(4) 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, which is applicable to the occupied Palestinian territory including east Jerusalem;

(5) calls upon all international human rights organizations, particularly the International Committee of the Red Cross, to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions worsening every day, and urges civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members and immediately to release all children detained in Israeli prisons;

(6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;

(7) to provide financial and technical support to the Palestinian public health and veterinary services;

3. EXPRESSES deep appreciation to the international donor community for their support of the Palestinian people in different fields, and urges donor countries and international health organizations to continue their efforts to ensure the provision of necessary political and financial support to enable the implementation of the 2008–2010 health plan of the Palestinian Authority and to create a suitable political environment to implement the plan with a view to putting an end to the occupation and establishing the state of Palestine as proposed by the Government of Palestine, which is working seriously to create the proper conditions for its implementation;

4. EXPRESSES its deep appreciation to the Director-General for her 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;

5. REQUESTS the Director-General:

(1) to provide support to the Palestinian health and veterinary services including capacity building;

(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 support the establishment of medical facilities and provide health-related technical assistance to the Syrian population in the occupied Syrian Golan;

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

(5) to also provide support to the Palestinian health and veterinary services in preparing for unusual emergencies;

(6) to support the development of the health system in the occupied Palestinian territory, including development of human resources;

(7) to establish, in cooperation with the International Committee of the Red Cross, an international committee of specialized medical teams to diagnose the serious health conditions of Palestinian prisoners and detainees in Israeli jails and provide them with all necessary and urgent treatment in accordance with relevant international conventions and agreements;

- (8) to make available the detailed report prepared by the specialized health mission to the Gaza Strip;
- (9) to report on implementation of this resolution to the Sixty-fourth World Health Assembly.

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

1. Resolution Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
5. To reduce the health consequences of emergencies, disasters, crises and conflicts and minimize their social and economic impact.	5.3 Norms and standards developed, capacity built and technical support provided to Member States for assessing needs and for planning and implementing interventions during the transition and recovery phases of conflicts and disasters.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
If fully funded and implemented, the resolution is expected to have an impact on the targets for the second and third indicators for the expected result.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
US\$ 3 970 000 over the one-year period of the resolution, including staff, travel, training activities, technical assistance, health supplies, security and operational equipment.	
The breakdown of the estimated cost of operative paragraph 4 is as follows:	
Subparagraph (1)	US\$ 100 000
Subparagraph (2)	US\$ 70 000
Subparagraph (3)	US\$ 50 000
Subparagraph (4)	US\$ 200 000
Subparagraph (5)	US\$ 500 000
Subparagraph (6)	US\$ 3 million
Subparagraph (7)	US\$ 50 000
Total	3 970 000
(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).	
US\$ 3 970 000 (one year "life-cycle").	
(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?	
Seventy-five per cent of US\$ 3 970 000 at headquarters, Regional and Jerusalem Office levels.	
4. Financial implications	
How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?	
Consolidated Appeal Process (CAP) and voluntary contributions. A substantial proportion of these resources have been raised as humanitarian voluntary contributions for addressing humanitarian health needs, implementing life-saving interventions, re-establishing the functionality of the disrupted health services and rolling out the Interagency Standing Committee (IASC) health cluster.	

5. Administrative implications

(a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).

The activities will be primarily implemented through the WHO Office in Jerusalem responsible for WHO's cooperation programme with the Palestinian Authority. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working in the areas of health action in crises, health security and environment.

(b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.

It will be necessary to sustain beyond May 2010 the actual presence at country level of the national and international staff recruited to implement humanitarian health activities and interventions in the occupied Palestinian territory.

(c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).

(d) Time frames (indicate broad time frames for implementation of activities).

One year.

Mr BADR (Egypt), speaking on behalf of the sponsors, introduced the draft resolution. The deterioration of the health situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, was a result of the continued Israeli occupation, in particular following the Israeli incursion into the Gaza Strip from December 2008 to January 2009, in violation of international customary law and instruments. The many years of Israeli occupation had already gravely violated the most basic human rights of the Palestinian people, but the situation had deteriorated in tragic fashion after the incursion. The excessive use of military force and internationally proscribed weapons and the Israeli army's policy of targeting civilians, including women, children and the elderly, which had also affected relief crews and teams from United Nations agencies, had seriously aggravated the humanitarian situation of the Palestinian people. The report by the Secretariat pointed to a persistent decline in health-care standards in the Gaza Strip, particularly with regard to indicators such as infant mortality. Other reports by United Nations organizations, including WHO, had catalogued a litany of disasters occasioned by the three-week aggression against the Gaza Strip, including the damaging or destruction of many hospitals and health centres, the complete destruction of the electricity infrastructure and wide-scale damage to roads, bridges, wells, irrigation systems and drinking-water and sanitation networks. In addition, many specialist medical treatments were unavailable or inaccessible, with the Israeli authorities also refusing to issue exit permits for patients, which had led to several deaths.

The draft resolution laid stress on the vital need for WHO to assume its responsibilities within its area of competence by seeking to deliver basic health services to the Palestinian people and facilitate immediate measures to prevent exacerbation of the health situation. He summarized the actions demanded of Israel, the occupying power; the assistance urged upon Member States; and the requests to the Director-General to provide support to end the acute suffering of the Palestinian people and uncover the facts about the health situation, including the publication of the detailed report of the specialized health mission to the Gaza Strip¹. Notwithstanding the deterioration in that situation, the sponsors had sought to build a consensus on the draft resolution and send a clear message to Israel concerning the unacceptability of its practices to the international community. The need for a further Health Assembly resolution on the subject was dictated by the continuing escalation of Israeli practices on the ground and Israel's refusal to respond to previous resolutions demanding that it comply with established international rules and shoulder its humanitarian responsibilities towards the

¹ Document A62/24 Add.1.

Palestinian people, in accordance with international humanitarian conventions and instruments. The text dealt only with matters directly related to the health situation of the Palestinian people under occupation and arising from documented Israeli policies. It therefore fell within the competence of WHO, which should unhesitatingly take on its responsibilities in that regard. He called for adoption of the draft resolution by consensus.

Dr KESKİNKILIÇ (Turkey) said that the health conditions in the occupied Palestinian territory were conspicuously dramatic and that essential health services could not be delivered because medicines and medical supplies were lacking. Many countries, including his own, were ready to provide assistance but were unfortunately prevented from doing so, a situation that was difficult to understand and accept when there was no lack of intent, resources and capacity to help people facing hardship. No political considerations or intergovernmental concerns could justify inaction in the face of a humanitarian and human tragedy of such dimensions. The international community should therefore do its utmost to provide essential health services to the population of the occupied Palestinian territory, without regard for political perspectives. WHO must also shoulder its responsibility by enhancing its role in the coordination of health assistance activities.

Dr ALI (Bangladesh) wished to place on record his appreciation of the Secretariat's ongoing support to the Palestinian Ministry of Health in developing the necessary policy and institutional framework for protecting and promoting the health of populations in the occupied Palestinian territory. He welcomed the progress in the development of integrated primary health-care services and the broadening of coverage to such areas as noncommunicable diseases and mental health. WHO's technical assistance for promoting specific health interventions should be expanded to meet emerging and persistent challenges. The fact-finding report annexed to document A63/28 presented a grim picture of the health and economic situation in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. Particularly concerned by the deteriorating health conditions in the Gaza Strip, he renewed the call for the lifting of the blockade of the Gaza Strip in order to allow the regular provision of medical support and supplies. Reconstruction and renovation of the medical infrastructure that had been severely damaged during the Israeli armed aggression in late 2008 and early 2009 were urgently needed. The slowdown in progress towards achievement of the Millennium Development Goals was another concern and reflected an unacceptable trend that should not be allowed to continue under the pretext of ongoing conflicts. Member States had a collective responsibility to redouble their efforts to sustain progress by overcoming challenges on the ground. Failure to deliver results in the most trying situations would seriously undermine all progress already made. As one of the sponsors, Bangladesh urged Member States to support the draft resolution.

Mr AHMADI (Islamic Republic of Iran) said that the ongoing aggression and state of siege in the Gaza Strip and residential areas of the West Bank, coupled with the economic pressure exerted by the Israeli regime, had worsened unemployment and poverty in the occupied Palestinian territory, with long-term adverse effects on health. Health-care standards were steadily declining, as shown by health indicators. The situation was exacerbated by the difficulties of access to medical facilities, including those available in specialist hospitals in east Jerusalem which served the populations of the Gaza Strip and West Bank. There was thus a clear picture of the reasons for the deaths of so many people in the occupied Palestinian territory, including women and children.

The report of the specialized health mission to the Gaza Strip¹ had also raised grave concerns, identifying as it did major health issues and also health risks highlighted in an earlier assessment and not yet addressed one year after the Israeli military operations. In the light of the dire health situation, it was vital to boost health and humanitarian assistance to civilians in the occupied Palestinian territory, and in the Gaza Strip in particular. WHO must also focus on medium- and long-term

¹ Document A62/24 Add.1.

planning to meet health-related needs in a lasting and sustainable manner. It was appalling that in the twenty-first century the civilized world should continue to witness the plight of an entire population that was starving and deprived of the most basic supplies. The international community must do its utmost to exert pressure on the occupying power to lift the siege on the Gaza Strip, as well as the restrictions on the Palestinian people, and to allow free access of people, goods and medical personnel to the occupied Palestinian territory, in order to avoid a further serious humanitarian crisis.

Mr PINO ALVAREZ (Cuba) said that the health situation described was bleak. Israel had not complied with its obligations under the Fourth Geneva Convention and continued to violate the human rights of the Palestinian population. Key indicators such as infant mortality rates, unemployment and poverty showed an alarming upward trend. The lifting of the blockade by Israel, the dismantling of the separation wall and the strengthening of the health infrastructure were urgent tasks that had to be undertaken. The international community and the major powers that were providing financial support to Israel had an important responsibility to make that country understand that respect for international law was not an option but an obligation. The situation in the occupied Syrian Golan was a further cause for concern: the population of that territory continued to be subjected to discriminatory policies that undermined their fundamental right to employment, water and day-to-day subsistence and health. His country favoured the creation of a sovereign independent Palestinian State with east Jerusalem as its capital. He urged all delegations to support the draft resolution.

Dr ALHAMER (Bahrain) also expressed great concern at the health situation in the occupied Palestinian territories. The Israeli military mechanism was responsible for the deterioration of the health situation in the Gaza Strip. The continuing humanitarian and economic crisis, together with the education and health crises, were affecting health services, especially those that required a convergence of international efforts to support educational institutions and to provide food, medicines and primary health care in the occupied Palestinian territories. He condemned the attacks of the Israeli military forces on medical staff and called on the relevant international and local institutions to provide support and medical services to the Palestinian people and put an end to the spread of disease and malnutrition among children. He called upon Member States to give unanimous support to the draft resolution.

Dr AL-ABDULLA (Qatar) said that the health situation in the occupied Arab territories had become a permanent item on the Health Assembly's agenda because the Israeli occupation of Palestine was still destroying all aspects of Palestinian daily life. The occupation had an especially adverse impact on women and children who were exposed to increasing violence and were unable to access medical facilities and education. Education and public health were deteriorating continuously. WHO should provide support and medical equipment to the health sector in the region and seek to ensure freedom of movement for all health-care professionals. He supported the draft resolution and called upon WHO to ask the Israeli authorities immediately to cease all practices and policies that had a serious impact on the health of civilians.

Mr NABEEL (Pakistan) expressed deep concern about the situation in the occupied Palestinian territory, including east Jerusalem, and the occupied Syrian Golan. High levels of poverty and unemployment continued to have an adverse effect on the Arab population in those territories and deaths resulting from the occupation had markedly increased since 2008. The occupied territories were on the brink of a humanitarian crisis caused by chronic malnutrition and associated micronutrient deficiencies. More than 30% of the overall burden of disease in adults was caused by noncommunicable diseases. The policy of closure in the Gaza Strip had resulted in decreased access to secondary and tertiary health care and the lack of essential supplies and medicines had further weakened the health-care delivery system, leading to the degradation of the health infrastructure. He urged WHO to increase its technical assistance and support to UNRWA and asked the Health Assembly to call for an end to the practices of economic and political oppression that continued to

jeopardize the provision of preventive and curative health services to the people in the occupied territories. Pakistan, as a sponsor of the resolution under consideration, strongly urged the international community to support the Palestinian people and make concerted efforts to achieve a just, comprehensive and lasting peace.

Dr RASAE (Yemen) said that women, children and the elderly in the occupied Arab territories were awaiting the results of the Health Assembly's deliberations so that they could enjoy their most basic human rights in the form of the simplest health services. The double standards of the international community encouraged the Israeli military to oppress the Palestinian people. He called on Member States to respond to the draft resolution and to give justice to the Palestinian people in the occupied Arab territories.

Dr SAID (Syrian Arab Republic), referring to the Secretariat's report, said that the annexed fact-finding report contained no information on the health situation in the occupied Syrian Golan. He asked the Secretariat to provide information on that topic. Measures should be taken to implement previous Health Assembly resolutions and therefore proposed that subparagraph 5(3) of the draft resolution be amended to provide for appropriate mechanisms for implementation in respect of the provision of health-related technical assistance to the Syrian population in the occupied Syrian Golan. He emphasized the necessity to guarantee health and medical services to those in need of them in all the occupied Palestinian territories. He proposed that the words "guarantee services for all the inhabitants of the occupied Palestinian territories including the West Bank" be added to subparagraph 5(5).

Mr AL-TAAE (Iraq) said that he saw no discrepancy between the adoption of any resolution that supported improving the health conditions in the occupied Palestinian territories and the achievement of the Millennium Development Goals. Noting that Iraq had sought to make human rights approaches a ninth Millennium Development Goal, he said that that addition would strengthen sustainable development which was crucial to the fulfilment of the Goals. It was therefore important to support improving the health conditions in the occupied Palestinian territories in order to attain the Millennium Development Goals.

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that the situation resulting from Israel's military operations and the prevention of institutions and governmental organizations from assisting those in need of health care in the occupied Arab territories was very serious. It was the responsibility of Israel, as the occupying power, to ensure that the inhabitants of those territories had access to health services. Israel was required to comply with the demands listed in paragraph 1 of the draft resolution in accordance with international law. At the same time, Member States and international and nongovernmental organizations were urged to carry out the measures provided for in operative paragraph 2 and the Director-General was to bear the responsibility of supervising implementation of the actions set out for alleviating the suffering of the Palestinian people and responding to their needs in respect of medicines, hospitals and medical equipment. The draft resolution should have the full support of all delegations.

Mr SALEH AZZAM (Lebanon) said that the health conditions in the occupied Palestinian territories had become serious, requiring practical solutions. He strongly supported the proposed draft resolution; the dire health conditions prevailing in the occupied Palestinian territories must not be allowed to continue. The Palestinian people were suffering as a direct result of the Israeli attack on the Gaza Strip, as was the Syrian population in the occupied Syrian Golan. He urged all countries to support the draft resolution in order to ensure social justice and improve the humanitarian and health conditions of those living in the occupied territory.

Dr ALFAYEZ (Jordan) condemned the aggression perpetrated by Israel against the Palestinian people living in the Gaza Strip and in the occupied Syrian Golan. The dire effects were manifold: there

had been many civilian casualties, hospitals and health infrastructure had been damaged, and the lack of medical support and supplies due to the embargo was compounding the suffering of the Palestinian people. He called on WHO to work on measures to reduce the suffering of the Palestinian people and ensure the safe transit of medicine and medical equipment. He deplored the inhumane conditions in which the Palestinian people were living; all parties were responsible for improving their plight. He called for a global response to lift the embargo.

Mr KOMAR (Indonesia), while expressing appreciation for the Secretariat's report (document A63/28), said that he was concerned about the ongoing restrictions in the occupied Palestinian territory which were impeding the effective functioning of health-care systems, including the provision of medical supplies and the treatment of patients, and hampering progress towards achievement of Millennium Development Goal targets, particularly those affecting women and children. He urged the international community to work towards lifting the restrictions, which would ensure better movement of people, goods and medical staff and allow those living in the occupied Palestinian territory, especially those in east Jerusalem, to fully enjoy their basic human rights. For those reasons, Indonesia wished to be added to the list of sponsors of the draft resolution.

Mr DELGADO (Bolivarian Republic of Venezuela) fully supported the draft resolution. It was wholly unacceptable that the embargo, which was preventing access to medicines and medical supplies in the occupied Palestinian territory, remained in place. It was therefore necessary to support the draft resolution as a way of showing solidarity with the Palestinian people and upholding social justice.

Ms KING (United States of America) expressed disappointment that the draft resolution was being discussed by the Health Assembly. Given its commitment to working with all nations to resolve global challenges, the United States would have welcomed the opportunity to discuss the issue with all interested parties in order to improve the health conditions of the Palestinian people. Although the United States was deeply committed to Israeli/Palestinian peace and, ultimately, to a two-State solution, the adoption of such a one-sided, politicized draft resolution would inflame tensions and not improve the health conditions of the Palestinian population in the West Bank and Gaza Strip. She expressed the hope that the delegates to the Sixty-fourth World Health Assembly could work together in a timely manner to adopt a harmonious resolution that would be accepted by all parties.

The United States' commitment to supporting the Palestinian people included contributions to UNRWA of: US\$ 267 million in 2009 and US\$ 115 million thus far in 2010, including US\$ 60 million for the General Fund to support core health, education and social services for the millions of refugees in the West Bank, the Gaza Strip, Jordan, the Syrian Arab Republic and Lebanon, and US\$ 35 million for emergency operations in the West Bank and the Gaza Strip. Through its contributions, the United States was helping to improve core health-care capacities in the Gaza Strip and the West Bank, including access to clean water and sanitation systems and mental health counselling. It also provided direct bilateral assistance to Palestinians in the occupied territory through the United States Agency for International Development which, among other things, supported governance activities and improved the capacity of Palestinian government at municipal and national levels, improved the delivery of health services and provided humanitarian assistance. In 2010 the Agency's contributions totalled US\$ 400.4 million, US\$ 17 million of which would go towards the promotion of quality health care, transparency and good governance in the Palestinian health system.

Her Government remained deeply concerned about the dire humanitarian conditions faced by Palestinians and would continue its work to address their basic human needs. She encouraged other countries to join in that effort. Regrettably, the draft resolution was overtly political and one-sided and failed to recognize the cooperation that could and did take place between Israelis and Palestinians. The United States' opposition to the draft resolution did not indicate a lack of commitment to the welfare of the Palestinian people. She therefore requested a roll-call vote on the draft resolution.

Dr ALMARZOOQI (United Arab Emirates) welcomed the efforts of the Director-General on the issue and asked her to continue to work towards a solution that would reduce the suffering of the Palestinian people, particularly women and people with disabilities. Because of the lack of provision of medical supplies, the Palestinian population was being denied its basic human rights. He supported the draft resolution and encouraged all delegations to do the same.

Mr TENG Fei (China) expressed concern for the Palestinian people in the occupied Palestinian territory and in the Syrian Golan who were suffering due to the prevailing dire humanitarian conditions. He agreed with the Secretariat and the international community that access to medical supplies in the occupied territory should be ensured. He called on all parties to support the Palestinian people and alleviate their suffering.

Dr DAKULALA (Papua New Guinea) supported the views put forward by the delegate of the United States. Health was a basic human right and, in that regard, all parties should show compassion for the suffering of the Palestinian people in the occupied territories and ensure the provision of medical supplies and health services. He could not, at that time, support the draft resolution.

Dr MOGHLI (Palestine) expressed his gratitude to WHO and to the humanitarian organizations that had supported and would continue to support the Palestinian people. He also thanked Arab countries, Muslim countries, the Non-Aligned Movement, Europe and the United States, which had provided help to the Palestinian people in their opposition to the occupying Israeli power and ongoing aggression against civilians, especially in the Gaza Strip.

Politics and health were two separate, but inextricably linked, issues. Good mental and physical health could not be achieved by people living in an occupied territory, and the Palestinian people were suffering as a result. The Israeli attack on the Gaza Strip had severely weakened core health capacities and infrastructure. The embargo, which had been in place in the Gaza Strip for the past four years, had hampered the delivery of construction materials, thereby preventing the reconstruction of hospitals and medical centres destroyed in the attack.

Health was a basic human right and it was the duty of all parties to ensure that all peoples had full access to that right. The Palestinian people were unable to enjoy that right because of the Israeli occupation and the inhumane policies implemented by the Israeli occupying power. The many checkpoints and the wall surrounding the occupied territory impeded access to hospitals, free movement of health staff and delivery of medical supplies: people had even died at checkpoints while awaiting vital medical attention. Nevertheless, the Palestinian people remained hopeful that they would one day achieve self-determination in their own State.

Various results had been achieved: communicable and noncommunicable diseases had been controlled and levels of infant and maternal mortality had been improved. However, the restrictions placed on the occupied Palestinian territory had hampered further plans to improve health. The devastating psychological effects should not be underestimated: 80% of Palestinian children were suffering from psychological trauma as a result of the devastating events they had witnessed, frequently involving family members.

He therefore urged Member States to support the draft resolution in order to improve the health conditions of the Palestinian people and lift the blockade of the Gaza Strip so that the Fourth Geneva Convention could be applied. That would constitute a step towards the achievement of a Palestinian State in which health standards and services were fully respected.

Mr ADAM (Israel) acknowledged the fact that there was a conflict in the Middle East, and that the Palestinians wished to and deserved to have an independent State, living in peace and security side by side with the State of Israel; there were two sides to every conflict, however. It was a fact that the health conditions of the Palestinians in the West Bank and of the Arabs in the Golan Heights were far better than in many countries around the world. Statistically there were more doctors per person in the Golan Heights under Israeli control than in some areas of western Europe. However, he did not see

how he could hope to convince Member States of the truth, given how many Member States misrepresented the facts. He commended the Secretariat's report (document A63/28), which accurately represented the situation. Inclusion of the issue on the agenda of the Health Assembly had nothing to do with the health conditions of the Palestinians, but served only to bring the Arab-Israeli conflict into the Organization, bringing an issue of war and peace into the professional body that was WHO. The public health figures were irrelevant; the draft resolution under consideration was entirely motivated by politics. Discussion of the conflict belonged in other forums of the United Nations, and health experts should not take upon themselves the responsibility of ending a conflict more than 60 years old. Moreover, the draft resolution was one-sided, misrepresented the situation on the ground, and reflected the views of only a few Member States. The Health Assembly should not ask the Director-General to take action in areas that were beyond her mandate. He urged Member States to vote against the draft resolution not because of their views on the conflict, but because they did not wish to politicize the Health Assembly. The Health Assembly should not wish to discuss the Arab-Israeli conflict, just as it did not wish to discuss the 70 other ongoing conflicts around the world, in which many more people were suffering from much worse health conditions.

Dr SAID (Syrian Arab Republic) offered to withdraw his proposed amendments if they presented problems.

Dr MOGHLI (Palestine) said that it was very sad that Israel should present itself as a modern country, yet could not make the distinction between political and health matters. Health and politics were intrinsically linked, and health could play a major role in helping to achieve peace. What was happening in Palestine was not a conflict, it was an occupation.

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

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the procedures for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution and would therefore be unable to participate in the vote were: Central African Republic, Comoros, Côte d'Ivoire, Dominica, Guinea-Bissau, Palau, Somalia, Tajikistan and Turkmenistan.

Professor ANONGBA DANHO (Côte d'Ivoire), rising to a point of order, said that his country had settled its arrears the preceding day.

Mr BURCI (Legal Counsel) said that he accepted the word of the delegate of Côte d'Ivoire, which would therefore be able to take part in the vote.

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

The result of the vote was:

In favour: Algeria, Argentina, Azerbaijan, Bahrain, Bangladesh, Bolivia (Plurinational State of), Brazil, Brunei Darussalam, Cape Verde, Chile, China, Congo, Cuba, Djibouti, Ecuador, Egypt, Gambia, Guatemala, India, Indonesia, Iran (Islamic Republic of), Iraq, Jamaica, Jordan, Kazakhstan, Kuwait, Kyrgyzstan, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Malaysia, Maldives, Mauritania, Mauritius, Mexico, Morocco, Mozambique, Namibia, Nepal, Nicaragua, Niger, Nigeria, Oman, Pakistan, Paraguay, Peru, Philippines, Qatar, Russian Federation, Senegal, South Africa, Sri Lanka, Sudan, Syrian Arab Republic, Togo, Tunisia, Turkey, Uganda, United Arab Emirates, Uruguay, Venezuela (Bolivarian Republic of), Yemen.

Against: Australia, Canada, Israel, Marshall Islands, Micronesia (Federated States of), New Zealand, Papua New Guinea, United States of America.

Abstaining: Albania, Andorra, Austria, Barbados, Belgium, Bhutan, Bulgaria, Burundi, Cameroon, Colombia, Côte d'Ivoire, Croatia, Cyprus, Czech Republic, Democratic Republic of the Congo, Denmark, Estonia, Finland, France, Germany, Greece, Haiti, Honduras, Hungary, Iceland, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Netherlands, Norway, Poland, Portugal, Republic of Korea, Romania, Rwanda, San Marino, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Thailand, Timor-Leste, Ukraine, United Kingdom of Great Britain and Northern Ireland.

Absent: Afghanistan, Angola, Antigua and Barbuda, Armenia, Bahamas, Belarus, Belize, Benin, Bosnia and Herzegovina, Botswana, Burkina Faso, Cambodia, Chad, Cook Islands, Costa Rica, Democratic People's Republic of Korea, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Georgia, Ghana, Grenada, Guinea, Guyana, Kenya, Kiribati, Lao People's Democratic Republic, Madagascar, Malawi, Mali, Mongolia, Montenegro, Myanmar, Nauru, Niue, Panama, Republic of Moldova, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Saudi Arabia, Serbia, Seychelles, Sierra Leone, Solomon Islands, Suriname, Swaziland, The former Yugoslav Republic of Macedonia, Tonga, Trinidad and Tobago, Tuvalu, United Republic of Tanzania, Uzbekistan, Vanuatu, Viet Nam, Zambia, Zimbabwe.

The draft resolution was therefore approved by 63 votes to 8, with 51 abstentions.

Dr JADUE (Chile), speaking in explanation of vote, said that, despite having voted in favour, she would have preferred the resolution to be adopted by consensus, since it dealt with a complicated health situation that was of concern to the international community. Political debates should be avoided as they could affect the Organization's humanitarian work, which all States supported.

Mr GARRIGUES (Spain), speaking in explanation of vote and on behalf of the Member States of the European Union, said that Croatia, Iceland and Norway associated themselves with his statement. The European Union remained concerned about the deteriorating health situation of the Palestinian people, as outlined in the report by the Secretariat (document A63/28). In contrast to previous years, the European Union had not been given sufficient time to engage constructively with all interested parties and especially the Palestinian delegation, which was directly concerned. The European Union had consistently advocated a more balanced text that focused more closely on health issues and took account of the report's findings. The resolution adopted did not meet those requirements. The European Union was deeply concerned at the unprecedented and inappropriate call within the text for independent international human rights organizations, particularly the International Committee of the Red Cross, to undertake specific actions. The European Union had therefore abstained in the vote.

The European Union welcomed the launch of proximity talks between Israel and the Palestinians, and called on all parties and all regional and international actors to support that political process, including through confidence-building measures, and to refrain from any provocative or unilateral action that could jeopardize it.

Mr TAN York Chor (Singapore), speaking in explanation of vote, said that his delegation's abstention was not a pronouncement on the merits or demerits of the issue. Singapore had always supported all efforts to bring about a just and lasting peace in the region and had consistently taken a principled stand on the right of the Palestinian people to a homeland and on the need for a two-State solution. While recognizing the difficult health situation faced by the Palestinian people, he considered

that it was inappropriate to introduce political elements into a Health Assembly resolution and he had therefore abstained in the vote.

Ms BROWN (Australia), speaking in explanation of vote, said that Australia was deeply concerned at the poor health conditions described in the report and at the unacceptable humanitarian situation in the Gaza Strip. Her delegation's decision to oppose the resolution reflected its concern that the current agenda item unnecessarily introduced political issues into the Health Assembly's work, failed to highlight the responsibility of all parties to address a situation of grave concern and offered no constructive contribution to the goal of a negotiated solution to the conflict or to improving the situation on the ground.

Australia had clearly demonstrated its strong support for efforts to achieve a comprehensive and enduring peace based on a two-State solution. It welcomed the proximity talks mediated by the United States of America, and urged the parties to use the talks as a first step towards direct negotiations and to refrain from any action that would undermine trust. It was the responsibility of all States to support those efforts. Australia was contributing to the development of Palestinian institutions and had provided more than 100 million Australian dollars in humanitarian assistance over the previous two years, which was going towards building the capacity of schools and health clinics, assisting the Palestinian Authority in its recovery and reconstruction efforts and helping to build the institutions necessary for statehood.

Ms HAMILTON (Canada), speaking in explanation of vote, said that Canada remained concerned at the health situation of the Palestinian people, particularly in the Gaza Strip, and was therefore committed to the provision of aid through nongovernmental and multilateral organizations and supported the Palestinian Authority in that regard. Canada had made maternal health a major theme of the upcoming G8 summit that it would be hosting, and it had provided an additional 20 million Canadian dollars for the Consolidated Appeals Process in March 2010, part of a total of 300 million Canadian dollars provided by Canada to the Palestinian people over five years.

She took the view that such a political resolution, which singled out one side for harsh criticism and called on civil society and indeed the Organization to undertake political lobbying, was inappropriate. She further questioned the utility of such a resolution when delicate proximity talks had begun, and she expressed the hope that progress would be made with respect to the Israeli-Palestinian Agreement on Movement and Access. Canada could not support such a one-sided, politicized resolution and she had therefore voted against it.

Ms HINTON (New Zealand), speaking in explanation of vote, said that New Zealand shared the concerns expressed in the resolution about the ongoing humanitarian crisis in the occupied Palestinian territory and the Gaza Strip and noted the reports by the Director-General and UNRWA on the declining health situation. She urged the governments concerned, including Israel and the Palestinian Authority, to ease restrictions on access for humanitarian goods and people, especially in and out of the Gaza Strip, and to work together to achieve a lasting improvement in the overall health situation of the Palestinian people.

If the resolution had restricted itself to addressing humanitarian needs, she would have supported it. However, the resolution sought to apportion blame in an unbalanced manner and addressed political issues that were outside the mandate of the Health Assembly. New Zealand had therefore voted against the resolution.

Dr MOGHLI (Palestine) thanked the delegations that had voted in favour of the resolution and enabled its adoption. He said that he understood the position of all those delegations that had abstained, as they were not familiar with the reality of the health situation of the Palestinian people and the extent of their suffering. His delegation was not simply seeking humanitarian assistance, but was striving for the right of the Palestinian people to health equality as recognized in international conventions. Implementation of that right was linked to ending the occupation and establishing a

Palestinian State with east Jerusalem as its capital. He expressed the hope that the resolution would lead to increased support for efforts to build the health institutions necessary for an independent Palestinian State.

The meeting rose at 17:55.

FOURTH MEETING

Tuesday, 18 May 2010, at 18:40

Chairman: Dr M. MUGITANI (Japan)

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 11.4 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R4, and A63/7) (continued from the second meeting, section 2)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB126.R4 and to the draft resolution on a WHO HIV/AIDS strategy for 2011-2015, proposed by Brazil and introduced at the Committee's second meeting.

Mr GALÁN RUEDA (Spain), speaking on behalf of the Member States of the European Union, the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine and the Republic of Moldova, said that the world had a duty to respond to the call of the United Nations Secretary-General to keep the most significant collective promise ever made to the vulnerable peoples of the world: the attainment of the Millennium Development Goals. WHO had an important leadership role to play: it must review thoroughly both the achievements and shortcomings of those efforts, and enable specific actions to enhance the compliance of countries in attaining the health-related Goals.

The Goals should not be seen as separate sectoral objectives and indicators but as interconnected and mutually reinforcing: in promoting inclusive leadership, human rights, democracy, good governance and gender equality, all were essential for healthy societies and vice versa. Health was a crucial factor in poverty reduction, sustainable growth and stability. The European Union therefore especially welcomed The world health report 2009¹ and reaffirmed its commitment to the major plans for international poverty reduction.

The European Union, through its new political framework for global health, had renewed attention to the health-related Goals and aimed to support universal coverage in comprehensive and multisectoral health services with greater coherence to the principles of aid effectiveness.

Although the Secretariat's report contained some good news, the rate of progress varied greatly within the Goals and between regions. High ratios of maternal mortality and high rates of child mortality continued in many countries, particularly among the poor and in some countries of sub-Saharan Africa, where those indicators were even higher than in 1990. The needs of women in family planning were not being met and access to reproductive health was limited: the failings of States to deal with the undervaluation of women's lives and human rights, which added to the problems of sexual violence, harmful practices and forced marriages. Nor were the rights of children to life, survival and development being observed. Better nutrition of pregnant women and children would result in significant improvements in both maternal and infant health. Concerted global action was needed to tackle hunger and food insecurity, without which many of the Goals, including those related to health, would not be achieved.

¹ *Women and health: today's evidence, tomorrow's agenda*. Geneva, World Health Organization, 2009.

The number of people in the developing world receiving antiretroviral therapy had increased 10-fold in the past five years; nevertheless, HIV/AIDS remained the primary cause of mortality in sub-Saharan Africa. Prevention and treatment in some regions, such as eastern Europe and central Asia, needed significantly increased efforts.

Some countries, often those in a fragile or post-conflict situation, were unable to implement effective public health policies that included access to adequate primary health care, sanitation, safe drinking water and education. Efforts to offer equitable and quality health care to all should concentrate on strengthening sustainable health systems: personnel, access to medicines, infrastructure, transport, and decentralized health management, together with the removal of financial barriers. That approach was particularly important to attaining Goal 5 (Improve maternal health), an indicator of strengthened health systems and fundamental to the attainment of the other Goals. The European Union called for a greater allocation of resources within the WHO budget to the achievement of both Goal 4 (Reduce child mortality) and Goal 5 and he praised WHO's cooperation in such areas as strengthening and increasing funding for health systems.

He welcomed the stated needs for "more money for health" and "more health for the money", which had been a core message of the High-Level Task Force on Innovative International Financing for Health Systems. According to its report, the improved governance, financing and performance of health systems required to achieve rapid progress towards the health-related Goals would need a doubling of investment in health by 2015. That would be possible, but only if the commitments made by both donors and governments were met.

In the years ahead the European Union would have to deliver on its commitment to increase official development assistance to 0.7% of gross national product by 2015, and policies would renew efforts to achieve the Goals.

He expressed support for the draft resolution contained in resolution EB126.R4 (which had been proposed by the remarkable figure of 61 sponsors and adopted by consensus), and said that its implementation would provide a clear framework for WHO in meeting the challenges of the Goals. It was essential for the governing bodies to promote consensus on questions ranging from health services to universal access to reproductive health, and to adopt specific measures to advance towards achievement of global public health objectives.

Mrs FALETOESE SU'A (Samoa), expressing appreciation for support provided to her country by WHO and development partners, said that the health-related Millennium Development Goals could not be implemented in isolation from the other Goals. For example, Goal 1 (Eradicate extreme poverty and hunger), Goal 2 (Achieve universal primary education) and Goal 3 (Promote gender equality and empower women) were crucial determinants of health and thus closely related to Goal 4 (Reduce child mortality) and Goal 5 (Improve maternal health). She supported the draft resolution recommended by the Executive Board in resolution EB126.R4.

Dr UGARTE UBILLUZ (Peru) said that in Peru 10 years of continuous economic growth, redistributive social policies, and the strategic linking of health actions with sectors responsible for nutrition, education and employment had all combined to reduce levels of child undernutrition. Programmes to reduce the rates of infant mortality, through immunization, monitoring growth and development in healthy children, and treatment of diarrhoeal and acute respiratory diseases, had led to the prevention of an estimated 23 400 deaths annually. Work would continue to narrow the gap between urban and rural areas and reach populations excluded from care. Furthermore, having reduced maternal mortality ratios by almost two thirds since the beginning of the 1990s, Peru was confident of attaining Millennium Development Goal 5 (Improve maternal health).

He expressed appreciation for the support received by his country from the subregional, regional and global forums, and from PAHO and WHO headquarters. He supported the draft resolution contained in resolution EB126.R4.

Dr AYDINLI (Turkey) observed that despite much progress globally, continuing inequities between countries might prevent many developing countries from attaining the health-related Millennium Development Goals. It would not be enough if a few countries achieved the Goals, achievements must be global. Under the leadership of WHO, countries had a responsibility to reinforce their cooperation and exchanges of experiences. His country stood ready to participate in that process. In Turkey over the past 10 years, maternal mortality ratios had decreased from 70 to 20 per 100 000 live births, and infant mortality rates from 43 to 13 per 1000, figures that were targeted to further decrease in 2010.

Mrs REITENBACH (Germany) observed that in adopting the Millennium Development Goals, countries had promised to make the world a better place: progress was mixed and great challenges remained. Achievement of the Goals by 2015 would require coordinated efforts by all partners: governments, civil society, the private sector, and international organizations and institutions.

Coherent national strategies to achieve the Goals must include enhanced investment and capacity-building in health systems, especially in meeting the health care needs of women at key moments of their lives. *The world health report 2009*¹ contained compelling evidence of widespread inequities in the health of women and girls, unacceptable when the world knew what was needed to resolve the situation. Strategies to improve women's health must be based on improving gender equality and the empowerment of women; thus Goal 3 (Promote gender equality and empower women) was vital for the achievement of all of the Goals.

She welcomed the decision of the Director-General to focus the forthcoming world health report on financing for universal health coverage. Germany would promote that topic through a high-level ministerial conference to be held in Berlin in November 2010 that would also provide a political platform for the launch of that report. A focus on strengthening and financing health systems would contribute significantly to the achievement of the Goals by 2015. She called on all Member States to participate in that process and to keep the promise they had made.

Mr ELIRA DOKEKIAS (Congo), expressing concern over the high prevalence of communicable diseases such as malaria, HIV/AIDS and tuberculosis, observed that certain congenital diseases that had not been covered in the report could have an impact on both infant and maternal mortality. For example, when girls with sickle cell anaemia reached childbearing age, their pregnancies were hazardous. Sickle cell anaemia, in its homozygotic form, affected between 1% and 2% of black African children at birth, and up to 1% of children in other regions. It existed, too, in the destination countries of migrants, but was kept under control by appropriate measures. Some five years earlier the Health Assembly had recognized the disease as a public health problem. Congo, which was one of the countries affected, was concerned by the fact that, if the problem was not specifically singled out among the noncommunicable diseases, the lack of development support would create obstacles to the achievement of the Millennium Development Goals. The draft resolution should make some mention of sickle cell anaemia which, together with other infectious illnesses, could seriously affect the achievement of the Goals.

Dr ALI (Bangladesh), commending the report, said that the outlook for attaining the health-related Millennium Development Goals confirmed the need for accelerated progress. Many best practices and instruments were available to Member States that could be replicated and deployed in response to specific local situations. Bangladesh was open to sharing experience and knowledge with countries at a similar level of development.

Bangladesh was on track to achieve Goal 4 (Reduce child mortality). However, like most developing countries, it was not on track to achieve all the target indicators for Goal 5 (Improve maternal health): childbirths were often attended by low-skilled professionals; the rates of institutional

¹ *Women and health: today's evidence, tomorrow's agenda*. Geneva, World Health Organization, 2009.

delivery and of antenatal care were low; adolescent fertility rates were high and an estimated 20% of family planning needs were not being met. The ratio of maternal mortality had almost halved but recent progress was being hindered by funding constraints, and by socioeconomic and cultural barriers.

Future reports on progress to achieving the Goals should provide an overview of the financing available both nationally and internationally; highlight the application of innovative financing mechanisms; detail the impact of trends in official development assistance in line with the Paris Declaration on Aid Effectiveness (2005) on achievement of the health-related Goals; provide monitoring of the adverse impact of climate change on the attainment of the Goals; and should also address the issue of barriers to innovation and to access to quality, affordable medication and treatment, notably in developing countries.

Dr MELNIKOVA (Russian Federation) welcomed the progress towards achievement of the Millennium Development Goals, especially in combating HIV/AIDS, tuberculosis and malaria and in reducing child and maternal mortality. The global financial crisis was adversely affecting health-care systems, especially developing countries. She supported the focus on accelerating progress towards Goal 4 (Reduce child mortality) and Goal 5 (Improve maternal health) but considered that resources should not be diverted from other health targets such as HIV/AIDS and other communicable diseases. She advocated an integrated approach to achieving all the health-related Goals, which were interdependent and interrelated. For instance, achieving Goal 7 (Ensure environmental sustainability) could help to reduce infant and child mortality by combating the spread of intestinal infections that killed 1.2 million children each year. Maternal and child mortality could be significantly reduced through access to antenatal care, provision of micronutrients and a safe water supply.

Social projects aimed at achieving the Goals were central to her Government's significant financial contributions to international development that included: international cooperation to combat pandemic influenza and develop vaccines against HIV infection; support to the countries of Africa and central Asia to combat malaria and other communicable diseases; and strengthening the international network in order to eliminate the pandemic consequences of disasters and combat tropical diseases.

She supported the draft resolution contained in resolution EB126.R4. Health-care systems must be strengthened and their funding secured; health-care workers must be trained and a supply system created, backed by the necessary medical resources and technologies.

Dr XABA (Swaziland), commending the report, said that most African countries, including his own, had made slow progress and might not achieve the health-related Goals, mainly owing to disparity of incomes and underfunding. The disease burden of HIV/AIDS and malaria was overwhelming African health systems that were often inefficient and uncoordinated; and lack of resources constrained programmes aimed at reducing rates of neonatal and child mortality and maternal mortality ratios. He urged the Secretariat to provide support to Member States to review their policy and legal frameworks; to enhance human resources and training for health; to assist with their pandemic preparedness plans; and to strengthen their capacity to compile information on progress in achieving the Goals. He supported the draft resolution contained in resolution EB126.R4.

Dr DAKULALA (Papua New Guinea) said that his Government had always promoted breastfeeding for child survival, healthy growth and development. Breastfeeding, which provided protection against diarrhoeal disease and pneumonia and contributed towards reducing childhood obesity and noncommunicable disease, was supporting the achievement of Goal 4 (Reduce child mortality) in his country. He therefore proposed that the following phrase should be inserted after "continuum of care" in subparagraph 1(5) of the draft resolution contained in resolution EB126.R4: "in particular through interventions that increase rates of exclusive and sustained breastfeeding ...". He also supported the amendments proposed by the delegations of Jamaica and the Bahamas in the Committee's second meeting, on monitoring of the Millennium Development Goals in small island States.

Mr SAMO (Federated States of Micronesia), commending the report, noted that the rate of tuberculosis detection had increased. The Secretariat should provide greater support to Member States for accessing second-line medicines to treat patients with multidrug-resistant tuberculosis. He supported the draft resolution contained in resolution EB126.R4.

Mr SIMBAO (Zambia) said that Zambia expected to reach certain targets for the health-related Millennium Development Goals by 2015. Those included a reduction in infant and child mortality rates and mortality due to malaria. Maternal mortality ratios had already dropped since 2002. Delivery of health services and the health of the population overall had also improved. In the context of those successes, he emphasized the significant contribution made by the Global Fund to Fight AIDS, Tuberculosis and Malaria, the GAVI Alliance and the World Bank, and he urged the continuation of those programmes.

Mr JHUGROO (Mauritius) expressed support for the draft resolution contained in resolution EB126.R4. Mauritius had made significant progress on the health-related Millennium Development Goals. Public health care was provided free of charge, the system functioned well and was oriented towards the Goals. Health strategies also addressed determinants of health such as gender equality; provision of water and sanitation; food security; nutrition; and education for all. The Goals had also focused attention on the importance of reliable data. In his country, the infant mortality rates and maternal mortality ratios had been substantially reduced, mainly because skilled personnel attended most deliveries. However, recently increased rates of Caesarean sections were cause for concern.

Dr AL HAMAD (Kuwait), agreeing that breastfeeding contributed significantly to reducing childhood morbidity and mortality, supported the amendment to the draft resolution proposed by the delegate of Papua New Guinea.

Kuwait had high rates of noncommunicable diseases such as childhood obesity and type-2 diabetes. Disease-surveillance programmes had been introduced in schools, breastfeeding was supported and baby-friendly hospitals had been established.

Dr SEAKGOSING (Botswana), welcoming the report, said that the current global recession threatened to reverse recent progress to attain the Millennium Development Goals. The HIV/AIDS prevalence rate of 17.6% overall in his country remained a significant challenge but progress had been made in reducing mother-to-child transmission of HIV and improving coverage of antiretroviral treatment. Audits of maternal mortality had made recommendations to improve maternal and neonatal health that included: strengthening the national referral system; expanding the coverage of antenatal care; increasing the number of supervised deliveries; and increasing contraceptive use. Strengthening domiciliary care was also a priority in order to prevent sepsis and neonatal deaths. The national strategy for accelerated child survival and development would emphasize interventions that had substantial impact, such as the introduction of *Haemophilus influenzae* type b vaccine in the national immunization schedule. He supported the draft resolution contained in resolution EB126.R4.

Mrs HAMADEH (Lebanon), expressing concern at the difference between recorded rates and WHO estimates, said that in her country studies had confirmed a maternal mortality ratio of 23 per 100 000 live births. Almost all births (98%) took place under specialist supervision, and post-natal care and rehabilitation services were provided by the primary health-care system. She expressed concern that estimates were being used in place of scientific data, casting doubt on the reliability of reports. It was important to establish the current situation and the progress that had been made towards achieving the Millennium Development Goals, in order to assess accurately indicators for the attainment of health-related Goals in 2015.

In the context of child health, significant progress had been made through improved coverage of child immunization programmes; however much remained to be done. Arrangements should be made

for Member States to obtain, through UNICEF, the inactivated poliovirus vaccine, which had not yet been prequalified by WHO.

Ms MÅRENG (Norway), supporting the draft resolution contained in resolution EB126.R4, noted the link between child and maternal health and the status of women, sexual violation and armed conflicts, and said that her country would continue to focus on those issues. The health of women and children had been on the agenda of the G8 development ministers' meeting (Halifax, Canada, April 2010), and would be discussed at the African Union Summit (July 2010), and the United Nations Summit on the Millennium Development Goals (September 2010). She expressed support for the United Nations Joint Action Plan for accelerating progress on maternal and newborn health. That Plan supported national health plans, making women and children the main entry point for health services and encouraged integrated health strategies. It had defined a financing shortfall of up to US\$ 45 000 million by 2015 and called on stakeholders to contribute US\$ 15 000 million by 2011. It also promoted consolidated action by WHO, the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the World Bank to meet the outcomes for Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health), and Goal 6 (Combat HIV/AIDS, malaria and other diseases). She requested the Health Assembly to acknowledge the Joint Action Plan and encouraged Member States to support it.

Mr PRAZ (Switzerland), welcoming the encouraging progress made towards achieving Millennium Development Goals, said that financing initiatives such as the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria and the GAVI Alliance had led to significant results. However, Goal 5 (Improve maternal health) had not received similar support in recent years. He therefore welcomed the initiative of Canada in making maternal health a priority for the G8 summit (Muskoka, Canada, June 2010). Funding was a determining factor in achieving the Goals and the global economic crisis was affecting national budgets in both developed and less developed countries. It would be difficult to meet the commitments made at the High Level Plenary Meeting of the United Nations General Assembly (2005), which meant that the Goals might not be attained. His country remained committed to the Goals, and was prioritizing the strengthening of health systems, the fight against communicable diseases, and maternal and child health. He welcomed cooperation in health initiatives on the ground, in line with the Paris Declaration on Aid Effectiveness (2005). WHO regional and country offices had special access to health ministries and therefore had a responsibility to communicate advice and foster political dialogue with Member States, and to promote collaboration among all stakeholders in the field of health.

Vice-Admiral BENJAMIN (United States of America) said that the Millennium Development Goals represented a global commitment to promoting development and eradicating poverty. Her Government was committed to preserving the momentum needed to meet the Goals, and ensure sustainable development. She welcomed the reported progress against undernutrition and child mortality, in particular in developing countries, but expressed concern about the lack of global success in reducing maternal mortality ratios. An approach centred on women was necessary to make pregnancy safer, increase the availability of family planning services and expand high impact interventions; such an approach should include initiatives to reduce both maternal and child mortality. Her Government would continue to support programmes relating to HIV/AIDS, tuberculosis, malaria and access to safe drinking-water and sanitation. She supported the emphasis on strengthening health systems, and the increased use of information technology to improve health-care quality and access to services. She urged the Health Assembly to adopt the draft resolution contained in resolution EB126.R4, which her country had cosponsored.

Dr SCALLY (United Kingdom of Great Britain and Northern Ireland), welcoming the progress made in reducing child mortality, said that increased support for effective health strategies and stronger health systems was needed, which would help to improve maternal mortality ratios and

neonatal mortality rates, furthering progress in attaining Goal 5 (Improve maternal health). He therefore requested WHO to give priority in 2010 to ensuring that health systems provided universal coverage. He encouraged Member States to support the recommendations of the new Global Consensus on Maternal, Newborn and Child Health (2009). Universal access to reproductive health care was essential for meeting Goal 5, and he encouraged the Secretariat to reinvigorate the family planning agenda, as indicated in the Global strategy on reproductive health (2008).

Dr NAGAI (Japan) said that her Government would continue to focus on maternal, neonatal and child health, developing specialized human resources, and improving obstetric care and access to relevant services. It was also committed to strengthening measures against infectious diseases, including support for the Global Fund to Fight AIDS, Tuberculosis and Malaria and other institutions. As the health-related Millennium Development Goals were interrelated, combined programmes should be developed and implemented, with cooperation in other sectors, including education, infrastructure and social welfare. It was essential to collect and analyse reliable data, through registrations, so as to provide accurate estimates relating to the attainment of the Goals.

She supported the adoption of the draft resolution contained in resolution EB126.R4, of which her country was a sponsor.

Dr NAKORN PREMSRI (Thailand), speaking on behalf of the Member States of the South-East Asia Region, said that political commitment was necessary for achieving the Millennium Development Goals. The Millennium Development Goals Report (2009) indicated that net disbursement of official development assistance in 2008 had been equivalent to only 0.3% of combined national income of developed countries. He thanked countries that were meeting the 0.7% target, and those committed to doing so by 2015. Official development assistance from countries on the Development Assistance Committee of OECD had not exceeded 0.1% of donors' gross national income between 1990 and 2008. Developing countries should rely not only on official development assistance, but also on national resources.

He proposed amendments to the draft resolution contained in resolution EB126.R4. A new preambular paragraph 13bis should be inserted to read: "Expressing deep concern over the weak institutional capacity in health-information systems, the inadequate coverage and poor quality of civil registrations in developing countries which hamper monitoring progress of the Millennium Development Goals, this requires significant increased investment in financial and human resources on health-information systems to generate accurate, reliable and timely evidence on MDG achievement, gender and geographical disparities;"

A new subparagraph 1(4)bis should be inserted to read: "to further commit in investment and strengthen the national health-information systems in order to generate accurate, reliable and timely evidence on MDG achievement and depict gender and geographical disparities;" In subparagraph 1(13), the phrase "for both levels and its allocation to the least developed countries;" should be added after "by 2015". A new subparagraph 1(14) should be inserted to read "to fulfil and sustain developing country governments' political and financial commitment in mobilizing adequate budget allocation to health sectors". Finally, paragraph 3 should become subparagraph 2(11), and the word "INVITES" should be replaced by "CALLS UPON".

Welcoming the proposed draft resolution on a WHO HIV/AIDS strategy for 2011-2015, he suggested amendments. In the third preambular paragraph, "protected" should be replaced by "sustained" and "equality" should be replaced by "equity". In the eighth preambular paragraph, "robust" should be replaced by "comprehensive" and "and noting that sustaining of these efforts is challenging" should be inserted after "primary health care, particularly". A new ninth preambular paragraph should be inserted to read: "Recognizing that antiretroviral treatment programmes take a major share of total national AIDS spending in most countries, which warrants immediate attention to review and improve the performance of ART through early recruitment, ensuring highest adherence to medications, lowering of drug resistance, and minimize risk behaviour enhancement and safeguard the level of national spending on prevention and control measures" and a new preambular paragraph 10

should be inserted to read: “Expressing deep concerns that financing HIV programmes in most developing countries relies on financial resources contributed by donor and global health initiatives, and limited national financial resources, which hampers the HIV programmes’ financial sustainability, while lack of donor harmonization creates fragmentation and inefficiencies”.

A new subparagraph 1(1)bis should be inserted to read: “to increase governments’ financial commitment on HIV/AIDS programme financing and advance steps towards donor harmonization while safeguarding expenditure on prevention interventions”. Subparagraph 1(2) should be amended to read: “to incorporate, based on national contexts, policies, strategies, programmes and interventions as recommended by WHO in order to implement effective HIV prevention measures, early diagnosis, treatment and care; and enhancing steps towards minimizing social stigma and discrimination which hamper access to prevention, care and treatment.” Subparagraph 1(3) should read: “to use existing administrative and legal mechanisms in order to promote access to affordable and cost-effective treatment and diagnostic technology”. In subparagraph 1(4), “HIV” should be replaced by “HIV/AIDS services programme”. A new paragraph should be inserted after subparagraph 1(5), to read: “to closely monitor an evaluation of HIV/AIDS programmes by ensuring the completeness, accuracy and reliability of the data and use this information to improve the programme efficiency”. Finally, in subparagraph 2(1), the words “to lead a broad consultative process” should be replaced by “to take the lead in convening broad consultative processes” and “Paris Principles for Aid Effectiveness” should be replaced by “Paris Declaration on Aid Effectiveness”.

Dr ABUDHER (Libyan Arab Jamahiriya) said that his country had made progress towards achieving the Goals, thanks to improvements in living standards and the education of young people, who made up a large proportion of the population. Efforts had also been made to promote gender equality, and to halve the child mortality rate by 2015 by ensuring coverage of health services and through a vaccination programme. Maternal mortality ratios had also fallen, from 77 per 100 000 live births in 1990 to 23 per 100 000 live births in 2008, as a result of improved services for maternal health. In the area of communicable diseases, the malaria mortality rate had been reduced to 11 per 100 000. He supported the draft resolution contained in resolution EB126.R4.

Ms USIKU (Namibia) said that her country had made progress towards achieving Goal 6 (Combat HIV/AIDS, malaria and other diseases), especially with regard to universal access to treatment. However, more remained to be done to reduce rates of child mortality and maternal mortality ratios: a road map with costings was in place, a multisectoral management committee for maternal and child health had been established, and guidelines had been formulated with WHO technical support. Training had been increased for health workers, particularly in emergency and obstetric care, and in neonatal resuscitation.

Obstetric and emergency equipment had been supplied to district hospitals and to most primary health care clinics. The Campaign on Accelerated Reduction of Maternal Mortality in Africa, launched in 2009, included promotion of training and skills development for midwives, improved neonatal care and strengthened coverage of routine immunization. The First Lady of Namibia had launched a campaign to involve traditional chiefs and their counsellors in supporting government efforts to tackle maternal and child health issues. She appealed to WHO for continued technical support, and expressed support for the draft resolution contained in resolution EB126.R4.

Dr MANSOURI (Tunisia) said that the Millennium Development Goals represented a synergy between all countries in the fight against poverty. The Secretariat’s report indicated that progress had been made towards achieving the health-related Goals but disparities persisted between regions and countries.

With regard to maternal and child health, international organizations should encourage the participation of other stakeholders; the education and living standards of women should be improved in order to ensure that they had easier access to health services and become true partners in achieving the Goals; policies should promote universal access to health services, particularly for the most

vulnerable; and indicators should reflect the national, regional and international situation. He expressed appreciation to the Secretariat for its efforts, notably in the area of maternal and child health, which should be maintained with a view to achieving the Goals in 2015.

Mr DE ALBUQUERQUE E SILVA (Brazil) said that WHO, as the United Nations agency responsible for catalysing actions in the health sector, played a critical role in leading a sustained response to HIV/AIDS, one of the world's most serious health problems. In regard to the main objections to the draft resolution proposed by Brazil, he could be flexible with regard to the language used in some parts of the text. All the amendments proposed by the delegate of Thailand were acceptable. However, the core of the draft resolution could and must be preserved and the text could be considered alongside the draft resolution contained in resolution EB126.R4. The latter dealt with health-related Goals as a whole, while the former focused on two specific targets, proposed separate actions, and complemented the European Union resolution, for which he expressed full support.

The draft resolution proposed by Brazil was intended to reinforce the role of WHO in tackling HIV/AIDS. Member States that had supported projects such as the "3 by 5" initiative and the United Nations call for work towards universal access to HIV prevention, treatment, care and support by 2010 could have no sound objection to the main goals of the draft resolution. It must be recognized that the aforementioned initiatives, despite fair and good intentions, had resulted in limited achievements.

The Director-General had a key role to play in the process of developing and implementing a WHO strategy on HIV/AIDS that would serve as a beacon for Member States and international civil society in elaborating and implementing sound responses to the epidemic and meaningfully change the lives of those who really mattered.

Dr KAMARUDDIN (Malaysia) said that significant progress had been made in her country towards achieving the Millennium Development Goals through political will, stability and the commitment of health-care providers to an effective health system. With regard to Goal 6 (Combat HIV/AIDS, malaria and other diseases), she drew attention to the issue of verification of targets for HIV/AIDS. AIDS was a complex disease with a long incubation period, and various screening mechanisms were in use around the world. It was difficult to determine the disease burden and the impact of control activities: the application of standard mathematical tools to verification might not be appropriate in all settings. Based on its extensive surveillance mechanism, Malaysia was confident of being on track to achieve the Goals and targets on HIV/AIDS, and of halting and reversing the epidemic earlier than 2015. Nevertheless, some organizations in the United Nations system disputed the data and doubted those achievements. She therefore urged WHO to work with UNDP on an acceptable and comparable verification process suitable for use in various epidemiological settings and countries.

Dr GAMARRA (Paraguay) said that her Government, firmly committed to achieving the Millennium Development Goals, had introduced public health policies that focused on social programmes with defined goals, conscious that achieving those goals depended on economic growth linked to public spending and social participation.

She expressed support for the pledges set out in the Abuja Declaration on HIV/AIDS, Tuberculosis and other Infectious Diseases (Abuja, Nigeria, 2001) which included the target for countries of allocating at least 15% of annual budgets to the improvement of the health sector.

Maternal mortality ratios in Paraguay had fallen by 26% between 2000 and 2008, but more remained to be done if Goal 5 (Improve maternal health) was to be achieved. Coverage of prenatal care stood at 90.5% and the proportion of births in health-care facilities had increased significantly. The overall fertility rate had decreased by half between 1990 and 2008. Since December 2008, 279 family health units had been established, for a total population of only six million. However, indicators could be improved in all areas, including HIV/AIDS and tuberculosis. Her Government was working in line with the report: sustaining political momentum; giving more money to health and

getting more value for that money; strengthening health information systems; and training human resources.

The CHAIRMAN, in response to a request from Mr HOHMAN (United States of America), said that he would ask the Secretariat to prepare revised versions of the two draft resolutions, incorporating all the amendments proposed.

Mr FAUVEAU (United Nations Population Fund) expressed appreciation for the renewed commitment to accelerating progress on Millennium Development Goal 5 (Improve maternal health) and the increased attention given to women's health. UNFPA was proud of its collaboration with UNICEF, WHO and the World Bank, which together had formed the United Nations Health 4 group.

The most significant advances in the area of women's health had been made following the recognition by the United Nations General Assembly at its 60th session (2005) that access to universal health was essential to improving maternal health. Target 5.B, Achieving universal access to reproductive health by 2015, was consequently added under Goal 5, but had yet to receive the recognition it deserved. In order to improve maternal health, a cost-effective and comprehensive package of sexual and reproductive health information, supplies and services would need to be scaled up and delivered, including family planning, and provide women with the right to make more choices about their lives. He called for enhanced political commitment to integrating Target 5.B into national policy dialogues, strategies and programmes.

Professor Shan-Chwen CHANG (Chinese Taipei), expressed his support for the Millennium Development Goals, including the health-related Goals. He urged the Health Assembly to adopt the draft resolution contained in resolution EB126.R4. He emphasized that Chinese Taipei, despite its strong health system, could not afford to be complacent about its health insurance system, which was being reviewed and strengthened. Chinese Taipei would be willing to share its experiences with countries as they progressed towards achieving the Goals.

Mr STURCHIO (Global Health Council), speaking at the invitation of the CHAIRMAN, expressed appreciation for the draft resolution proposed by Brazil, as a renewed WHO strategy on HIV/AIDS would be essential in helping countries to achieve Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases). The Council considered that research and innovation were also crucial to achieving the health-related Goals. Reference to research needs should therefore be integrated into the draft resolution.

The Council supported efforts to establish a common framework on health system strengthening and emphasized a focus on leadership and management in order to improve the recruitment, retention and productivity of health professionals and to provide greater accountability and effective use of resources. It urged the Secretariat and Member States to provide a clear plan of action at the United Nations Summit on the Millennium Development Goals to be held in September 2010; that would encourage efforts by civil society, private-sector organizations as well as governments. Member States should also commit to investing the resources needed to meet the Goals, as a complement to donor funding.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that the draft resolution contained in resolution EB124.R4 should call for the removal of fees at the point of access to health services as those fees had a detrimental impact on the poor and most vulnerable people such as mothers and children. The fees led to a selection based on wealth, not health needs, and violated the principle of the right to health that had been recognized by all governments; furthermore, there was a global consensus on the need to move to fairer funding mechanisms.

Ms BRAUEN (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that her organization remained concerned about the high maternal mortality ratios

and infant mortality rates in countries with low resources. Despite the efforts of the Secretariat and governments, about 350 000 women continued to die each year in childbirth. The Confederation welcomed the timely commitment of the United Nations Secretary-General and WHO's Director-General to promote maternal and child health and urged all countries to provide the services necessary to protecting women's health during pregnancy and childbirth.

In order to accelerate progress towards Millennium Development Goal 3 (Promote gender equality and empower women), the challenges relating to Goal 4 (Reduce child mortality), Goal 5 (Improve maternal health) and Goal 6 (Combat HIV/AIDS, malaria and other diseases) would need to be resolved. In particular, the lack of skilled midwives compromised the provision of quality maternal and neonatal care. WHO should urge strategies to extend midwifery education, regulation and training and to manage the migration and retention of health workers.

Mr JAFRI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, noted that the Millennium Development Goals provided the opportunity for all stakeholders to focus efforts on tackling some of the biggest challenges facing people around the world. The Alliance welcomed the increasing recognition of the link between noncommunicable diseases and attainment of the health-related Goals. A progress indicator specific to noncommunicable disease should be included in the Goals and further resources should be committed to improving their prevention and control. The Alliance supported WHO in its efforts to meet the Goals.

Ms SOZANSKI (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, urged the Secretariat and its Member States, in their discussions on achieving the Millennium Development Goals, to recognize the value of local communities, their knowledge and traditions, and the critical data observed by those implementing health strategies at the community level. All partners needed to be aware of how the significant differences in cultural environments affected health outcomes. She emphasized that improving newborn care in the first month of life was essential for reducing child deaths in developing countries. Her organization was currently assisting in the development of a knowledge base of best practices in health promotion that focused specifically on community assets and cultural dynamics.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, reaffirmed the innovative commitment of the pharmaceutical industry to help in achieving the health-related Millennium Development Goals. Highlighting Goal 8 (Develop a global partnership for development), he said that since 2000, members of the Federation had made significant contributions to health assistance for access and capacity building in developing countries and represented the third largest source of funding of research and development for diseases in developing countries. The Federation produced annually an extensive inventory of projects that confirmed the growing commitment of the industry to achieving the Millennium Development Goals.

Dr OTTO (Consumers International), speaking at the invitation of the CHAIRMAN, said that the many Member States struggling to achieve Millennium Development Goal 4 (Reduce child mortality) could prioritize breastfeeding, a proven factor in ensuring the survival, healthy growth and development of young children. Breastfed infants had a stronger immune system, were less vulnerable to mortality due to diarrhoea, pneumonia and noncommunicable diseases, and were less predisposed to childhood obesity. Major reports by organizations in the United Nations system and government departments had emphasized the need to incorporate improved nutrition into programmes for child survival. Indicators in the *World health statistics* included data on the percentages of infants exclusively breastfed in the first six months of life. He called on Member States to support the proposal to incorporate the words "in particular, through interventions that increase rates of exclusive and sustained breastfeeding" into subparagraph 1(5) of the draft resolution contained in resolution EB126.R4.

Ms GORNA (International AIDS Society), speaking at the invitation of the CHAIRMAN, recalled that leaders present at the G8 Summit (2005) had pledged to strive to achieve universal access to HIV prevention, treatment and care for those in need by 2010. Efforts to that end had resulted in a reduction in the prevalence of tuberculosis and other infectious diseases and in the strengthening of health systems, and had significantly reduced maternal, neonatal and child morbidity. However, with millions awaiting treatment in keeping with WHO's new recommendations, she urged all Member States to ensure that the Global Fund to Fight AIDS, Tuberculosis and Malaria successfully completed its replenishment for the period 2011 to 2013; and that efforts to achieve universal access were further advanced by placing health, AIDS and development on the agenda of the G20 Summit to be held in Seoul in November 2010. She welcomed the draft resolution proposed by the delegation of Brazil, as amended by the delegation of Thailand. She commended the Secretariat's efforts to date, especially the rapid issue of the revised guidelines for HIV treatment, which should be adopted immediately by all Member States. She called on the Health Assembly to request the Director-General to develop a bold new HIV/AIDS strategy that would secure optimal health services; WHO must continue to play a central leadership role.

Ms KEITH (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the recognition of learning from success and from the experience of Member States that had achieved significant reductions in child mortality. International leaders must strive to protect health budgets, to pledge aid and to ensure more effective spending that prioritized maternal and child health. Member States should emphasize global health governance and include an item on the subject in the agenda of the Sixty-fourth World Health Assembly. Referring to the best practice principles for global health partnerships developed under the aegis of the High-Level Forum on the Health Millennium Development Goals (2006), she said that the Organization's work with global partners was encouraging but should be more inclusive of civil society.

She supported the draft resolution contained in resolution EB126.R4. Subparagraph 1(4), however, should be amended through wording to help countries to move away from health-service charges at the point of access and to increase resources for social protection mechanisms such as cash transfers. It should also include a reference to resolution WHA58.31. Subparagraph 2(4) should refer to health governance and accountability.

Mr HOHMAN (United States of America) suggested some amendments to the draft resolution proposed by Brazil. A new preambular paragraph 3bis should be added, reading: "Further recognizing the need to strengthen the linkages between prevention and treatment of HIV/AIDS to achieving Millennium Development Goals 4 and 5;". The beginning of the seventh preambular paragraph should be amended to read: "Recognizing the need for countries to sustain their commitments to address the HIV/AIDS epidemic at all levels, including at the highest political level, and to be supported in...". The words "harm reduction for drug users" in the eighth preambular paragraph should be replaced by "comprehensive prevention and treatment programmes for injecting drug users"; and the end of subparagraph 1(3) should be amended to read: "to promote access to prevention, treatment and care;". The words "harm reduction" in subparagraph 1(4) should be replaced with "prevention and treatment programmes for injecting drug users"; and subparagraph 2(2) should be amended to read: "to promote the translation of research results into efficient public health policies for HIV/AIDS;". The word "endorsement" should be replaced by "consideration" at the end of subparagraph 2(3).

Mr PARRONDO (Spain), speaking on behalf of the European Union, suggested that subparagraph 1(3) of the draft resolution proposed by Brazil should be amended, in line with subparagraph 2(8) of the resolution contained in resolution EB126.R16, to read: "to consider, whenever necessary, using existing administrative and legal means in order to promote access to preventive, treatment and diagnostic technologies;". Furthermore, the word "ensure" should be replaced by "encourage" at the beginning of subparagraph 2(2).

Dr EVANS (Assistant Director-General) said that all the various comments and suggestions had been noted, especially those concerning future reports on progress towards the achievement of the health-related Millennium Development Goals. Responding to the comment on the statistical assessment of progress in the absence of baselines, he said that the Secretariat had recommendations on managing such situations using models and drawing on statistics from neighbouring countries. As for the matter of the differences in the definition of neonatal mortality that were affecting inter-country comparability, the Secretariat encouraged adherence to the standard WHO definition.

Regarding the comments by the delegate of Lebanon regarding estimates of maternal mortality ratios, the Secretariat was working with local experts to revise estimates as and when new sources of data became available. Recently revised estimates for Lebanon and Turkey were reflected in *World health statistics 2010*. WHO and its partners furthermore advocated more aggressive investment in developing direct measurement systems for making such estimates.

Meanwhile, further to the comment by the delegate of the Congo on sickle-cell anaemia, he said that the subject would be considered under agenda item 11.7 on birth defects.

With regard to the comment by the delegate of Malaysia, the Secretariat agreed on the importance of working with United Nations partners to improve estimates of the prevalence and incidence of HIV/AIDS.

On the matter raised by the delegate of Germany and the representatives of The Save the Children Fund and World Vision International about the financing of health systems without charging for services at the point of access, he stressed that *The world health report 2010* on universal health coverage would emphasize the importance of moving more swiftly towards pre-payment systems as the standard for equitable and efficient financing in all countries.

Dr NAKATANI (Assistant Director-General) said that delegates could be reassured concerning the follow-up to the second phase (2006–2010) of WHO's strategic activities in the field of HIV/AIDS, which would end on 31 December. The Secretariat had already begun work on the next phase and the scope of the strategy would extend beyond HIV/AIDS to deal with many related aspects that deserved attention.

The CHAIRMAN requested the Secretariat to prepare a document taking into account the proposed amendments to the draft resolution proposed by Brazil and to the draft resolution contained in resolution EB126.R4. He proposed that the discussion on agenda item 11.4 should be suspended.

It was so agreed.

(For continuation of the discussion on a draft resolution on a WHO HIV/AIDS strategy for 2011–2015 and approval of a revised draft resolution on the item recommended by the Executive Board in resolution EB126.R4, see the summary record of the tenth meeting.)

2. ORGANIZATION OF WORK

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to bring forward its consideration of agenda item 11.20 on counterfeit medical products to the following afternoon.

It was so agreed.

In response to a question by Mr HOHMAN (United States of America) the CHAIRMAN said that a drafting group would be formed to consider agenda item 11.5 (International recruitment of health personnel: draft global code of practice) and announced that informal consultations would take

place on agenda item 11.3 (Public health, innovation and intellectual property: global strategy and plan of action).

The meeting rose at 21:25.

FIFTH MEETING

Wednesday, 19 May 2010, at 9:30

Chairman: Dr M. MUGITANI (Japan)

1. SECOND REPORT OF COMMITTEE A: (Document A63/59)

Dr MISHRA (India), Rapporteur, read out the draft second report of Committee A.

Dr MEMISH (Saudi Arabia) apologized for not having been present at the third meeting for the vote on the draft resolution on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. Had his delegation been present, it would have voted in favour of the text.

Mr HOHMAN (United States of America) said that in issue number 3 of the *Journal*, under Item 13, it was stated that there had been eight votes against the resolution, whereas the names of only seven countries were listed.

Mr HIGGINS (Australia) said that Australia had been omitted from the list of countries voting against the draft resolution.

The CHAIRMAN said that that omission would be corrected. He took it that, subject to that correction, the Committee wished to adopt the report.

The report was adopted.¹

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

Infant and young child nutrition: Item 11.6 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R5, and A63/9)

Dr ZARAMBA (representative of the Executive Board), said that, at its 126th session in January 2010, the Executive Board had considered the quadrennial progress report on infant and young child nutrition and adopted resolution EB126.R5, in which it recommended a text to the Health Assembly for adoption.

Dr RASAE (Yemen), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the situation with regard to infant and young child nutrition had deteriorated, particularly in countries with high density of population. The financial crisis had exacerbated the predicament of infants and children under five years of age, particularly in Afghanistan, Djibouti, Pakistan, Somalia and Yemen. Nonetheless, malnutrition in many countries in the Region had

¹ See page 321.

decreased, including in Jordan, Tunisia and Oman, which were on the way to achieving the health-related Millennium Development Goals.

He thanked the Regional Office for its assistance in establishing new criteria for development and growth. The criteria had been standardized and adapted to cover regional issues, and a strategy for infant and young child nutrition was being implemented as the backbone of national programmes and integrated into local actions. However, the information was inadequate and could not be applied to everyone who required assistance. He therefore called on WHO and the international community to provide resources for programmes to improve the nutrition of infants and young children and reduce the mortality rate, and to facilitate coordination of projects between countries in the Region. He expressed concern that some countries, because of current emergencies, were making no progress towards achieving the health-related Millennium Development Goals; in others, climate change was indirectly affecting the nutrition of infants and young children. It should be possible to put an end to all types of promotion of formula feeding for infants and young children, particularly the placing of advertisements in newspapers and magazines, to ensure compliance with health plans that encouraged breastfeeding, and to provide evidence and data based on those programmes.

Mr OBAMA ASUE (Equatorial Guinea), speaking on behalf of the 46 Member States of the African Region, said that in order to meet the health-related Millennium Development Goals, international commitments should be adhered to and nutrition should be placed at the heart of the development process, with a strategic vision reflected in public policies and translated into specific measures. In the African Region about one third of infants were exclusively breastfed during the first six months of life, about two thirds of infants between six and nine months of age received breast milk together with suitable complementary foods, and more than half of infants aged 20 to 23 months were still breastfed.

The inadequacy of those practices led to general malnutrition in children under five years of age. In Africa 43% of children under five years of age suffered from stunted growth and 23% were underweight. Globally, nearly half of all children of pre-school age suffered from anaemia, mainly due to iron deficiency. That was a particularly serious problem in Africa, as was vitamin A deficiency. Access to food, the nutritional value of foods, food preparation and hygiene also affected infant and young child nutrition. Community involvement was important in the development of nutritional strategies through primary health care activities. With regard to the International Code of Marketing of Breast-milk Substitutes, six countries had introduced or were in the process of introducing relevant legislation.

Infants and young children in all countries should enjoy the right to the highest possible standard of health, and nutrition played a key role in that regard. The progress achieved in some countries in the African Region was encouraging. However, there remained many challenges, particularly because of the lack of financial and human resources at national level. The international food crisis jeopardized the food security of households and the nutritional status of vulnerable populations, particularly women and children. He requested WHO and the international community to provide technical support and human resources and encouraged Member States to approve the draft resolution contained in resolution EB126.R5.

Mr XIMENES (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, supported the draft resolution. In his Region the rate of exclusive breastfeeding for the first six months of life ranged from 10% to 65%, with an estimated regional average of 25%; the prevalence of low birth weight, an indicator of maternal nutrition and fetal development, ranged from 7% to 30%; the prevalence of underweight children below the age of five ranged from 9% to 49%; stunting or chronic malnutrition in that group ranged from 12% to 54%; and wasting or acute malnutrition ranged from 3% to 25%. There was a wide variation in micronutrient deficiencies and availability of iodized salt, although an estimated 65% of households had access to adequately iodized salt. The prevalence of anaemia in children aged 6 months to 5 years was in the range of 25% to 82%, with half of such cases being due to iron deficiency. Thus far, eight Member States in the Region had adopted the new

WHO Child Growth Standards for children under five years of age; the new growth references for children of school age and adolescents had still to be adopted. Nutrition monitoring of infants and young children was conducted in Member States to varying degrees. Work had been done on the operational targets of the global strategy for infant and young child feeding, but policies and plans of action in that area had not yet been implemented satisfactorily. Higher prices of staple food items affected household food security, and the monitoring and evaluation of food and nutrition programmes remained inadequate.

The Regional Office for South-East Asia had assisted in identifying nutrition, food security and safety issues affected by climate change and organized counselling workshops to improve infant and young child feeding practices. Extensive technical and financial assistance had been provided for improving national programmes to control iodine deficiency. In addition, it would continue to emphasize nutrition awareness and advocacy with a life-course approach to nutrition interventions.

Member States should establish integrated plans of action and strategies through predictive modelling to respond to the impact of climate change, including support for the national infant and young child feeding policy or plan of action; national guidelines on diet and cooking to retain the nutritive value of food; strengthened monitoring systems in order to identify changes in the nutrition profiles of vulnerable populations; and urgently standardize strategies for the control and prevention of more moderate forms of malnutrition in children at community level through protocols that emphasized locally available food items. As iodine deficiency was the single most preventable cause of brain damage, Member States would need to provide more support to their national programmes for iodine deficiency control.

Ms BLAKER (Norway), speaking on behalf of two Nordic countries, Iceland and Norway, said that breastfeeding was a most important factor in reducing child mortality; together with timely and appropriate complementary feeding it was a prerequisite for infant and child health. Efforts to improve infant and young child nutrition contributed directly to the achievement of the Millennium Development Goals.

The thirtieth anniversary of the International Code of Marketing of Breast-milk Substitutes would be celebrated in 2011. The Code was an important tool for supporting, protecting and promoting breastfeeding nationally and globally and it was crucial that WHO should continue to lead the work of strengthening and monitoring compliance. WHO must continue to advocate for the provision of resources for worldwide implementation of the WHO Child Growth Standards, which formed the basis of prevention and treatment of both undernutrition and obesity.

Another important measure in support of breastfeeding was the Baby-friendly Hospital Initiative. Priority must be given to infant feeding in the context of HIV/AIDS, and she appreciated the recent recommendations on that subject. Regarding emergency preparedness, the Organization should strengthen awareness of international guidance, support the elaboration of national guidelines on infant and young child feeding in emergencies and assist countries to monitor compliance. The protection of breastfeeding was crucial to infant survival. The uncontrolled use of artificial feeding in emergencies put infants at unnecessary risk of death. She supported the draft resolution and the further elaboration of the proposed plan of action mentioned therein.

Mr PARRONDO (Spain), speaking on behalf of the European Union, welcomed the progress report and supported the draft resolution. The European Union shared the recognition of the vital importance of tackling malnutrition in any attempt to improve global health. Malnutrition in all its forms represented an important risk to health in all countries. The impact of the financial crisis on food prices and the effects of climate change had contributed to the net increase of undernourished children, mainly in poor communities. None of WHO's efforts towards achieving the health-related Millennium Development Goals would be sufficient if the Organization did not effectively respond to the challenge posed by the fact that more than one third of under-five mortality was attributable to poor nutrition.

He welcomed the efforts being made by many Member States to implement the global strategy for infant and young child feeding. The double burden of malnutrition was a global challenge, which the European Union, facing growing rates of childhood obesity, recognized as a priority. The European Union had increased support for partner countries through food security and food assistance and emphasized comprehensive health strategies that included nutrition as a main element in prevention, care and rehabilitation services and linked to education, social protection and food security policies. In the European Council's conclusions on the "European Union role in Global Health" adopted on 10 May 2010, the European Union had made a commitment to "strengthen the links between food security, nutrition and health, with particular support to the most vulnerable groups, inter alia children under five and women in pregnancy and lactating period." He therefore endorsed the call in the draft resolution for enhanced political attention to malnutrition, comprehensively addressed rather than in isolation, reflecting evidence, participation and aimed at equitable and universal coverage. He affirmed the special attention given to the International Code of Marketing of Breast-milk Substitutes, linked to the promotion of breastfeeding practices, including the needs of lactating mothers, especially at the place of work.

He approved the call for strong leadership by the United Nations and the division of labour between the many agencies and structures concerned with global nutrition. He welcomed the commitment of WHO, in close collaboration with FAO and building on the lessons learnt from the global strategy for infant and young child feeding, to develop the global multisectoral nutrition framework. He supported the Director-General's call to make nutrition central to all WHO policies.

Miss APIRADEE TREERUTKUARKUL (Thailand) said that malnutrition and childhood obesity were prevalent in the South-East Asia Region owing to inappropriate feeding practices and dietary imbalance, which was a major factor contributing to the double burden of infant and young child malnutrition. The draft resolution should be amended in order to make it clearer and more specific, and she proposed that the following two new subparagraphs should be added to preambular paragraph 7:

"Expressing deep concern over evidence showing high and increasing incidence of violations of the International Code of Marketing of Breast-milk Substitutes by some infant food manufacturers and distributors with regard to promotion targeting mothers and health-care workers;

Expressing further deep concern over the ineffectiveness of voluntary measures to enforce compliance with the International Code of Marketing of Breast-milk Substitutes;"

In addition, a new subparagraph (2) bis should be added to paragraph 1, which would read: "to develop and/or strengthen legislative measures to control the marketing of breast-milk substitutes;"

In order to underscore other relevant Health Assembly resolutions and ensure the focus of corporate social responsibilities on improving child health, she proposed that paragraph 2 be amended to read: "CALLS UPON infant food manufacturers and distributors to fully comply with their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions".

Finally, she proposed that the following new subparagraph be added to paragraph 3: "to support Member States in their efforts to develop and/or strengthen legislative measures to control marketing of breast-milk substitutes;"

Dr UGARTE UBILLUZ (Peru) said that, despite the progress presented in the report, efforts must be intensified by all stakeholders through a multisectoral approach, and resources mobilized in order to facilitate the breastfeeding of babies for at least their first year of life, with exclusive breastfeeding for the first six months; strengthen health-care services; improve access to water and sanitation; increase employment opportunities; and guarantee food security. Excellent results had already been achieved in his country under local schemes which included vaccination programmes and centres to monitor the growth, education and development of children, especially among the poor. Existing success in combating chronic child malnutrition provided the impetus to achieve the health-related Millennium Development Goals. He supported the draft resolution.

In the context of the global multisectoral nutrition framework provided for in subparagraph 3(5) of the draft resolution, Peru had consulted extensively with interested delegations and organizations and passed on those contributions to WHO's Secretariat for consideration.

Dr AL HAMAD (Kuwait), welcoming the draft resolution, supported the amendments proposed by the delegate of Thailand and proposed further amendments, starting with the addition of the following paragraph to the preamble:

“Recognizing that promotion of commercial foods for infants and young children continues to undermine progress in optimal infant and young child feeding;”

In subparagraph 1(3), the words “including childhood obesity” should be inserted after “the double burden of malnutrition”; and subparagraph 1(4) should be amended to read: “to scale up interventions to improve infant and young child nutrition in an integrated manner with the protection, promotion and support of breastfeeding and timely, safe and appropriate complementary feeding as core interventions; the implementation of interventions for prevention and management of severe malnutrition; and the targeted control of vitamin and mineral deficiencies.”

Paragraph 2 should be amended to read: “CALLS UPON the food industry to fully comply with their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions;”

Dr ZHANG Lingli (China) said that she shared the views expressed in the report on the current status of infant and young child nutrition and on the measures to be taken to improve the situation. Nutritional problems during infancy could lead to a child suffering irreversible stunted growth and slow cognitive development, resulting in adverse consequences. WHO should play a greater role in promoting improved infant and young child nutrition, the key to achieving the health-related Millennium Development Goals and needing the urgent attention of all governments and the international community. China was ready to strengthen international exchanges and cooperation and share experiences in order to contribute to the process.

Ms RAO (India) said that India had based its nutrition policy on direct intervention to reduce malnutrition in children, which focused on educating mothers in good feeding practices for infants and young children. It also promoted exclusive breastfeeding for the first six months of life; the introduction of complementary feeding thereafter; and continued breastfeeding for up to two years, consistent with cultural practices. Furthermore, to give full effect to the International Code of Marketing of Breast-milk Substitutes and subsequent Health Assembly resolutions, domestic legislation had been strengthened in order to eliminate all forms of marketing and commercial promotion of complementary foods, baby foods and milks marketed as suitable for children under two years of age. Government policy promoted therapeutic feeding with locally available and culturally acceptable foods. The Secretariat should provide Member States with more information on ready-to-use therapeutic foods in order to provide for their proper evaluation. India had also revised its policy on iron, folic acid and vitamin A supplementation and had set up nutrition rehabilitation centres. She supported the draft resolution as amended by the delegates of Thailand and Peru.

Dr SULEIMAN (Oman) endorsed the amendments proposed by previous speakers and said that the implementation of the global strategy for infant and young child feeding, with emphasis on the International Code of Marketing of Breast-milk Substitutes, would speed up achievement of many of the Millennium Development Goals. He thanked the Secretariat for highlighting in the report the issue of infants suffering from intrauterine stunting. The establishment of scientific criteria for measuring that birth defect would help to improve prenatal and postnatal care and combat infant malnutrition. WHO's work in that area was essential to combating child stunting and obesity and he urged the Organization to raise awareness of supplementation with iron, folic acid, vitamin A and zinc as a low-cost way of providing children with vital micronutrients.

Mr AL-TAAE (Iraq), expressing support for the draft resolution and the proposed amendments, in particular those proposed by the delegate of Kuwait, said that several points should be emphasized in the draft resolution: the link between maternal and child nutrition; diagnosing the health of the mother and offering good care before, during and after birth; mention of an approach based on the WHO and UNICEF Integrated Management of Childhood Illnesses strategy; and micronutrient deficiencies and their correction. Iraq was investigating micronutrient deficiencies through laboratory screening. WHO should conduct research into micronutrient supplements, and the possible use of vaccination as a means to provide supplements that could be delivered in schools.

A reference to the health-related Millennium Development Goals should also be included in the resolution, specifically Goal 1 (eradicate extreme poverty and hunger), Goal 4 (reduce child mortality) and Goal 5 (improve maternal health). The resolution should make provision for both Baby-friendly Hospital Initiatives and Mother-friendly Hospital Initiatives, which should be interlinked.

Mr DOKEKIAS (Congo) said that he joined previous speakers in supporting the draft resolution. The report could have made reference in paragraph 3 to food availability for children, since children in countries where there were conflicts, natural disasters or extreme poverty might suffer from consequent malnutrition. Furthermore, children in those countries often depended on donations and the poor quality of the food donated could lead to nutrition deficiency or even obesity. He stressed that donations should if possible match the needs of a particular population group. Furthermore, regarding paragraph 9, he would have appreciated more information on the percentage of births that had taken place in baby-friendly facilities around the world and a more detailed global picture.

Dr SABB (Bahrain) said that Bahrain had implemented a range of measures to deal with infant and young child nutrition including: establishment of an early detection mechanism for malnutrition; a system to deal with acute cases; adoption of the global strategy for infant and young child feeding in April 2006 with related workshops; active promotion of breastfeeding with legislation enacted to control the marketing and use of breast-milk substitutes and provisions made for women to take a total of two hours out of the working day to breastfeed.

Studies undertaken on child growth and aspects of malnutrition, including iron deficiency, had made recommendations on the marketing of quality foods designed specifically for infants and young children in order to improve nutrition. Bahrain required those responsible for marketing food products aimed at children to comply with WHO resolutions on breast-milk substitutes.

Mr SAMO (Federated States of Micronesia) expressed support for the draft resolution as amended by the delegates of Thailand and Kuwait.

Mr MAPHOSA (Swaziland) agreed with the delegates of Thailand, Kuwait, Peru and others that the Director-General should be requested to ban the marketing of breast-milk substitutes. He proposed several amendments to the draft resolution. First, in order to acknowledge the publication *Rapid advice: Revised WHO principles and recommendations on infant feeding in the context of HIV* (2009), he suggested that an additional phrase should be inserted in paragraph 1, to read: "to implement the 2009 Revised principles and recommendations, Rapid advice on HIV and infant feeding, in order to address the HIV and infant feeding dilemma for HIV-infected mothers and their families while ensuring protection, promotion and support of exclusive and sustained breastfeeding for the general population, including those that are HIV-positive."

With a view to integrating WHO's support for the implementation of those revised principles and recommendations on infant feeding and making them central to nutrition efforts, the phrase "including integration of the Revised principles and recommendations, Rapid advice on HIV and infant feeding" should be inserted in subparagraph 3(2), after "essential nutrition actions". Furthermore, the draft resolution should include a clear reference to the Baby-friendly Hospital Initiative: the words "with particular emphasis on the Baby-friendly Hospital Initiative" should be inserted in the seventh preambular paragraph, after the words "health systems and communities".

Following from that amendment, subparagraph 2, in addition to referring to the implementation of the International Code of Marketing of Breast-milk Substitutes, should emphasize implementation of the Baby-friendly Hospital Initiative; and in subparagraph 3(4), the Director-General should be requested to support implementation of the Baby-friendly Hospital Initiative alongside the WHO Child Growth Standards and to expand it to the community to ensure sustainability.

Although the report emphasized infant feeding in emergency situations, there was no mention of that in the draft resolution. Children affected by emergency situations were most vulnerable and breastfeeding provided a real lifeline in such situations. Therefore the call for national implementation of the operational guidance for emergency relief staff should be reflected in paragraph 1 of the draft resolution.

Dr MOMAH (Nigeria) said that in her country overall infant and young child nutrition had been improved but undernutrition remained a challenge. Nigeria had established national feeding and nutrition guidelines; promoted exclusive breastfeeding with support groups in all states; enhanced training on the management of acute malnutrition; and introduced surveillance systems in most states. Biannual maternal and newborn child health weeks had been introduced by all states, with the aim of increasing interventions such as screening for undernutrition at the community level.

As a result of the aggressive marketing of breast-milk substitutes, rates of exclusive breastfeeding had fallen from 17% in 2003 to 13% in 2008. Further steps had to be taken to strengthen the prevention of mother-to-child transmission of HIV in order to ensure that breastfeeding was made safer. She requested technical support for advocacy campaigns and social mobilization that would engage sectors such as agriculture, education and water. It also required support to build capacity for service providers, counselling and surveillance. Expressing support for the draft resolution, she said that an amendment emphasizing prevention would be submitted to the Secretariat in writing.

Dr GAYE (Senegal), recalling the double burden of malnutrition, said that reference should be made to efforts to tackle obesity in subparagraph 1(4) of the draft resolution.

Mr DE ALBUQUERQUE E SILVA (Brazil) said that the draft resolution, which he welcomed, should refer to the United Nations Standing Committee on Nutrition, which was the United Nations body mandated to promote coherence and harmonization in nutrition policies and programming. Accordingly, he proposed the insertion in subparagraph 3(3), after the words “to continue and strengthen”, of the phrase “the existing mechanisms, especially the United Nations Standing Committee on Nutrition, for”.

Dr LEE Duk-Hyung (Republic of Korea) said that his country had been successfully implementing the NutriPlus programme since 2005, which offered nutrient supplements to expectant and breastfeeding mothers and young children who were nutritionally and financially at risk; it would be expanded to include older children and the elderly. Recent legislation had paved the way for the systematic formulation and implementation of nutrition policies. His Government’s efforts to promote breastfeeding included financial support for the installation of breastfeeding rooms in public facilities and within companies. He expressed support for the draft resolution.

Dr WAMAE (Kenya) said that nutrition was known to reduce maternal and child mortality and deserved to be given greater importance. Her country had taken steps to protect and promote nutrition: maternity leave had been increased from one to three months, and paternity leave had been introduced; legislation concerning the International Code of Marketing of Breast-milk Substitutes was at an advanced stage; the WHO Child Growth Standards had been adopted and incorporated into a booklet on maternal and child health that included prevention of mother-to-child transmission of HIV infection. The food safety and security policy was at an advanced stage: interventions known to reduce malnutrition were being implemented, and the infant and young child feeding strategy had been adapted.

Despite those efforts, nutrition indicators remained low: the rate of exclusive breastfeeding was only 35%; the rate of stunting among children had remained constant over the three previous decades at about 20%; and childhood obesity was rising, particularly in urban areas. Cost-effective interventions to address the double burden of malnutrition must be increased.

The draft resolution should be amended to cover issues that included obesity, the prevention of mother-to-child transmission of HIV, and further protection of breastfeeding. As more mothers returned to work, the private sector must be made aware of the importance of breastfeeding and offer assistance in that regard, for example through the provision of baby-care or breastfeeding rooms, as two companies already had.

Dr PANT (Nepal) said that his Government had adopted a multisectoral approach to redressing the fact that almost 50% of Nepalese children suffered from undernutrition and 13% suffered from severe undernutrition. Adequate nutrition in early childhood, particularly under the age of two, was critical to the health and development of children, and the Baby-friendly Hospital Initiative was being expanded in his country. He fully supported the statement made by the delegate of Thailand.

Dr SEAKGOSING (Botswana) said that his Government recognized the importance of nutrition for the health, growth, development and survival of children. The International Code of Marketing of Breast-milk Substitutes had been incorporated into national regulations. Policies to guide service providers on infant and young child feeding and use of the WHO integrated course were well developed, particularly in the context of HIV infection. The Baby-friendly Hospital Initiative had been revived. Two fortified products made from locally produced raw materials were given to all children under five that attended child welfare clinics; clinic cards included the adapted WHO Child Growth Standards; and the surveillance system had been strengthened to track more comprehensive indicators, including the emerging problem of childhood obesity. Routine supplementation had been initiated following a study showing that 35% of children under five had a marginal vitamin A deficiency. Voluntary salt iodization had been undertaken since 1992, and Botswana would enact regulations in that regard.

His Government would appreciate further assistance from WHO in expanding nutritional interventions and strengthening research and surveillance systems. He supported the draft resolution, but suggested that paragraph 2 should be reworded so as to ensure full compliance by the food industry with the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions.

Dr TANGI (Tonga) said that cow's milk was meant for calves, not babies, and its consumption contributed to obesity in young children. The WHO term "breast-milk substitute" was originally coined by the food industry and could not disguise the fact that the product was actually animal milk, not human milk. He suggested that the term "cow's milk" be inserted in brackets immediately after the term "breast-milk substitute" throughout the relevant documentation. He expressed support for the draft resolution and the amendments proposed by the delegate of Thailand.

Mr HOHMAN (United States of America), praising WHO on its widespread activities in support of improving global nutrition, said that the Organization was well positioned to prioritize maternal nutrition in malnutrition prevention programmes. His Government would appreciate further information on WHO's overall strategy to improve infant and young child nutrition and reduce malnutrition. Although WHO had given strong support to the subject of nutrition and HIV-affected populations, more attention might be given to the role of nutrition in the case management of other child illnesses affecting the largest proportion of children. WHO should lead on appropriate feeding during and after illness, and emphasize the Integrated Management of Childhood Illness approach.

His Government would welcome an analysis by WHO of the scientific and programmatic evidence on the impact of the International Code of Marketing of Breast-milk Substitutes in some of the countries that had enacted Code-related legislation. The Secretariat should share its detailed

information on country implementation with Member States. Recent research had indicated that interpretation at country level was often ambiguous and could result in the outlawing of marketing of anything that might be fed to a child during the breastfeeding period; some countries had enacted legislation prohibiting the marketing of commercial fortified food products of all types. The Secretariat should focus attention on crucial nutrition issues, such as vitamin and mineral deficiencies, iron supplementation and in-home fortification, and the iodization of salt and its use in processed foods.

With regard to the draft resolution, he proposed that, in the eleventh preambular paragraph, the words “the improvement of breastfeeding practices could save” be replaced by “the improvement of infant and young child feeding practices could contribute to saving”. In subparagraph 1(1), the word “reducing” should be replaced by “prevent and reduce”. The words “aim and principles of the” should be inserted before “International Code” in subparagraph 1(2). In subparagraph 1(4), the words “in an integrated manner” should be inserted after “young child nutrition”, the words “prevention and management of” should be inserted before “severe malnutrition”, and the adjective “targeted” should be inserted before “control”. A revised version of the draft resolution incorporating the numerous amendments proposed in the course of the debate should be produced for subsequent consideration.

Dr TAKEI (Japan), welcoming WHO’s leadership in promoting child nutrition, said that an approach that encompassed clinical hospital care and local community services was essential in the pursuit of the Organization’s goals and in the recognition of the importance of breastfeeding. He supported nutrition programmes in developing countries that focused on vulnerable populations, such as refugees in conflict areas; he also called on the global community to strengthen its efforts to tackle childhood obesity. He supported the global strategy for infant and young child feeding.

Dr KHADRA (Syrian Arab Republic) welcomed the draft resolution as amended by the delegate of Kuwait. He emphasized the importance of breastfeeding, and criteria should be established to ensure that complementary foods were not introduced until after the sixth month. His country supported the International Code of Marketing of Breast-milk Substitutes and had established a system to monitor child feeding, identify cases of overnutrition and undernutrition, and ensure that interventions were properly targeted.

Mrs GIDLOW (Samoa) said that in her country infant and young child feeding was a focus of nutrition and emphasized the need for increased exclusive breastfeeding rates in infants up to six months of age. A recent health survey had revealed that, although 94% of children under six months were breastfed, only 60% of babies under one month old were exclusively breastfed and 14% of babies under two months were given complementary mushy or semi-solid food.

Efforts were being made to ensure that school canteens sold only healthy foods; child and maternal health services were prioritized throughout the health sector and intersectorial partnerships were being strengthened. Evidence-based interventions were required to address the high rates of anaemia observed in young children and pregnant women in Samoa, and a health promotion approach would be a valuable component of a prevention programme. She supported the draft resolution and the amendments proposed by the delegates of Thailand and the United States of America.

Mr TEMENGIL (Palau) proposed that a new subparagraph be inserted in the draft resolution under paragraph 1, to read: “to end all forms of promotion for foods for infants and young children and in particular the use of nutrition and health claims”. He supported the amendment to subparagraph 3(3) proposed by the delegate of Brazil.

Dr N’GORAN (Côte d’Ivoire), expressing support for the draft resolution which provided an opportunity to promote comprehensive policies, said that her country’s health policy was seeking to protect, promote and support breastfeeding through community involvement in the launch of its Baby-friendly Hospital Initiative. National criteria for complementary foods and therapeutic foods for

malnutrition had been established, and there was a special programme on nutrition for infants exposed to HIV infection.

Dr HYDER (Pakistan) said that Pakistan's health strategy for infant and young child nutrition was in line with the global strategy for infant and young child feeding; was based on evidence of proven interventions; comprised comprehensive activities to improve legislation, policies and standards to protect optimum infant and young child feeding practices, and supported the strengthened and collective capacities of health services and communities. The goal was to improve the nutritional status, growth and development, health and survival of infants and young children; to standardize infant and young child feeding practices; to specify the responsibilities of partners in promoting those practices, and to outline technical directives for interventions. He supported the draft resolution.

Dr GASHUT (Libyan Arab Jamahiriya) supported the draft resolution and the amendments proposed by the delegate of Kuwait, and endorsed the comments made by the delegate of Oman. Emphasizing the importance of clear planning with budget allocations, she proposed the addition of the words "through a specific plan and a targeted budget" at the end of subparagraph 1(2). The draft resolution should refer to previous relevant resolutions and commitments. Subparagraph 3(5) should be amended to highlight the need to give priority to breastfeeding and to avoid any duplication of effort by the different sectors involved.

Ms USIKU (Namibia) said that the unsatisfactory nutritional status of a large proportion of the population in her country contributed to poor maternal and newborn infant outcomes. Although more than 90% of babies were breastfed early in life, a survey in 2006–2007 showed that the prevalence of both moderate acute and severe acute malnutrition in children were high and rising. Nearly one third of children were stunted and 17% were underweight. Child undernutrition rates were higher in rural areas and low-income households. Namibia had launched a programme for integrated management of acute malnutrition and research to determine the health outcomes of infants exposed to HIV infection and their relation to feeding practices. She supported the draft resolution.

Mr MENESES GONZÁLEZ (Mexico) expressed support for the draft resolution but requested the preparation of a revised text that incorporated the many proposed amendments for consideration by the Committee at a later meeting.

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, and Mr OBAMA ASUE (Equatorial Guinea), speaking on behalf of the Member States of the African Region, supported the previous speaker's proposal.

Dr MOTSOALEDI (South Africa) proposed that the draft resolution should be amended so as to clarify the position regarding the marketing of foods for infant and young children, and thereby strengthen the promotion of exclusive breastfeeding in the first year of life, by adding a subparagraph to read: "to end all forms of promotion of foods for infants and young children and, in particular, to end nutrition and health claims".

Dr VILLENEUVE (United Nations Children's Fund) said that UNICEF was collaborating with WHO, other partners and governments in efforts to scale up interventions to improve young child nutrition. The UNICEF report *Tracking progress on child and maternal nutrition* (2009) had compared data in order to establish progress towards attainment of the target within Millennium Development Goal 1 of reducing underweight prevalence: 63 developing countries, from a total of 117 with available data, were on track, compared with 46 countries from a total of 96 with available data three years earlier; 34 countries had made insufficient progress; and 20, mostly in Africa, had made no progress.

Prevalence of stunting, a better indicator of inadequate nutrition in pregnant women and young children, was far higher than underweight prevalence, underlining the need to implement evidence-based interventions in the period from conception to the age of two years. Suboptimal nutrition and subsequent growth deficits in infants and young children could have a lasting negative impact on survival, growth and development, and adult productivity. A recent UNICEF review of infant and young child feeding programmes in several countries emphasized the more comprehensive balance needed between breastfeeding and complementary feeding; capacity building through a continuum of care from the community level to the health system; adoption of regulatory frameworks; implementation of the International Code of Marketing of Breast-milk Substitutes; and maternity protection that benefited child nutrition.

Nutrition education should be complemented by targeted provision of fortified complementary foods, multiple micronutrient powders and measures to improve food availability for children over six months of age. Some countries had defined a minimum package of nutrition interventions, but many had not yet established the infrastructure for provision of counselling for young child feeding. Member States were urged to ensure that child nutrition was covered in the most effective way.

Mr GÜRKAN (Food and Agriculture Organization), recalling the importance of health and nutrition for the achievement of the Millennium Development Goals, said that multisectoral collaboration and coordination was needed between partners at the national, regional and international levels, especially in times of global economic crisis and climate change. FAO and WHO had long been collaborating closely to support Member States in their efforts to combat undernutrition and malnutrition, through, for instance, the work of the joint expert meetings on nutrition that provided the scientific basis for defining nutrient requirements, and developing standards and guidelines on the nutrition-related work of the Codex Alimentarius Commission.

FAO, UNICEF, WFP and WHO were supporting the Second International Conference on Nutrition to be held in Rome in October 2012, which was expected to determine major constraints to implementing the 1992 Plan of Action for Nutrition; to identify challenges and opportunities and actions; and to mobilize political will and the resources necessary for achieving the nutrition-related Millennium Development Goals. Those four organizations were also collaborating in the Renewed Efforts Against Child Hunger initiative, which was aimed at accelerating efforts to achieve the target of Millennium Development Goal 1 of halving between 1990 and 2015 the proportion of people who suffered from hunger. The initiative entitled “Scaling-up Nutrition: A Framework for Action”, aimed at increasing investment in a set of nutrition interventions, had been endorsed by more than 100 organizations and institutions. More than 1000 million people had inadequate access to food supplies. Interventions based on quick impact must be combined with locally appropriate and sustainable solutions to remedy that unacceptable situation.

Dr Shu-Ti CHIOU (Chinese Taipei) expressed appreciation for the draft resolution and looked forward to further international collaboration in the area of infant and young child nutrition. In Chinese Taipei, the Baby-friendly Hospital Initiative had been launched 10 years earlier and 54% of births currently took place in baby-friendly facilities; the adoption of the International Code of Marketing of Breast-milk Substitutes had facilitated the acceptance of breastfeeding as a social norm. The monitoring system for breastfeeding practices indicated that the current rate of exclusive breastfeeding for six months was 22%. Husband support was cited by women as a factor in initiating breastfeeding. Legislation to support the right to breastfeed in public places and the workplace, and to stipulate the provision of rooms for breastfeeding, was currently under review.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcoming the progress made in implementing the Baby-friendly Hospital Initiative, said that a reference to the Initiative in the draft resolution would emphasize the further action needed to improve maternity facilities, needed in many countries. Commending WHO’s work in developing norms and standards for use in emergency nutrition responses, she also looked forward to the inclusion

of responses to climate change emergencies, and reporting on provision of breastfeeding support in the context of the recent earthquake in Haiti.

She welcomed the call for wider application of the International Code of Marketing of Breast-milk Substitutes and encouraged Member States to intensify funding support to the Secretariat for the implementation of the Code. The Association was concerned at the detrimental impact on breastfeeding of health and nutrition claims made by the manufacturers for breast-milk substitutes that undermined the confidence of mothers in breast milk. The Association monitored such practices and reported Code violations to the International Baby Food Action Network. Manufacturers and distributors were urged to comply fully with the Code, not as an exercise in corporate responsibility but out of a real desire to protect the life and health of children.

She commended the action being taken by WHO and UNICEF on marketing of complementary foods and ready-to-use therapeutic foods. Regulations were needed to ensure that complementary foods did not displace breastfeeding or locally prepared and home-made foods, and that ready-to-use therapeutic foods were only used for the treatment of severe malnutrition in infants older than six months. Breastfeeding remained the single most effective preventive intervention for improving the survival and health of children and she urged delegates to adopt a strong resolution.

Dr JAVET (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN and on behalf of the International Association of Infant Food Manufacturers, commended WHO's efforts to reduce child malnutrition and mortality and welcomed the draft resolution. Exclusive breastfeeding during the first six months of life was essential to infant nutrition and the use of complementary foods after that period forestalled nutritional deficiencies. Through various projects, including the Process for the Promotion of Child Feeding, his Association had provided support to Member States in the identification of locally available foods for infants and young children. He noted that WHO had acknowledged that some locally available foods given to infants might lack vital nutrients. Care providers should receive instruction on the different options, including industrially processed and fortified foods that contained important micronutrients and macronutrients.

Dr ALWAN (Assistant Director General), responding to the delegates of Norway and Thailand, said that an important element of the global strategy for infant and young child feeding was the enforcement of the International Code of Marketing of Breast-milk Substitutes. The Secretariat had requested information from Member States on the status of the Code in their national legislation. Of the 97 Member States concerned by the survey, 63 had Code-related legislation in place, 22 had only adopted voluntary measures, and 9 had not completed the questionnaire. The issue of Code-related legislation had also been referred to in previous resolutions, for example resolution WHA35.26. Furthermore, paragraph 11.7 of the Code made provision for the Secretariat to support Member States in the development and strengthening of such legislation.

Replying to the delegate of Congo, he explained that WHO had been working with UNICEF and WFP to review the characteristics of foods used during emergency relief operations and in countries with ongoing nutrition issues. With regard to the Baby-friendly Hospital Initiative, a biennial report was being prepared by the Secretariat on the basis of the information provided by Member States. More detailed information was available on request.

Responding to the delegates of the United States of America and Yemen, he said that the Secretariat had conducted an in-depth review of its nutrition programmes in order to identify key priorities for the scaling up of its work with Member States in dealing with the double burden of malnutrition. The priorities for such scaling up included the areas mentioned by the delegate of the United States of America, for example in the context of the Nutrition Guidance Advisory Group that had been established to study different approaches to the issue of vitamin and mineral deficiency, and which included the fortification of food for young children and pregnant women.

He agreed with the statements by several delegates about the inclusion of nutrition issues in emergency programmes and the banning of the promotion of alternatives to mother's milk in

emergency situations. The Secretariat was in the process of reviewing the scientific evidence related to the micronutrient programmes referred to by the delegates of Iraq and Oman.

The CHAIRMAN requested that the Secretariat prepare a revision of the draft resolution, incorporating the various proposed amendments, which would be distributed for consideration at a subsequent meeting.

It was so agreed.

(For continuation of the discussion, see the summary record of the eleventh meeting, section 1.)

Birth defects: Item 11.7 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R6, and A63/10)

Dr ZARAMBA (representative of the Executive Board) said that, at its 126th session in January 2010, the Executive Board had considered the report on birth defects and, on the basis of amendments proposed by Member States, had adopted resolution EB126.R6, in which it recommended a text to the Health Assembly for adoption.

Dr AL OMAIRI (Kuwait), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that in his Region many initiatives and policies related to maternal and child health had recently been implemented and updated leading to improved results in the rates of births without defects. Simple interventions and cost-effective projects were needed to achieve Millennium Development Goal 4 (reduce child mortality), for example through the raising of awareness of the potential consequences of consanguinous and late marriage and the need for health care during pregnancy. Nutrition programmes based on the use of folic acid and iodized salt were being promoted as a means to prevent many birth defects. Special care for infants with birth defects was a crucial requirement.

Successful initiatives introduced in the Region included the establishment of a national birth defects network in Lebanon; the creation of a successful model for early detection in the United Arab Emirates; and the establishment of a centre dedicated to the detection of blood and pulmonary disorders in Kuwait. More general progress included legislation for the promotion of early detection; screening for HIV/AIDS and viral hepatitis; and increased financial support for families of children suffering from birth defects. He urged the Secretariat to continue its collaboration with Member States on the issue of birth defects, particularly with regard to the nutritional aspects.

Mrs SANIEWSKA (Poland), expressing her country's appreciation for the report and the efforts of the international community in the prevention and treatment of birth defects, emphasized that interventions aimed at preventing and treating birth defects should be carried out within a national legal framework.

Dr TIN TUN AUNG (Myanmar), speaking on behalf of the Member States of the South-East Asia Region, welcomed the report and expressed support for the draft resolution. Birth defects were still not recognized as a public health priority, and insufficient epidemiological data on the prevalence of birth defects and their causes, determinants and preventable factors could hamper their management. Member States should commit resources and develop plans to integrate management of birth defects into existing maternal, reproductive and child health services. Effective delivery of services for the prevention and treatment of birth defects depended on the availability of specialist clinical and diagnostic services and a primary care system equipped to use them. National policies should include interventions such as vaccination against rubella; the fortification of food with iodine and folic acid; the prevention and treatment of syphilis; legislation against alcohol consumption and nicotine intake during pregnancy; the use of diagnostic tools, including ultrasound; and the creation of

a surveillance system for birth defects and related risk factors. However, prenatal screening had ethical and legal dimensions, so that any guidelines would need to be country-specific and based on sociocultural and religious considerations. Member States should include new indicators in their health information systems and encourage ministries and civil society to contribute to developing those indicators.

At the end of the third preambular paragraph of the draft resolution contained in resolution EB126.R6, he proposed that the phrase “and interventions to limit the exposure of birth defect risk factors” be added after “child health services”. In subparagraph 1(2), the words “who need them” should be replaced by “and effective preventive interventions on prenatal tobacco and alcohol use”. In subparagraph 2(3), the phrase “addressing tobacco and alcohol use among pregnant women and women trying to conceive” should be inserted after “such as measles and rubella”.

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland), expressing support for the draft resolution, said that his country wished to be added to the list of sponsors.

Birth defects fell into three main categories in terms of prevention, depending on whether, first, risk factors were known and evidence-based prevention strategies were available; secondly, risk factors were known but no effective prevention strategies were available; and thirdly, risk factors had not yet been established. The third category should be addressed in more detail in the draft resolution, in particular with regard to possible linkages between other health surveillance systems, for example those concerned with pharmacovigilance or environmental hazards, and the system for birth defects. Consequently, he proposed that in subparagraph 1(5), the phrase “and to link to other surveillance systems where relevant;” be added after “national health information systems”.

The CHAIRMAN suggested that further discussion of item 11.7 should be deferred to a later meeting.

It was so agreed.

(For continuation of the discussion, see the summary record of the eleventh meeting, section 1.)

The meeting rose at 12:25.

SIXTH MEETING

Wednesday, 19 May 2010, at 14:35

Chairman: Dr M. MUGITANI (Japan)

1. ORGANIZATION OF WORK

The CHAIRMAN recalled that the General Committee, at its first meeting, had agreed to provide the President of the Health Assembly the flexibility to adjust the allocation of items to the main committees. The President had accordingly decided on the transfer to Committee B of agenda items 11.13 (Leishmaniasis control), 11.14 (Chagas disease: control and elimination), 11.15 (Global eradication of measles), 11.16 (Smallpox eradication: destruction of variola virus stocks), 11.17 (Availability, safety and quality of blood products), 11.18 (Strategic Approach to International Chemicals Management), 11.19 (WHO's role and responsibilities in health research), 11.21 (Human organ and tissue transplantation), 11.22 (Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services), 11.23 (Treatment and prevention of pneumonia) and 11.24 (Progress reports).

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

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3)

The CHAIRMAN drew attention to three draft resolutions. The first, on a plan of work to support the prevention and control of counterfeit medical products, had been proposed by the delegate of Ecuador on behalf of the Union of South American Nations and read:

The Sixty-third World Health Assembly,

PP1 Considering resolutions WHA41.16 and WHA47.13 on the need to provide guidelines to Member States on the development of their own structures and the adoption of national measures to prevent and control falsified medical products;

PP2 Bearing in mind the Conference of Experts on the Rational Use of Drugs (Nairobi, 25–29 November 1985) which first addressed this issue at the international level;

PP3 Aware of the risks that falsified medical products entail for the population;

PP4 Observing that the falsification of medical products has an international dimension and that the prevention and control of this problem necessitates cooperation at the regional and subregional levels and between countries;

PP5 Reaffirming that health authorities must perform an important function in applying health regulations that strengthen a chain of safe, high-quality and efficacious medical products,

DECIDES:

(1) to establish an intergovernmental working group comprising delegates of Member States and the Secretariat to consider and implement cooperation at the regional and subregional levels and between countries, with a view to preventing and controlling falsified medical products from a public-health perspective, excluding commercial and intellectual property considerations;

- (2) that the working group should examine the following topics:
 - (a) education measures such as training of consumers and public-health sector stakeholders;
 - (b) measures to strengthen the chain of production and distribution of medical products, specifically in relation to regulation and inspection;
 - (c) action strategies at the national, subregional and regional levels providing for mechanisms to improve sharing of information and experiences between countries;
 - (d) strategies to improve the capacity of the health sector to apply health regulation measures;
- (3) that, with the approval of Member States, the working group should be authorized to form technical subgroups of an ad hoc and provisional nature, and to invite experts to examine specific issues.

The second draft resolution, on counterfeit medical products, had been proposed by the delegations of Algeria, Angola, Benin, Botswana, Burkina Faso, Burundi, Cameroon, Cape Verde, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, Equatorial Guinea, Ethiopia, Gabon, Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Lesotho, Liberia, Madagascar, Malawi, Mali, Mauritius, Namibia, Niger, Nigeria, Rwanda, Senegal, Sierra Leone, South Africa, Swaziland, Togo, Uganda, United Republic of Tanzania, Zambia and Zimbabwe and read:

The Sixty-third World Health Assembly,

PP1 Having considered the report on counterfeit medical products;¹

PP2 Recalling resolution WHA41.16 on the rational use of drugs requesting the Director-General to initiate programmes for the prevention and detection of export, import and smuggling of falsely labelled, spurious, counterfeited or substandard pharmaceutical preparations;

PP3 Recalling resolution WHA47.13 on the rational use of drugs requesting the Director-General to support Member States in their efforts in combating the use of counterfeit drugs;

PP4 Recalling resolution WHA52.19 on the revised drug strategy and in particular the request to the Director-General to develop and disseminate uniform guidelines on the regulatory control, export, import and transit conditions of pharmaceutical products; and to develop standards of practice for entities involved in international trade in pharmaceuticals and pharmaceutical starting materials;

PP5 Recalling the continuous and repeated request from drug regulatory authorities of Member States that met in the framework of the International Conferences of Drug Regulatory Authorities to WHO to assist Member States to adopt measures to combat counterfeit medicines;

PP6 Concerned about the situation in which counterfeit medical products continue to move in international commerce, representing a major threat to public health, especially in the poorer areas of developing countries where regulatory capacities and law enforcement authorities are weak, and in which counterfeit medical products pose a challenge to the credibility and effectiveness of health systems;

PP7 Recognizing that the primary focus of combating the manufacture, distribution and use of counterfeit medical products is the protection of public health and that the main victims of counterfeiters are patients and the general public;

PP8 Recognizing that combating counterfeit medical products is one specific aspect of assuring quality, safety and efficacy of medical products;

¹ Document A63/23.

PP9 Recognizing the importance of ensuring that combating counterfeit medical products does not result in hindering the availability of legitimate generic medicines;

PP10 Recognizing the various initiatives and progress achieved since 1988 by specific WHO guidelines for combating counterfeit medical products, and improvement of guidelines on import procedures for pharmaceutical products, inspection of drug distribution channels and good distribution practices for pharmaceutical products;

PP11 Aware of the importance of ensuring effective collaboration among patients, health professionals, the private sector and government institutions to combat counterfeit medical products effectively;

PP12 Cognizant of the importance of ensuring international collaboration and exchange of information in order to combat counterfeit medical products effectively;

PP13 Noting with satisfaction that the Director-General has intensified activities aimed at strengthening international collaboration to combat counterfeit medical products and that WHO has a leading role in these activities;

PP14 Recognizing the contribution of all parties concerned to the fulfilment of their responsibilities in compliance with the components of resolutions WHA41.16, WHA47.13 and WHA52.19 that specifically focus on combating counterfeit medical products, and encouraging all parties to continue that action;

PP15 Inviting bilateral agencies, multilateral bodies inside and outside the United Nations system, and voluntary organizations to collaborate and to provide support to developing countries in setting up and carrying out programmes aimed at combating counterfeit medical products, and acknowledging the work of those countries that are already doing so;

PP16 Requesting governments, pharmaceutical manufacturers and other concerned parties to cooperate in the detection, investigation and prevention of the increasing incidence of counterfeited or other substandard medical products moving in international commerce;

PP17 Aware of the public health impact of counterfeit medicines in achieving Millennium Development Goal 8 as it relates to international collaboration, in particular Target 8.E on the availability and access to quality medicines,

1. URGES Member States:

(1) to reaffirm their commitment to develop, implement and monitor national policies and to take all necessary measures in order to ensure access to medical products that meet regulatory standards;

(2) to establish and enforce legislation and regulations that prevent counterfeit medical products from being manufactured, exported, imported or traded in international transactions as well as to regulate and monitor the supply and distribution systems;

(3) to establish effective mechanisms of coordination and collaboration, including exchange of information among health, law enforcement and other relevant authorities in order to improve prevention, detection, investigation and prosecution of cases of counterfeit medical products;

(4) to promote awareness among health professionals and consumers of the risks posed by the use of counterfeit medical products including those acquired through unauthorized outlets including Internet sites;

2. REQUESTS the Director-General:

(1) to continue to address counterfeit medical products as an integral part, within the existing framework, of standard setting for quality, safety and efficacy;

(2) to provide support to Member States in developing and implementing policies and programmes aimed at combating counterfeit medical products, including facilitating the exchange of information at the international level and the development of tools, guidelines, training and awareness initiatives, and methodology for evaluation and monitoring;

- (3) to continue the development and dissemination of independent and timely information on instances of counterfeit medical products;
- (4) to cooperate with Member States, at their request, and with international organizations and other relevant parties in detecting, monitoring and analysing cases of counterfeit medical products and their impact on public health;
- (5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, both on progress achieved and problems encountered in the implementation of this resolution.

The third draft resolution, on measures to ensure access to safe, efficacious, quality and affordable medical products, had been proposed by the delegates of India and Thailand on behalf of the Member States of the South-East Asia Region and read:

The Sixty-third World Health Assembly,

PP1 Recalling the Constitution of WHO, which states that “the objective of WHO shall be the attainment by all peoples of the highest possible level of health”;

PP2 Recalling the principles of the Global strategy and plan of action on public health, innovation and intellectual property as adopted by the World Health Assembly in resolution WHA61.21;

PP3 Emphasizing the importance of ensuring access to affordable medicines, technologies and other health products among people in need while ensuring the quality, safety and efficacy of medical products¹ and promoting the rational use of medicines;

PP4 Concerned about reports of medical products with compromised quality, safety and efficacy, and stressing the need to ensure the availability of safe, efficacious, quality and affordable medical products;

PP5 Recognizing that falsely labelled or substandard medical products can have serious consequences for the health of the population;

PP6 Noting that the term and definition of “counterfeit” relates to infringement of intellectual property rights and should not be equated with medical products with compromised quality, safety and efficacy;

PP7 Noting that the definition in the Agreement on Trade-related Aspects of Intellectual Property Rights definition that “counterfeit trademark goods” shall mean any goods, including packaging, bearing without authorization a trademark which is identical to the trademark validly registered in respect of such goods, or which cannot be distinguished in its essential aspects from such a trademark, and which thereby infringes the rights of the owner of the trademark in question under the law of the country of importation;²

PP8 Recognizing that issues of protection and enforcement of intellectual property rights are distinct from issues of quality, safety and efficacy of medical products;

PP9 Seriously concerned about numerous incidences of intellectual property enforcement measures that have resulted in unwarranted seizures of generic medicines, affecting timely access to efficacious affordable medical products for people in developing countries, including least-developed countries;

PP10 Recognizing that infringement of intellectual property rights is being confused with the issues of quality, safety and efficacy;

PP11 Recognizing that high prices of medical products result in inequitable access and facilitate proliferation of medical products with compromised quality, safety and efficacy;

¹ The term “medical products” hereafter should be understood to include vaccines, diagnostics and medicines in accordance with resolution WHA59.24.

² Agreement on Trade-related Aspects of Intellectual Property Rights Article 51, footnote 14(a).

PP12 Resolving to take immediate steps to promote the availability of affordable, quality, safe, and efficacious medical products;

PP13 Recognizing the need to promote measures to address quality, safety and efficacy of medical products that do not themselves become barriers to timely availability of affordable medical products and production of generic medical products;

PP14 Recognizing that the International Medical Products Anti-Counterfeiting Taskforce, or its Terms of Reference, has not been approved by any governing body of WHO and that there are conflicts of interest in its composition,

1. URGES Member States:

(1) to take measures to strengthen national drug regulatory authorities by enhancing their capacity to ensure for all, and particularly to vulnerable groups, access to safe, efficacious, quality and affordable medical products;

(2) to address the basic causes of the circulation of medicines with compromised safety, efficacy and quality such as weak regulatory capacity, unethical promotion of medicines, and high prices of medical products;

(3) to take measures to remove barriers to access to quality, safe, efficacious and affordable medical products;

(4) to ensure incorporation of public health safeguards, including as reaffirmed by the Doha Declaration on the TRIPS Agreement and Public Health, in their domestic intellectual property legislation;

(5) to implement trade, intellectual property and other policies without constraining policy space for health, including access to quality, safe, efficacious and affordable medical products and production of generic medical products;

(6) to refrain from applying measures to enforce intellectual property rights, such as the seizure of medical products in transit, that result in creating barriers to legitimate trade of generic medicines and impeding access to medical products, particularly in developing countries;

(7) to promote close collaboration among the national drug regulatory authorities to share information inspection techniques and testing methods;

2. REQUESTS the Director-General:

(1) to provide support to Member States, upon request, in strengthening their national drug regulatory authorities with a focus on enhancing their capacity, technical knowledge, infrastructure, facilities, and promoting robust systems to ensure that medical products available in their jurisdiction are of quality, safe and efficacious;

(2) to provide support for the development of new techniques and test methods for the use of national drug regulatory authorities to ensure the quality, safety and efficacy of medical products;

(3) to replace WHO's involvement in the International Medical Products Anti-Counterfeiting Taskforce with an effective programme to address the issues of quality, safety and efficacy as detailed in this resolution and ensure that the new programme avoids conflicts of interests, is evidence-based, transparent and Member-driven;

(4) to advocate that WHO does not get involved with infringement of intellectual property rights and other measures that could potentially undermine availability of quality, safe, efficacious and affordable medical products and production of generic medical products;

(5) to create measures to ensure that intellectual property enforcement does not inhibit access to affordable medical products;

(6) to report on implementation of this resolution to the Sixty-fourth World Health Assembly and subsequently biennially, through the Executive Board.

Professor ORHII (Nigeria), speaking on behalf of the Member States of the African Region and introducing the second draft resolution, said that counterfeit and fake medicines had become a global health problem, which plagued developing and developed countries alike. Ineffective regulation and poor technical capacities in countries in the Region had led to the continued importation, distribution, sale and use of counterfeit medicines, especially those aimed at the treatment of malaria, HIV/AIDS and tuberculosis. The increasing availability of counterfeit medicines, including generic medicines, and the increasing expertise of those who produced and marketed them severely threatened public health in the Region; national measures alone were not sufficient. The proposed draft resolution reflected the concern over the trade in counterfeit medical products and the recognition of the need for greater international collaboration in combating it.

Ms RAO (India) said that her country supported international efforts to combat medical products that did not meet high standards of quality, safety and efficacy. India also upheld the primacy of health over issues of intellectual property rights, as agreed in the Doha Declaration on the TRIPS Agreement and Public Health. However, she continued to be concerned at the use of the term “counterfeit” in WHO’s work. In her view, it was a juridical term linked to intellectual property rights, as it was used in the TRIPS agreement to define “counterfeit trademark goods”. The TRIPS agreement, as a multilateral legal instrument, had been incorporated into the national legislations of the 153 Members of the WTO, including India, and any issue regarding the definition of “counterfeits” could be dealt with only in that Organization. WHO’s mandate was to deal with the challenges to public health posed by medical products that compromised quality, safety and efficacy. Moreover, adopting an overbroad definition of counterfeit medicines had the potential to prevent countries from using the flexibilities in the TRIPS agreement that could improve access to safe, effective and affordable medicines.

No accurate data existed on the extent of counterfeit medical products, as acknowledged in the Secretariat’s report. The survey conducted by WHO in 2009, regarding use of the term “counterfeit medicines” and equivalent terminology in national legislation, demonstrated that in collecting data Member States used a range of different terms to describe such products, including “falsified”, “illicit”, “unregistered” and “adulterated”. Without accurate assessments of the extent of the problem and in the absence of a consensus on the use of the term, statistical analysis had no value. Member States needed to explore alternative terms to describe products of compromised quality, safety and efficacy.

The issue of the quality, safety and efficacy of medical products had been confused with the issue of intellectual property rights. That had led to the linking of counterfeit medicines with generic medicines, which were essential to the public health programmes of developing countries, and thus to the seizure of consignments of generic medicines at ports within the European Union. Those false linkages impeded legitimate trade in generic medicines and led to increased public health budgets; detracted from the principle of universal access to medicines; and constrained the use of the flexibilities in the TRIPS agreement.

She noted with concern from the report that the International Medical Products Anti-Counterfeiting Taskforce had become the main conduit for WHO’s work on counterfeit medicines. However, the terms of reference of that Taskforce had not been approved by the Member States; conflicts of interest could arise from its non-representative nature, and the lack of transparency regarding its funding sources and decision-making processes. India could not accept any document issued by the Taskforce unless it had been expressly approved by WHO’s governing bodies: the work of the Taskforce served to enforce intellectual property rights and provide market access in developed countries for large pharmaceutical companies.

WHO should devote its activities to improving public health, strengthening surveillance systems and promoting access to medicines. Involvement with issues relating to the enforcement of intellectual property rights would dilute its work in those areas. In that context, Member States of the South-East Asia Region had submitted a draft resolution that sought the Secretariat’s support in strengthening the

national drug regulatory authorities to ensure the availability of high-quality, safe and efficacious medical products.

Dr HAMBURG (United States of America) said that counterfeit, falsified or substandard medical products had a severe impact on public health. They could be harmful, could increase resistance to medicines, undermine the security of health systems and prevent patients from obtaining the genuine medical products. Counterfeiting was growing in complexity, scale and geographical scope, and combating those threats required the active engagement of all stakeholders at all levels. Lack of reliable data prevented public health policy-makers from addressing the issue in a systematic way. WHO should lead in raising awareness of those problems at the highest political levels and in building global surveillance systems to identify areas of public health risk.

Her Government recognized the role of WHO and the International Medical Products Anti-Counterfeiting Taskforce in addressing public health aspects of the counterfeiting of medical products. It appreciated efforts of WHO to articulate its role within the Taskforce and those of Member States to increase the transparency of the Taskforce's decision-making processes.

Her Government took every possible step to protect its citizens from counterfeit medical products; the global focus, however, should be on preventing the manufacture and distribution of such products in the first place. Her Government was thus committed to continued collaboration with the Secretariat and Member States in strengthening their capacity to produce high-quality medicines, detect fraudulent and falsified products, track responsible parties, respond to toxicity cases and raise public awareness. She stressed that WHO was the forum in which to address public health issues relating to counterfeit and falsified medical products; the other issues should be addressed in other forums.

She called on Member States to support a strong resolution focused on public health that would guide WHO in addressing the challenges of counterfeit medical products.

Mr AL-TAAE (Iraq) said that he would support a resolution that provided for the formation of higher committees and anti-counterfeiting taskforces at the international, regional and country levels; and develop partnerships to build capacity and training for quality control laboratories. WHO should support the efforts of Member States in developing their national strategies to combat counterfeiting.

Dr SALMAN AL-SAYYAD (Bahrain) said that a comprehensive strategy was needed to combat counterfeit medical products. Bahrain had taken measures to prevent the importation of such products, to detect their presence and to respond to toxicity cases arising from their use. Bahrain worked in close coordination with customs authorities and other countries in the Gulf region. He supported the draft resolution.

Dr CUI Enxue (China) said that China had taken several measures to prevent the manufacture and distribution of counterfeit medical products. Its food and drug agency had been made responsible for supervision of medicines safety; a comprehensive supervisory and testing system had been established; and the selling of counterfeit medical products had been classified as a crime. His Government worked closely with the law enforcement agencies. Greater international cooperation and exchange of information was required to prevent international trade in counterfeit medical products.

Dr CHIRIBOGA (Ecuador), speaking on behalf of the Union of South American Nations, said that the difficulties in detecting counterfeit medical products were aggravated by weak health surveillance and monitoring systems. The supply of generic essential medicines in some countries in his region had been disrupted: under the oversight mechanism for detecting counterfeit medical products in transit, the seizure of some consignments of generic products had impeded access to genuine health products. It was incumbent on governments to develop strategies to combat the global problem of counterfeit medical products, a serious risk to health and unrelated to the protection of trade rights.

At their meeting in Ecuador in April 2010, the ministers of the Union of South American Nations Council of Health had resolved to submit to the Health Assembly a draft resolution proposing the creation of an intergovernmental group, whose members would be approved by Member States or by subregional groups, as the only body within WHO responsible for preventing and combating such products. That body would aim to define measures for training consumers and actors in the public sector; strengthen the production chain and distribution of medical products; develop proposals to promote information exchange among Member States at the national, subregional and regional levels; and enhance capacities in the public health sector to implement regulatory health measures. The proposed group would avoid conflicts of interest and focus on public health, which must prevail over trade interests.

Counterfeit medical products posed a global threat to health and efforts must be pooled in seeking strategies to combat it. He therefore urged the Committee to support the draft resolution submitted by the Council of Health.

Dr EVSEENKO (Russian Federation) said that, within the framework of measures to combat the distribution of counterfeit medical products in his country, his Government was screening medical products through a network of modern control laboratories. The Russian Federation actively participated in implementing the agreement among member countries of the Commonwealth of Independent States to combat counterfeit medical products, and cooperated with the Council of Europe in its efforts to control such goods. Under the aegis of WHO, international cooperation should be expanded among the international regulatory bodies that controlled the production of medical products.

Mr PARRONDO (Spain), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. The European Union was aware that the counterfeiting of medical products posed a serious threat to health and public safety. The manufacture of counterfeit medicines had become increasingly sophisticated and complex methods of distribution had resulted in the introduction of counterfeit medical products into the official supply chains in the European Union. That threat to public health had led to the revision of European Union legislation on medicines, which had been welcomed by a majority of the stakeholders.

He commended the progress made by WHO since 1999 and its efforts to take a leading role in international cooperation to combat counterfeit medical products. WHO had supported the creation of the Taskforce which had the task of putting forward national legislation for counterfeit medical products. It was offered to Member States as a tool to develop effective policies aimed at combating counterfeit medical products.

The European Union had created a directive that aimed to prevent the entry of counterfeit medical products into the legal distribution channels. That included producing a definition which involved the labelling, origin and history of a product. He acknowledged that the term "counterfeiting" gave rise to confusion because it was used in the context of trade and of intellectual property. However, he stressed that the combat against counterfeit goods should not be confused with patents and other intellectual property rights. The aim of the Taskforce had never been to consider issues of trademarks or patents and that principle could be replicated more clearly in the terminology that WHO adopted in its reports. It would be useful to create a definition of counterfeit medical products that was acceptable to all Member States. The Secretariat should expedite its work in that regard; the European Union was prepared to make a constructive contribution. Anti-counterfeiting actions should not lead to restrictions on the availability of legal products or hinder legal trade in medicines. WHO must work with all the relevant partners and the Taskforce was a useful instrument to achieving that purpose.

Dr SEAKGOSING (Botswana) said that the counterfeiting of medical products put human lives at risk and undermined the credibility of the public health system. His Government was revising legislation to include measures to discourage counterfeiting of medicines; strengthening the medicines regulatory system; building local capacities that included sampling and testing of medicines circulating in the country; enhancing collaboration between police and customs departments to control the importation of medicines; and establishing port health services. Increased information sharing was needed between regulatory and enforcement agencies in the countries of the Southern Africa Development Community and throughout the world.

Dr SAID (Syrian Arab Republic), emphasizing the seriousness of the problem of counterfeit medical products, which included medical and surgical equipment, said that his country had promulgated strict legislation that would lead to imprisonment of up to 15 years and a penalty of the equivalent of more than US\$ 1 million for those who produced counterfeit medical products. He called upon Member States to collaborate in combating the problem through stringent legislation to deal with all aspects of production and by standardizing measures to enable consumers to identify genuine and safe products.

Dr TAKEI (Japan) said that the distribution of counterfeit medical products posed a risk to human life, and damaged trust in a health system and its legal framework. His country therefore actively promoted the measures listed in the guidelines, including the surveillance frameworks and inspection methods; he supported cooperation with the efforts of the Taskforce. He supported the draft resolution introduced by the delegate of Nigeria and endorsed WHO's leadership in providing support to Member States in combating counterfeit medical products.

Mr AHMADI (Islamic Republic of Iran) said that the term "counterfeit" related to international property rights. WHO should focus on public health, in accordance with its constitution. Intellectual property rights were handled by other agencies and were subject to other regulations and procedures. He called on the Secretariat to support Member States in strengthening their national drug regulatory authorities and to replace its programme on counterfeit medical products with a programme focused on quality, safety and efficacy. He welcomed the suggestion by the Director-General at the Sixty-second World Health Assembly to replace the term "counterfeit" with a more appropriate term.

He was concerned that measures taken to enforce TRIPS-plus standards had resulted in unwarranted seizures of generic medicines, thus adversely affecting access to medicines. He urged the Director-General to convene an expert task force to examine whether TRIPS-plus enforcement policies circumscribed the flexibility that had been provided for in the TRIPS agreement. He expressed concern regarding WHO's participation in the activities of the Taskforce, which had still to be endorsed by Member States, the lack of transparency of the Taskforce activities and its links to bodies involved in the enforcement of intellectual property rights. He supported the draft resolution proposed by the delegates of India and Thailand.

Dr SIRIWAT TIPTARADOL (Thailand), commending the report, said that his country recognized the threat to public health posed by unsafe and substandard medical products. He agreed with the delegate of India that a clear distinction should be made between counterfeit medical products and good quality generic products. He was concerned that generic medicines manufactured legally in India for use in developing countries had been seized in transit through the European Union because of intellectual property concerns. He repeated a previous request by Thailand for information about the function and potential conflicts of interest among the members of the Taskforce. Any resolution adopted by the Health Assembly should be in line with resolution SEA/RC62/R6 adopted by the Regional Committee for South-East Asia and should contain a definition of counterfeit medical products that eliminated all scope for confusion with patenting issues.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that his country was committed to combating substandard and inefficacious medical products. He had several concerns: that the work of the Taskforce was linked to the issue of intellectual property rights; that protection of trade interests worked to the detriment of access to affordable medicines for people on low incomes; and that WHO was supporting an initiative that had no proper mandate and was more focused on commercial criteria than public health. The draft resolution proposed by the delegate of Ecuador would enable governments to adopt specific actions designed to promote public health.

Professor BISHOP (Australia) welcomed the focus in the report on strengthening the Member States' regulatory authorities for medicines, in particular to develop and enforce quality, safety and efficacy standards and good manufacturing practices. He supported the work of the Secretariat to foster global and regional cooperation and support Member States in implementing strategies to combat substandard medicines. The Taskforce was established to enable its members and partner organizations to work towards a common goal under WHO's leadership. Substandard medical products were predominantly a public health concern, therefore leadership by WHO was important. However, WHO should liaise with other bodies, such as WIPO, WTO and INTERPOL, to ensure that technical assistance and enforcement were available where required.

Ms FARANI AZEVÊDO (Brazil) observed that there were two dimensions to the term "counterfeit medicines", one concerning trade and commerce and the other public health. WHO should focus on the dimension of counterfeit medicines which concerned falsified medical products that were detrimental to public health. Counterfeit medicines were a matter for WTO and WIPO. Progress could only be made once it had been formally clarified that the Secretariat's role centred on ensuring good-quality, safe, efficacious medicines rather than on trade and intellectual property rights. In that regard, during the 124th session of the Executive Board, she requested that the Director-General define the term "counterfeit" in relation to WHO's mandate,¹ but that definition had thus far not been provided.

Some Member States had disguised their commercial and economic interests under a false public-health perspective. She claimed that certain private companies, with the Secretariat's support, were waging a war against generic medicines. She argued that the companies currently holding the patents of branded medicines did not want to compete with cheaper, generic medicines when those patents expired. She stressed that, although Brazil was an important producer of generic medicines, it would never condone falsified generic medicines. Generic medicines should not be conflated with falsified medicines as branded medicines could equally be falsified.

Brazil and India were currently working with WTO on the issue of counterfeit medicines, which came under WTO's competence. Brazil supported the proposal, set out in the draft resolution submitted by the delegate of Ecuador, to create an intergovernmental working group to discuss falsified medicines. The pharmaceutical industry, because of its conflict of interest, should not take part in the discussions, but governments should be fully involved due to their genuine concern for public health. Until an intergovernmental working group had been formed and until the definition of "counterfeit medicines" had been clarified, all discussion of the issue within the Organization should be suspended.

Mr PINO ALVAREZ (Cuba) expressed support for the comments made by the delegate of Brazil. He was concerned by the impact of counterfeit medical products, including counterfeit generic medicines, on public health; and by attempts to restrict the production and distribution of genuine generic medicines under the pretext that they could be counterfeit. WHO should focus on providing global access to good-quality, safe, efficacious and affordable medical products. He stressed the important role of generic medicines. Such a sensitive, multifaceted issue required further in-depth

¹ Document EB124/2009/REC/2, summary record of the ninth meeting.

discussion on an intergovernmental level. He supported the draft resolution proposed by the delegate of Ecuador.

Dr GAD (Egypt) said that the Secretariat had an important role to play in supporting Member States in the provision of good-quality, safe and efficacious medical products. A distinction should be made between ensuring the quality, safety and effectiveness of medicines, which fell within WHO's competence, and counterfeit medical products: that was an issue of intellectual property and violation of trademark, as referred to in the TRIPS agreement and should therefore be dealt with by national legislation and international organizations, specifically WTO and WIPO. He stressed that WHO's mandate clearly related to public health. Substandard medical products and counterfeit medical products were two separate issues which should not be confused; the former posed a far greater public health risk than the latter. He pointed out that Egypt's legislation made clear that distinction; the national legislation of Member States, which currently varied greatly between jurisdictions, should also recognize that distinction.

At the Sixty-second World Health Assembly, the Director-General had stated her intention to avoid the term "counterfeit medicines" and had subsequently referred to "substandard medicines", a term he welcomed as a good starting point for clarification of the current issue. He observed that the Taskforce was not working under a mandate from any of WHO's governing bodies and therefore questioned its objectiveness. He supported the idea of forming an intergovernmental working group to examine counterfeit medical products from a public-health perspective.

Professor ADITAMA (Indonesia) said that counterfeit medicines represented a global threat to public health, especially in developing countries, where national regulatory capacities and law enforcement authorities were weak. He therefore supported the draft resolution proposed by the delegates of India and Thailand on behalf of the Member States of the South-East Asia Region. Good-quality, safe, and affordable medical products were essential for global public health. He supported the formation of an intergovernmental working group that would support the development of new techniques and tests to be used by medicines regulatory authorities.

He expressed the hope that the Director-General would support Member States in strengthening their medicines regulatory authorities; disseminate related independent and timely information; and encourage the exchange of information among Member States.

Dr SAID (Syrian Arab Republic) supported the comments made by the delegates of Thailand, India and Brazil. It was important to distinguish between generic and counterfeit medicines. The Secretariat should support the rights of developing countries to generic medical products. WHO's mandate was to fight for public health, not to defend the economic interests of industry.

Dr ALI (Bangladesh) said that the Secretariat should focus on its core mandate in order to ensure the quality, safety and efficacy of medical products and support Member States in achieving that objective. The term "counterfeit" conflated public health concerns with intellectual property rights. Counterfeit products came within the remit of the TRIPS agreement. As a least developed country entitled to flexibilities and exemptions under that agreement, Bangladesh could not tackle substandard medicines under the term "counterfeit". Those confused issues, together with seizures of generic drugs in transit, had undermined access to good-quality, safe and affordable generic medicines in developing countries.

In Bangladesh, although legislation took account of the threat of substandard and falsified medicines, there were no specific legal provisions and regulatory mechanisms to ensure due oversight. Bangladesh strongly condemned criminal activity involving such medicines. During the 124th session of the Executive Board, he had questioned the legitimacy of WHO's involvement with the Taskforce,¹

¹ Document EB124/2009/REC/2, summary record of the ninth meeting.

since it was not acting under a specific mandate, and he reiterated that question. He urged WHO to dissociate itself from the Taskforce documentation and activities. The Director-General had discussed use of an alternative term to “counterfeit” at the previous Health Assembly, and progress was needed in that regard. He supported the draft resolution proposed by the delegates of India and Thailand.

Mr SILBERSCHMIDT (Switzerland) supported the comments made by the delegate of Brazil: WHO should focus on public health, not intellectual property rights. He described the problem as three partially overlapping circles: falsified medicines, substandard medicines and intellectual property rights. The first two concerned public health and required criminal law enforcement. Intellectual property infringement, however, was mainly a question of private law. He welcomed the technical work carried out by the Taskforce; but its mandate and organizational set-up should be clarified. He would support any process that could lead to a clarification of WHO’s public health role, which should be strengthened, not curtailed.

Mr NABEEL (Pakistan) said that the Health Assembly was debating intellectual property matters unrelated to global public health. WHO should focus on the public-health dimension of counterfeit products; the term “counterfeit” should not be confused with quality, safety and efficacy.

He questioned the role of the Taskforce: only an intergovernmental working group would have the legitimacy to perform the work thus far undertaken by the Taskforce. The broad concurrence of views among Member States should be built on in order to maintain a global public-health perspective.

Mrs MALLIKARATCHY (Sri Lanka) expressed concern over the direction that the issue had taken. She supported the draft resolution proposed by India and Thailand. She was concerned that the Taskforce had been established without the full consultation of Member States and was working under the auspices of the Secretariat; that issue should be discussed under agenda item 18.1 (Partnerships) of the current Health Assembly.

Mr LANDAETA (Bolivarian Republic of Venezuela) said that falsified medical products in the supply chains of Member States posed a risk. He supported the draft resolution proposed by the delegate of Ecuador and the establishment of an intergovernmental working group. The term “counterfeit” was misleading in the context of public health, since it was used in relation to the TRIPS agreement. The definition used by the Taskforce could therefore give the impression of protecting intellectual property rights, thereby restricting access to medicines for the majority of the world’s population. He stressed the need to separate health monitoring and regulatory actions from legal actions. The term “counterfeit” should be redefined and emphasize the public-health aspects.

Dr YANO (Kenya) said that the issue of the legitimacy of the Taskforce had also arisen at the Sixty-first and Sixty-second World Health Assemblies. The continued use of the WHO logo by the Taskforce and its activities, such as in Kenya where it had assisted the Ministry of Industry to legislate against counterfeits without going through the Ministry of Health, prompted questions about who in the Secretariat persisted in advancing the interests of that entity when its legitimacy was in question, who funded the Taskforce’s activities, who were the constituents of the Taskforce and how had they been chosen. The issue should be resolved definitively.

Dr JADUE (Chile) supported the draft resolution proposed by the delegate of Ecuador but she opposed the development of the current relationship with the Taskforce.

Dr Jaw-Jou KANG (Chinese Taipei) said that counterfeit medical products not only jeopardized patient safety, they also infringed intellectual property rights and could obstruct the development of new medicines. Measures taken in Chinese Taipei to tackle the counterfeiting of medical products included: a task force set up in 2007; work to develop the new infrared rapid screening system; and an interdepartmental collaboration mechanism. Considerable resources had been devoted to establishing a

superior research environment and promoting the development of innovative medical products. Chinese Taipei valued every opportunity to cooperate with Member States, especially those in the Western Pacific Region, to ensure the safety of medicines and promote public health.

Mrs BILINSKA (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that the Alliance had prioritized the issue of counterfeit medical products and was committed to taking action. It worked closely with WHO and through the World Alliance for Patient Safety, and with other stakeholders, including the Taskforce. It had elaborated instruments on patient safety issues, including information to enable patients to identify potentially counterfeit medical products and obtain safe and effective medicines. Urgent action was required to protect patients and WHO had a central role to play in bringing together the relevant stakeholders, including other organizations of the United Nations system, and coordinating action to communicate the risks of counterfeit medical products to patients.

Mr LANDAETA (Bolivarian Republic of Venezuela) said that the term he had used in Spanish in his earlier statement, *falsificación*, had been interpreted into English as "counterfeit". In fact the term "falsification" was closer to his intended meaning.

Mr PISANI (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the Federation's members contributed to global health primarily through the development of innovative medicines and vaccines. Mortality and serious morbidity resulting from counterfeit medical products posed a serious and growing threat to public health worldwide. Counterfeiters did not discriminate: fake versions of both generic and branded medicines had entered the supply chain in developed, as well as developing countries, a trade facilitated by the Internet.

The Federation had just launched a document entitled "Ten Principles on Counterfeit Medicines", which made clear that counterfeiting of medicines was a crime against patients. The issue was not patent law. The focus of his organization's concerns was the health consequences of counterfeits. Although not all substandard medicines were counterfeits, counterfeits were by their nature at high risk of being substandard. For that reason, combating counterfeit medicines should be an important part of strategies to assure the quality, safety and efficacy of medicines. Cooperation at both local and global levels was fundamental and all stakeholders across the pharmaceutical supply chain must be aware, vigilant and ready with a robust response. Since counterfeit medicines prevented the attainment of the highest levels of health, the leadership of WHO was fundamental.

Mr CHAN (The International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN and also representing the World Dental Federation, World Medical Association, World Confederation for Physical Therapy and the International Council of Nurses, said that the five health professions on whose behalf he spoke supported the goal of protecting the well-being of patients in all parts of the world from poor quality, substandard and counterfeit medical products. Pro-active steps must be taken in collaboration with Member States and the Secretariat to ensure the quality, safety and efficacy of all medical products, in accordance with recognized international standards. Quality assurance of that kind applied to both branded and generic products, to both the private and public sectors, and to both imported and locally manufactured products.

The Federation was supporting the Secretariat's efforts to strengthen Member States' regulatory capacity and public education on the dangers of counterfeit medicines. WHO's survey of the use of the term "counterfeit medicines" and/or equivalents in national legislation demonstrated clearly that, regardless of the term used, disputes in trademark infringement and other crimes related to intellectual property should never be the basis on which to define whether or not a medical product was counterfeit. He cautioned Member States against adopting an overly broad definition in their legislation: factors such as similar name, colour or shape as proof of counterfeit could hinder access to legitimate, safe, effective and affordable generic medicines.

WHO was the only global agency to recognize that the protection of public health was the primary focus of combating counterfeit medical products and that the main victims of counterfeiting were patients. WHO should assume a leadership role in combating counterfeit medical products, based solely on its public health mandate. A new resolution to renew WHO's mandate on the public health issue of counterfeit medical products would send the right message to the rest of the world.

Dr ETIENNE (Assistant Director-General), having thanked Member States for their interventions, said that for more than 50 years the Secretariat had provided normative and technical assistance to facilitate access to good-quality, safe and efficacious medicines, and had supported mechanisms and measures to reduce the price of medicines and promote the use of generic medicines. It was clear from the debate that all Member States agreed that supporting Member States in promoting the safety, quality and efficacy of medicines should be the strongest emphasis of WHO's work, as was supported by numerous Health Assembly resolutions. The Secretariat was in full agreement and was complying with those wishes.

Work on quality, safety and efficacy formed 50% of the work of the Department of Essential Medicines and Pharmaceutical Policies. A variety of norms and standards that addressed quality were being worked on. For more than 50 years, WHO had assigned the international non-proprietary names for every new medicine that was produced anywhere in the world. WHO had a strong pharmacovigilance programme, had supported more than 100 countries in building the capacity of their national regulatory agencies and authorities. In medicines, it supported the work of several expert committees involved in the development of norms and standards. The Prequalification of Medicines Programme unified quality standards for all agencies of the United Nations system, and a large component of work was to build efficacy: the WHO Model List of Essential Medicines was entirely evidence-based and was well known to all Member States.

There was consensus among Member States that WHO should only focus on public health aspects of the problem of counterfeit, falsified or spurious medicines and leave issues of intellectual property to other organizations; that activities to combat counterfeit medicines must not hamper the legitimate trade in generic medicines; and that quality defects in legitimate products should not be labelled as counterfeits. The Secretariat agreed fully in all respects. There was some dissonance among Member States regarding the use of terms, as well as a divergence of views about the role and work of WHO with regard to the Taskforce.

The DIRECTOR-GENERAL said that she understood clearly what Member States were asking of her: WHO should focus on its mandate and address the public health aspects of counterfeit medicines. She gave an assurance that everything WHO was doing was in accordance with Health Assembly resolutions WHA41.16, WHA47.13 and WHA52.19. WHO had no role and no competency in the enforcement of intellectual property rights. WHO's role in the Taskforce was to provide advice and information on public health matters.

For patients, any medicine that compromised quality, safety and efficacy was dangerous. For Member States, the credibility of their health systems and of governments would be compromised if medicines did not fulfil their purpose. At the global level, the development of resistance to medicines was a risk to all. Medicines could become compromised as a result of a deliberate criminal act or as a result of failure in the manufacturing process. The complexity of the problem of addressing substandard, falsified, spurious and counterfeit medical products required a multidisciplinary and multisectoral approach.

WHO had been given a clear mandate to promote quality generic medicines and must not create the impression that it was overstepping its competence and enforcing intellectual property law. That there appeared to be such a perception was already not good, but she wished to see evidence. Referring to the specific assertion made by the delegate of Brazil that private companies, with the support of WHO, were waging a war against generic medicines, she urged Brazil to provide her with the evidence. She would then conduct a thorough investigation and take disciplinary action against any staff member concerned.

The challenge was knowing how to collaborate with other agencies and stakeholders without becoming a part of their agenda. WHO must maintain its independence as the health organization. WHO's agenda could be summarized by the words "quality, safety, efficacy and evidence". WHO's task was to help countries to build the capacity they needed to tackle the problem of substandard, falsified, spurious and counterfeit medicines. At the Sixty-second World Health Assembly, she had drawn attention to the need to find an elegant way to deal with the issue until Member States reached an agreement. She was making sure that WHO implemented the provisions of all the relevant resolutions. She requested Member States to allow her to continue to address the public health dimensions of the issue, and proposed using the admittedly cumbersome designation "substandard, falsified, spurious, counterfeit medical products" until such time as a definition could be found that reduced the confusion and satisfied Member States. She had no desire to be a policewoman, and WHO was not a police department. She would review WHO's engagement with other international organizations. Acknowledging that most of the countries participating in the Taskforce were from the developed world, she said that participation of countries from all regions would be welcome, so that their voices might also be heard. She was keen to ensure that nothing gave the impression that WHO was engaging in policing. She asked Member States to give her some time so that she could find a solution that would be to their satisfaction.

The CHAIRMAN proposed that a drafting group should be set up to consider the three draft resolutions.

Ms FARANI AZEVEDO (Brazil) said that establishing such a drafting group would be premature since there was still much to discuss on the issue. An intergovernmental working group should be established, as suggested in the draft resolution proposed by the delegate of Ecuador.

She thanked the Director-General for her clarification, but restated her discomfort at the close relationship between WHO and the Taskforce, as evidenced by, for example, the link to its web site from the WHO web site. That relationship must be discussed: much work remained to be done and WHO had a key role to play in the area, but Member States had not given the Organization the mandate of acting as the secretariat of the Taskforce.

The DIRECTOR-GENERAL said that, while it was not her wish to abdicate responsibility, it was nevertheless a fact that the Taskforce had been established in 2006, the year before she had taken office. That partnership, along with many others, including that with the international drug purchase facility UNITAID, had been formed without prior consultation of the Health Assembly. She had undertaken never to form such partnerships without prior consultation. Indeed, she had not formed any new partnerships since taking office, in order to concentrate on finding an appropriate solution for partnerships previously formed. She had suggested the inclusion of a separate item on the Health Assembly's agenda to that end. Her commitment to that course of action remained as strong as ever.

Ms RAO (India) said that, although many divergent views had been expressed, three points of consensus had emerged: the need for safe and efficacious medicines, the need to combat counterfeit drugs and concern about the way in which the Taskforce functioned. The comparison made by the Director-General of the Organization's relationships with UNITAID and with the Taskforce was unfair, given that the work of the Taskforce was rather more controversial than that of UNITAID, which sought to assist developing countries in gaining access to medicines.

As views were so many and divergent, nothing was to be gained by establishing a drafting group at the current stage. The creation of an intergovernmental working group, which would report back to the Executive Board and the Health Assembly the following year, would be preferable, since it would be unlikely that such a serious matter could be resolved in a drafting group or in the current meeting.

Mr HOLGUIN (Ecuador) expressed support for the position of Brazil and India. The three draft resolutions under consideration, far from contradicting each other, were complementary, and no delegates had taken the floor to oppose them. An intergovernmental working group would be the best medium for agreeing on coherent proposals that best reflected the wishes of Member States.

Mr LANDAETA (Bolivarian Republic of Venezuela) appealed to the Director-General to help in abolishing the Taskforce, in the interests of the developing countries. He was in favour of continuing the debate in the current forum since there were many points of consensus between States.

Dr ASIN-OOSTBURG (Suriname) expressed support for the proposal by Brazil to continue the debate in an intergovernmental working group.

Professor ADITAMA (Indonesia) expressed support for the proposal by Brazil and India.

Dr YANO (Kenya), while accepting the Director-General's point that she had taken office after the partnership with the Taskforce had been formed, said that that fact was no reason to continue the partnership; the problem of an unhappy marriage could be solved by divorce, and Member States had clearly expressed the view that they wanted the Organization to divorce the Taskforce. Noting that the Taskforce had been attempting to assist developing countries to develop anti-counterfeit legislation, he said that the damage caused could increase if the partnership continued.

Ms EPHREM (Canada) said that counterfeit health products had become a significant problem in many developing countries and had been identified as an emerging issue for many developed countries, posing an unacceptable risk to the health and safety of citizens of every country. Although no country was immune, those with weakly regulated supply chains would suffer the most, as counterfeit activities exploited gaps in overall regulatory frameworks. The magnitude and scope of the problem required a collaborative effort at the national and international levels. She fully supported the Organization's work to develop an internationally coordinated anti-counterfeit strategy – that was an essential component of promoting the safety, quality and efficacy of all health products – and to do so through its partnership with the Taskforce. Canada was keen to make progress, and she supported the Director-General's proposal to try to achieve a resolution during the current Health Assembly and to allow her to examine the Organization's relationship with the Taskforce. Canada further supported the Director-General's recommendation that Member States should work together to make progress. She favoured the establishment of a drafting group, but was prepared to be flexible if other Member States would prefer to continue discussions on the resolutions.

Ms FARANI AZEVÊDO (Brazil) noted that much remained to be discussed. She expressed support for the comment by the delegate of Kenya that it was time for WHO to end its relationship with the Taskforce. The Organization had an important role to play in combating the falsification of medical products and the draft resolution proposed by the delegate of Ecuador had proposed the establishment of an intergovernmental working group, with a clear mandate. She expressed the hope that Member States would support that draft resolution.

Mr PARRONDO (Spain), speaking on behalf of the European Union, said that there was general consensus among the Member States of the European Union on the principles of the issue, but not on all points. The European Union did not believe that it was the appropriate time for the Organization to end its partnership with the Taskforce, although that relationship should be examined. It was essential that all efforts to combat counterfeit medicines, which could include those of the Taskforce, should come under the umbrella of the Organization. Counterfeit medicines was a public-health issue and had nothing to do with intellectual property. Expressing support for the statement by the delegate of Canada, he was open to the holding of consultations between Member States or

establishing a drafting group that would report back to the next Health Assembly, taking into account the basic principles shared by all parties.

Dr HAMBURG (United States of America) expressed support for the position of the previous speaker and reiterated the urgent need to address the problem of falsification of medical products and its serious impact on health. The Organization was the appropriate forum for that, and the first step was to establish a drafting group.

Mr AHMADI (Islamic Republic of Iran), supported by Dr AL-NAAMI (Yemen) and Dr UGARTE UBILLUZ (Peru), endorsed the proposal for the establishment of an intergovernmental working group.

Dr TAKEI (Japan), supported by Professor BISHOP (Australia), Mr TOMLINSON (United Kingdom of Great Britain and Northern Ireland), Mr HOHMAN (United States of America) and Dr ASIN-OOSTBURG (Suriname), said that the issues were best discussed in a small drafting group in order to consolidate the differing ideas and views into a single draft resolution.

Dr UHOMOIBHI (Nigeria) said that in 2009, 84 children in Nigeria had died as a result of the fraudulent practices that were ongoing in some countries. Collective decisions to end those practices were imperative and point-scoring on political and other issues had no place in the discussion. It was purely a question of saving lives in the public health context, which was the primary responsibility for which WHO had been established.

Dr GAD (Egypt) agreed with earlier speakers that the subject would be more usefully and productively deliberated in an intergovernmental working group, which could take all public health elements into account and draw conclusions as to those in which WHO should be involved. He remained uncomfortable with the role of the Taskforce, which should be examined in depth by the proposed group.

Dr BLOOMFIELD (New Zealand), supported by Mr BULL (Norway), suggested that a small group of interested delegates be tasked with identifying the appropriate mechanism or group to identify the issues to be addressed by any such group, including, for example, the future role of the Taskforce and the question of whether relations with it should be severed.

The CHAIRMAN asked whether there were any objections to the proposal to establish a drafting group.

Mr GOPINATHAN (India), supported by Ms ESCOREL DE MORAES (Brazil), expressing surprise at that question, said that it was evident from the discussion that most delegations that represented developing countries were overwhelmingly opposed to the establishment of a drafting group with a sole purpose of consolidating the three draft resolutions as one. The mandate of any such drafting group must be clarified. He would support the establishment of a group tasked with producing a road map or terms of reference on the issue of counterfeit medical products but not of one simply tasked with the futile exercise of discussing the draft resolutions.

The CHAIRMAN said that he had meant a small group that would meet to explore ways forward, rather than a drafting group *per se*.

Mr ARIAS PALACIO (Bolivarian Republic of Venezuela) said that he also failed to understand the Chairman's question when it was clear that most Member States supported the establishment of an intergovernmental working group. He suggested that the Chairman should suspend the meeting for a few minutes and meet with representatives of the various sides to discuss the way forward.

The DIRECTOR-GENERAL said that she detected broad support for the proposal to establish a small group, provided that it had a clear and well-defined mandate to determine the priority issues to be discussed and develop a road map.

Dr UHOMOIBHI (Nigeria) said that a simple approach would be for the cosponsors of the three draft resolutions to meet in a bid to reconcile the differences among them and subsequently report back to the Committee on the outcome. Those who still wished thereafter to table a draft resolution should be able to do so.

The CHAIRMAN said that discussion of the matter would resume at a later meeting.

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

The meeting rose at 17:30.

SEVENTH MEETING

Wednesday, 19 May 2010, at 18:45

Chairman: Dr M. MUGITANI (Japan)

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

Birth defects: Item 11.7 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R6, and A63/10) (continued from the fifth meeting, section 2)

Dr ZHANG Lingli (China) expressed support for the draft resolution contained in resolution EB126.R6. As indicated in the report, birth defects could result in lifelong disability. It was estimated that they caused 7% of the four million neonatal deaths that occurred worldwide each day, and 85% of the eight million infants born with birth defects each year were born in developing countries. To date, however, birth defects had not been seen as a public health priority. A global strategy to mobilize resources, emphasize prevention in developing countries and enhance national prevention capacities would make an important contribution to the achievement of Millennium Development Goal 4 (reduce child mortality). China, India and the Republic of Korea had therefore submitted a draft resolution to the Board at its 126th session, which had resulted in the draft resolution before the Committee. It was important to target prevention activities, to undertake appropriate screening before and during pregnancy and in the neonatal period, and to include surveillance in national health plans. He supported the amendment to subparagraph 1(5) proposed in the previous meeting by the delegate of the United Kingdom. China was committed to collaborating with Member States, other international and nongovernmental organizations, and the Secretariat in activities to prevent birth defects.

Mr AL-TAAE (Iraq) said that reproductive health, maternal and child health care and primary health care services should incorporate workplans for preventing and treating birth defects and caring for those born with them. Emphasis should be given to premarital and neonatal screening, including serological testing for antibodies to toxoplasmosis, rubella, and cytomegalovirus and herpes simplex virus infections. There was also a need for strengthening of health information systems, individual training and institutional capacity-building and further research in the area. In addition to the priority actions for the international community listed in the report, the prevention and control of birth defects should be included in primary health care programmes and health promotion activities, and in actions to achieve the Millennium Development Goals.

Dr ALI (Bangladesh) said that, with high-level political support, Bangladesh was making satisfactory progress in establishing a network of community clinics, each covering a population of 6000, across the country. Basic screening and electronic reporting of birth defects would be carried out at that level, and cases would be referred to secondary and tertiary levels of health care as appropriate.

Dr KASSIM (Brunei Darussalam) observed that her country faced challenges in obtaining reliable statistics as there was only a limited database at the tertiary level hospital where congenital abnormalities were recorded. Antenatal care was free and accessible to all and included blood tests, assessment of nutritional status and ultrasound examination. High-risk pregnancies were referred to the tertiary level centre for further management and counselling. Antenatal screening was limited and termination of pregnancies was not deemed to be ethically or socially acceptable. Newborn infants were examined physically and their cord-blood was tested for congenital hypothyroidism and glucose-

6-phosphate dehydrogenase deficiency. Birth defects were recorded and appropriate follow-up and referral were instituted. Facilities for surgical correction were available but complex cases were referred to tertiary centres abroad. Her Government recognized the need for a national programme for the prevention and treatment of birth defects and aimed to strengthen existing services. She requested the Secretariat's support for capacity-building in order to improve early detection, rehabilitation and palliative care, and for the establishment of surveillance systems and a national database for birth defects. She supported the draft resolution.

Ms SONG Kyung-min (Republic of Korea) welcomed WHO's commitment to action to prevent and control birth defects. Birth defects were a serious public health problem in developing countries, because of a lack of screening and planning of health services, and in developed countries, where birth defects were a prominent cause of mortality relative to overall neonatal mortality rates. She supported the draft resolution.

Mr KOVALEVSKIJ (Russian Federation) said that birth defects occurred in 50 per 1000 births in the Russian Federation. In many cases those defects required immediate and long-term follow-up treatment, including surgical correction, involving complex and expensive technology. Moreover, the wide variety of defects increased the range of technical interventions required. The most effective prevention measure was a comprehensive perinatal diagnostic system that took into account the latest research findings, including those from genetic research. Affected families should be provided with information on perinatal diagnosis and on the prognosis and care for infants born with birth defects.

In his country, specific legislation on perinatal diagnostic services had been enacted in 2000. However, although every effort was made to screen pregnant women and newborn infants, which included the use of ultrasound examination and blood tests for biochemical markers, early detection was hampered by lack of equipment and trained health personnel in some regions of the country. Further action was therefore needed to strengthen existing systems. He supported the draft resolution in principle but would like to see a reference to the need for targeted prevention activities at the prenatal and postnatal stages.

Dr WACHARA RIEWPAIBOON (Thailand) drew attention to a recent article in *The Lancet*,¹ which estimated that, in 2008, around 0.3 million neonatal deaths and 0.1 million deaths in children aged under five years were attributable to congenital abnormalities. Congenital abnormalities and birth defects accounted for 3% of total global mortality in that age group; the proportion varied regionally, from 2% in Africa to 11% in Europe. The higher proportions in developed countries were probably due to greater accuracy in vital registration systems. The low level of registration coverage in developing countries, especially in Africa and Asia, was a serious barrier to accurate estimation of birth defects.

Her Government was concerned also at the growing published evidence of fetal alcohol exposure as a leading cause of defects, especially given the availability of preventive measures in that area. She proposed that the draft resolution should be strengthened with the addition of a new paragraph after the sixth preambular paragraph, to read: "Recognizing that the lack of, or inadequate, vital registration systems in developing countries and inaccurate records of the cause of death are major barriers in estimating the size of public health problems attributable to birth defects". Subparagraph 1(4) should be amended by inserting "including rubella vaccination, folic acid supplementation, programmes addressing tobacco and alcohol use among pregnant women and women trying to conceive" after "measures" and by deleting "through" before "health education programmes". Subparagraph 1(5) should be amended to read: "to strengthen civil registration and surveillance systems in order to capture accurate epidemiological data on birth defects and birth defect

¹ Black RE et al. Global, regional, and national causes of child mortality in 2008: a systematic analysis. *The Lancet*, 2010, **375** (June 5):1969–1987.

risk factors as part of a national health information system, and to develop a national birth defect registry, where feasible, for continued care and support to individuals affected by birth defects”.

Ms WAKEFIELD (United States of America) said that in her country the National Institutes of Health and the Centers for Disease Prevention and Control had a long history of funding research to guide the development of effective public-health and health-care strategies for the prevention, detection and treatment of birth defects, which affected some 120 000 newborn infants annually and were a major cause of infant mortality and long-term disability. More than US\$ 200 million had been awarded for research and prevention activities in 2008. January had been designated the National Birth Defects Prevention Month and September was National Newborn Screening Awareness Month; in January 2010 a National Folic Acid Awareness Week had been held. She supported the draft resolution and proposed that a new subparagraph 1(7)bis should be inserted to read: “to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with congenital birth defects”.

Mr MENESES GONZÁLEZ (Mexico) agreed that the lack of accurate epidemiological data on birth defects was hampering public health responses in many Member States. He therefore supported the draft resolution and proposed that subparagraph 1(5) should be amended to read: “to develop and strengthen surveillance systems for birth defects within the framework of national health information systems in order to have information available for taking decisions on prevention and control of these birth defects and on health promotion”.

Dr ABUDHER (Libyan Arab Jamahiriya) said that antenatal and postnatal tests for early detection of birth defects was of great importance in preparing families and health services for the treatment and care needed for affected infants. That was especially relevant in countries such as his own where termination of pregnancy was illegal. He therefore proposed that the eleventh preambular paragraph should be amended by inserting the words “before and after birth” after “defects”.

Dr MHLANGA (South Africa) welcomed WHO’s attention to birth defects and supported the draft resolution. Among the various birth defects recorded in South Africa, fetal alcohol syndrome was a major challenge as a result of the practice of remunerating farm workers with alcoholic beverages. Efforts were under way to phase out that practice. South Africa was also taking steps to fortify basic foods with micronutrients, such as folic acid and trace elements. It was important to raise awareness of the harmful effects of drinking alcohol during pregnancy and to ensure that affected children had access to adequate services.

Dr GAMARRA (Paraguay) said that data on congenital abnormalities were lacking or were not always taken into consideration. In addition to recognized risk factors, such as inadequate nutrition, rubella and, increasingly, alcohol consumption, governments should also take into account a growing number of environmental risk factors. She called on Member States to support and implement the draft resolution.

Dr ITURRIA CAAMEÑO (Bolivarian Republic of Venezuela) supported the draft resolution and endorsed the comments made by previous speakers. WHO should speak out against the discriminatory practices of private health insurance companies, which often included exclusion clauses in their policies, sometimes added in small print, concerning the treatment and care of people with birth defects.

Dr WAMAE (Kenya), welcoming the inclusion of the item of birth defects on the agenda, said that in Kenya relevant interventions were implemented as part of existing programmes, including antenatal care and family planning. Surgery camps had been conducted for treatment of cleft lip and

palate and repair of congenital cardiovascular defects. However, there was no specific policy on the prevention, detection and management of birth defects, and surveillance and needs assessments were lacking. She requested support from WHO and other partners for the formulation of appropriate policies and programmes. She supported the draft resolution on the understanding that it was not advocating termination of pregnancy when fetal abnormalities were detected.

Dr ALWAN (Assistant Director-General) thanked delegates for their constructive comments and for their proposals to strengthen the draft resolution. As indicated in its report, the Secretariat agreed that prevention of birth defects should be integrated in primary health-care services, in particular those concerned with maternal and child health. The Secretariat would be pleased to provide technical support to Member States that sought to establish or strengthen relevant prevention and care services.

The CHAIRMAN suggested that further consideration of the draft resolution should be postponed pending the circulation of a revised text that took into account the proposed amendments.

It was so agreed.

(For approval of the draft resolution, see the summary record of the eleventh meeting, section 1.)

2. ORGANIZATION OF WORK

Dr UHOMOIBHI (Nigeria) asked when further discussions would be held on item 11.20, Counterfeit medical products. It was his understanding that discussions would follow consideration of item 11.7 in order for the Committee to hear a report on the progress of informal consultations held between the sixth and seventh meetings. It would be difficult to achieve consensus on a single draft resolution, but he had consulted with several of the proposers of the three draft resolutions tabled at the sixth meeting and it appeared that some progress had been achieved; it might be useful to inform the Committee about that development.

The CHAIRMAN replied that it was his understanding that informal consultations were continuing and that more time had been requested.

After a discussion, in which Dr UHOMOIBHI (Nigeria), Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), Mr SUDHIR (India), Dr GAMARRA (Paraguay), Mr MISATI EVANS (Kenya), Dr MHLANGA (South Africa), Mr OTEBA (Uganda) and Professor ADITAMA (Indonesia) participated, clarification was required regarding: the current status of informal consultations, the matters being considered (the method of proceeding, the texts of the three draft resolutions tabled, or both) and the Member States involved. It was observed that many informal consultations and meetings of drafting groups took place during the Health Assembly and it was essential that Member States should be kept informed of the status of those discussions. Member States that had not been able to participate, through lack of information about where and when those consultations were taking place, would find it more difficult to accept proposals that emanated from those discussions. Agenda item 11.20 was complex and there should be sufficient time for the Committee to consider it properly.

The CHAIRMAN recalled that, at the sixth meeting, three options for proceeding had been proposed: (1) establishment of an intergovernmental working group to consider the matter further; (2) formation of a drafting group to consider the three proposed draft resolutions; and (3) informal consultations to consider the best way forward. It was his and the Secretariat's understanding that it had been agreed to proceed with option (3), that those informal consultations were continuing, and that

some Member States had asked for more time to complete the discussions. Given the views expressed by delegates, however, he suggested that the discussions on the item could be reopened immediately and focus on the procedures to be followed.

Dr BLOOMFIELD (New Zealand) said that, if the Committee agreed to reopen the discussions, it might be useful to begin with a report on the consultations regarding the three draft resolutions held between the sixth and seventh meetings, as mentioned by the delegate of Nigeria.

Mr DE ALBUQUERQUE E SILVA (Brazil) said that the countries of the Union of South American Nations were continuing with the consultations mentioned by the delegate of Nigeria and there appeared to be room for some understanding. However, there was not as yet any concrete progress to report to the Committee. Therefore, it would not be appropriate to reopen consideration of the item at that juncture.

Mr SUDHIR (India) said that the Member States of the South-East Asia Region had not taken part in those consultations and more time would be needed for them to participate. Therefore, further consideration of the item should be postponed.

The CHAIRMAN took it that, in the absence of any objection, the Committee wished to postpone further discussion of item 11.20 pending the outcome of the informal consultations.

It was so agreed.

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

Food safety: Item 11.8 of the Agenda (Documents EB/126/2010/REC/1, resolution EB126.R7, and A63/11)

Dr ZARAMBA (representative of the Executive Board) said that, at its 126th session in January 2010, the Executive Board had considered a report on food safety and had adopted resolution EB126.R7 in which it recommended a text to the Health Assembly for adoption.

Mr GULLY (Canada) said that resolutions WHA53.15 and WHA55.16 had focused on the development and implementation of food safety policies and programmes by Member States and had also reflected the view that food safety could not be seen solely within the confines of national borders, nor as a distinct entity within public health policy. Since the adoption of those resolutions, global events had demonstrated that food safety authorities needed to work even more closely together than in the past. The increasing globalization of the world's food supply could contribute to the rapid international spread of foodborne hazards, pathogens and contaminants. Evidence was growing of the inextricable links between food safety and other crucial issues facing Member States, such as food security, increasing occurrence of chronic diseases, emerging zoonotic diseases, sustainable development and climate change.

It was timely for Member States to consider a new draft resolution that would help to advance food safety initiatives. The draft resolution that Canada had proposed was intended to complement the recommendations in earlier resolutions, and he encouraged Member States to engage fully in international activities and forums in order to assess, manage and communicate risks.

Dr JIDDOU (Mauritania), speaking on behalf of the Member States of the African Region, said that food safety was a major issue for the Region, in which there were on average five episodes of foodborne or waterborne diarrhoeal illness per child, every year. The full measure of the burden of

morbidity associated with that pathology and the cost related to the ingestion of unsafe foods was not yet known. Given the propagation across borders of pathogens and contaminants, food-based infections had become a threat to the safety of food worldwide. Recent events related to the contamination of foodstuffs had all highlighted the global scale of the problem: for example, by chemicals, such as melamine and dioxin, and microbes, both traditional pathogens such as salmonella and new ones such as the Reston subtype of Ebola virus.

In Africa, 25 Member States had participated in training programmes organized by the International Food Safety Authorities Network; the African Region had developed instruments, guidelines and manuals that would strengthen capacities, including tools to assess national food control standards and guidelines for enhanced surveillance of foodborne diseases. Food insecurity remained a major obstacle to reducing the number of outbreaks of foodborne disease in the African Region. Serious public health problems arose as a result of foodborne disease and it remained the principal cause of malnutrition in infants and young children. In most African countries, food safety programmes continued to be underfinanced and fragmented, and responsibility for administering them was spread between different ministries and agencies. He supported the draft resolution.

Dr HAMBURG (United States of America), supported by Ms FALETOESE SU'A (Samoa), also supported the draft resolution and the implementation of its recommendations.

Dr FERDINAND (Barbados) said that efforts were being undertaken in her country to ensure food safety. Barbados requested continued technical support from the Secretariat in order to strengthen its food safety management system, through the implementation of the Hazard Analysis Critical Control Point approach. She supported the draft resolution.

Dr KESKİNKILIÇ (Turkey) said that there was still a need to strengthen the functional capacity of the International Food Safety Authorities Network. It was important to provide accurate and rapid technical support for such a critical health issue and therefore a mechanism that was capable of working around the clock was required. There was a need to clarify the role and responsibilities of the Network given the immense workload and given that other networks were actively engaged in food safety activities; however, in a globalized world, some overlap of functions and duties had to be accepted. It would also be important to determine the functions and the ethical principles according to which networks operated if they were to secure the support of Member States.

Sharing information through the networks must be fast, but the information must also be evidence-based and care must be taken to avoid causing panic among people while seeking to protect them. In the light of those considerations, Turkey supported the draft resolution.

Ms SONG Kyung-Min (Republic of Korea), expressing support for the draft resolution, said that WHO should demonstrate its commitment by allocating resources to the pursuit of key initiatives in partnerships with organizations such as the FAO.

Mr EL MENZHI (Morocco), emphasizing the importance of food safety, supported the draft resolution. He urged WHO to undertake, in collaboration with FAO, the actions necessary for the implementation of the strategic plan for food safety that had been recommended by the FAO/WHO Regional Conference on Food Safety for Africa (Harare, 2005).

Dr ZHANG Xudong (China) said that food safety was a common challenge faced by all Member States. Strengthened international cooperation and oversight were needed and could be achieved through further development and use of international networks for food safety such as the International Food Safety Authorities Network.

Ms BLAKAR (Norway), welcoming WHO's thorough work in the area of food safety, stressed that close cooperation was needed among different sectors, including agriculture, fisheries, trade, environment, consumer affairs and health. The health sector was important in providing the scientific basis for work on food safety, and she welcomed the strengthening of WHO's commitment. The WHO Initiative to estimate the Global Burden of Foodborne Diseases would give a clearer picture of the challenges, particularly as they related to the achievement of Millennium Development Goal 1 (Eradicate extreme poverty and hunger). Safe food and drinking water, adequate nutrition and sustainable food production all required a common approach.

WHO should give priority and allocate appropriate funding to the development of standards that would have an impact on consumer health and food safety, the first priority in the Codex Alimentarius Commission. However, it was also important to support other activities related to food safety, such as scientific advice and capacity-building.

Mr AL-TAAE (Iraq) said that ensuring food safety from the farm to the consumer was a critical challenge. Partnership among all stakeholders, including nongovernmental organizations, civil society and international organizations, particularly WHO, was needed in order to implement the standards of the Codex Alimentarius Commission. It also required capacity-building in food product testing, as well as in the legal measures to be taken when food that did not comply with the standards was detected. The efficiency of food safety controls at international borders needed to be enhanced. Laboratories should also test food within production facilities, and there should be a regular exchange of information related to food safety between Member States. In all of those areas, WHO should provide support to enterprises and individuals.

Miss PATCHAREEWAN PHUNGNIL (Thailand) supported the draft resolution and warmly encouraged all Member States to implement the strategies set out in paragraph 1. Technical and financial support would be necessary, in order to implement food safety initiatives in developing countries; to establish infrastructure and networking mechanisms for cooperation among agencies along the food chain; and to build human resources capacity at national and regional levels. Food safety systems in developing countries should be improved in respect of their capabilities in risk assessment, risk management and risk communication. The contamination of food products with melamine had illustrated the importance of risk communication in order to foster trust among stakeholders in crisis management. In developing countries, capacity-building and technical support should be priority activities, and thus enhance the implementation of the International Food Safety Authorities Network.

Mr KOVALEVSKIJ (Russian Federation) said that the issue of food safety was one of the priorities of his Government's policy on health protection, and that new food safety policies were being created to cover the period up to 2025. He welcomed the Secretariat's efforts in support of food safety and supported the draft resolution.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union and the candidate countries Turkey, Croatia and The former Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Ukraine, the Republic of Moldova, Armenia and Georgia, said that the European Union supported the global food safety initiatives being promoted by WHO, and agreed that specific actions should be directed towards the whole of the food chain, as well as towards the animal feed sector. Experience in Europe had demonstrated that, in the context of farm animals intended for the production of human food, the use of safe feed was vital in guaranteeing the highest level of food safety.

She drew attention to the importance of adequate and sustainable financing for the Joint FAO/WHO Expert Committee on Food Additives and for the Codex Alimentarius Commission in order to avoid delays in their work. Currently, WHO financed only 14.5% of the budget of the Commission, the primary regulatory body in the field of food safety; the rest of the budget was financed by FAO. The imbalance in the funding of the activities of the Commission should be corrected in order to reflect the importance that WHO assigned to food safety. She supported the draft resolution.

Dr MALEFHO (Botswana) said that his Government had created the intersectoral National Food Control Board comprising all relevant stakeholders. Efforts had been made to develop regulations based on the WHO, FAO and Codex Alimentarius Commission recommendations. Campaigns were organized to educate the public, with a view to reducing the burden of foodborne illnesses.

Botswana depended heavily on imported foods. Globalization had enabled the importation of food products from anywhere in the world but that had also created food safety challenges. He supported the idea of an international agreement on global management of food safety, based on general scientific principles, cross-sectoral collaboration and action at international and national levels. He supported the draft resolution.

Mr PRASAD (India) said that foodborne diseases and threats to food safety constituted a growing public health problem. In his country, the Food Safety and Standards Authority of India had become the single reference point for all matters relating to food safety and standards; and the country focal point for international agreements on global management of food safety and the Codex Alimentarius Commission.

Further research was needed on the ecological impact resulting from new varieties of genetically modified foods and plants that were being developed; and similarly on the types of chemicals present in food resulting from the use of pesticides and chemicals, and the consequent adverse impact on human health. Coordinated research on those two issues was needed so that informed public policies could be developed. Similarly, there was a need for data and information on the extent of zoonoses. He supported the draft resolution.

Mr GÜRKAN (Food and Agriculture Organization of the United Nations) detailed the range of initiatives on which FAO and WHO cooperated, under a multidisciplinary and cross-sectoral approach. The regular high-level management meetings between WHO and FAO ensured optimal coordination between the two organizations and the realization of synergies in the implementation of their food safety strategies and programmes.

Dr MIYAGISHIMA (Organization Internationale des Épizooties) said that his organization supported and encouraged WHO in advancing food safety initiatives and would continue to cooperate with WHO and FAO in order to address the global burden of foodborne disease. It participated in networks that coordinated verification processes, such as the Global Early Warning and Response System for Major Animal Diseases that combined the alert and response mechanisms of the three organizations. He also highlighted collaboration with WHO and FAO in the context of his organization's Animal Production Food Safety Working Group.

Dr Jaw-Jou KANG (Chinese Taipei) said that Chinese Taipei had established a thorough monitoring and surveillance system for food products at its borders and in the domestic market, supported by abundant experience, state-of-the-art equipment and sufficient professional staff to ensure accurate testing and adequate assessment of food safety incidents. The surveillance data collected on the concentration of heavy metal and dioxins in food could be helpful to WHO. The International Food Safety Authorities Network was the only international platform for exchanging food safety information and Chinese Taipei was willing to support the Network and to share

information and knowledge through it. Chinese Taipei requested that its food safety authority should be included as a Network Emergency Contact Point and Focal Point.

Dr SCHLUNDT (Food Safety, Zoonoses and Foodborne Diseases) affirmed that foodborne diseases were an issue of international concern, both because production systems in all countries had weaknesses and because food was increasingly traded globally. The Secretariat had noted the comments on the measures that needed to be taken in order to estimate the burden of foodborne disease, and to strengthen WHO's global networks including the International Food Safety Authorities Network. The Secretariat was aware that it needed to assess, manage and communicate foodborne risks and zoonotic risks, sharing the information in a timely manner with all Member States, in collaboration with other international organizations including FAO and OIE.

The Secretariat had also noted that Member States considered that the standard-setting by the Codex Alimentarius Commission was an important area for WHO's work, and that the Secretariat needed to ensure funding for that normative action.

The CHAIRMAN said that, as no amendment had been proposed, he took it that the Committee was prepared to approve the draft resolution.

The draft resolution was approved.¹

Prevention and control of noncommunicable diseases: implementation of the global strategy:
Item 11.9 of the Agenda (Document A63/12)

The CHAIRMAN drew attention to a draft resolution on the marketing of food and non-alcoholic beverages to children, which had been proposed by the delegation of Norway:

The Sixty-third World Health Assembly,

PP1 Having considered the report on prevention and control of noncommunicable diseases: implementation of the global strategy and its annexed set of recommendations on the marketing of foods and non-alcoholic beverages to children;²

PP2 Recalling resolutions WHA53.17 on the prevention and control of noncommunicable diseases and WHA60.23 on the prevention and control of noncommunicable diseases: implementation of the global strategy;

PP3 Reaffirming its commitment to acting on two of the main risk factors for noncommunicable diseases, namely, unhealthy diet and physical inactivity, through the implementation of the Global strategy on diet, physical activity and health, endorsed by the Health Assembly in 2004 (resolution WHA57.17), and the action plan for the global strategy for the prevention and control of noncommunicable diseases,³ endorsed by the Health Assembly in 2008 (resolution WHA61.14);

PP4 Deeply concerned about the high and increasing prevalence of noncommunicable diseases in low- and middle-income countries which, together with the communicable diseases still affecting the poor, contribute to a double burden of disease which has serious implications for poverty reduction and economic development and widens health gaps between and within countries;

PP5 Deeply concerned that in 2010 it is estimated that more than 42 million children under the age of five years will be overweight or obese, of whom nearly 35 million are living in

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA63.3.

² Document A63/12.

³ Document A61/2008/REC/1, Annex 3.

developing countries, and also concerned that in most parts of the world the prevalence of childhood obesity is increasing rapidly;

PP6 Recognizing that unhealthy diet is one of the main risk factors for noncommunicable diseases and that the risks presented by unhealthy diets start in childhood and build up throughout life;

PP7 Recognizing that unhealthy diets are associated with overweight and obesity and that children should maintain a healthy weight and consume foods that are low in saturated fat, *trans*-fatty acids, free sugars, or salt in order to reduce future risk of noncommunicable diseases;

PP8 Cognizant of the research that shows that food advertising to children is extensive and other forms of marketing of food to children are widespread across the world;

PP9 Recognizing that a significant amount of this marketing is for foods with a high content of fat, sugar or salt and that television advertising influences children's food preferences, purchase requests and consumption patterns;

PP10 Recognizing the steps taken so far by segments of the private sector to reduce the marketing of foods and non-alcoholic beverages to children, while noting the importance of independent and transparent monitoring of commitments made by the private sector at national and global levels;

PP11 Recognizing that some Member States have already introduced legislation and national policies on the marketing of foods and non-alcoholic beverages to children,

1. ENDORSES the set of recommendations on the marketing of foods and non-alcoholic beverages to children;¹
2. URGES Member States:
 - (1) to take all necessary measures to implement the recommendations on the marketing of foods and non-alcoholic beverages to children, while taking into account existing legislation and policies, as appropriate;
 - (2) to identify the most suitable policy approach given national circumstances and develop new and/or strengthen existing policies that aim to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt;
 - (3) to establish a system for monitoring and evaluating the implementation of the recommendations on the marketing of foods and non-alcoholic beverages to children;
 - (4) to take active steps to establish intergovernmental collaboration in order to reduce the impact of cross-border marketing;
 - (5) to cooperate with civil society and with public and private stakeholders in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children in order to reduce the impact of that marketing, while ensuring avoidance of potential conflicts of interest;
3. REQUESTS the Director-General:
 - (1) to provide technical support to Member States, on request, in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children and in monitoring and evaluating their implementation;
 - (2) to support existing regional networks, and where appropriate to facilitate the establishment of new ones, in order to strengthen international cooperation to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt;

¹ Document A63/12, Annex.

- (3) to cooperate with civil society and with public and private stakeholders in implementing the set of recommendations to reduce the impact of marketing of foods and non-alcoholic beverages to children, while ensuring avoidance of potential conflicts of interest;
- (4) to strengthen international cooperation with other international intergovernmental organizations and bodies in promoting the implementation, by Member States, of the recommendations on marketing of foods and non-alcoholic beverages to children;
- (5) to use existing methodologies for evaluating the action plan for the global strategy for the prevention and control of noncommunicable diseases to monitor policies on marketing of foods and non-alcoholic beverages to children;
- (6) to report on implementation of the set of recommendations on the marketing of foods and non-alcoholic beverages to children as part of the report on progress in implementing the global strategy on prevention and control of noncommunicable diseases and the action plan for the global strategy for the prevention and control of noncommunicable diseases to the Sixty-fifth World Health Assembly through the Executive Board at its 130th session.

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

1. Resolution Marketing of food and non-alcoholic beverages to children	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.	6.5 Evidence-based and ethical policies, strategies, recommendations, standards and guidelines developed and technical support provided to Member States with a high or increasing burden of disease or death associated with unhealthy diets and physical inactivity, enabling them to strengthen institutions in order to combat or prevent the public health problems concerned.
(Briefly indicate the linkage with expected results, indicators, targets, baseline)	
The resolution is linked to the above-mentioned expected result together with its indicators, namely, the number of Member States with a multisectoral strategies and plans for healthy diets (indicator 6.5.1) and the number of WHO technical tools that provide support to Member States in promoting healthy diets (indicator 6.5.2). The resolution proposes endorsement of a set of recommendations to reduce the impact of marketing of foods and non-alcoholic beverages to children; it also urges Member States to develop and/or strengthen action to reduce the impact of marketing on children and to monitor the implementation of the recommendations. The resolution requests the Director-General to provide support to Member States in implementing the set of recommendations and in monitoring and evaluating implementation, to support regional networks and cooperate with other international intergovernmental organizations and bodies, civil society and private stakeholders in implementing the recommendations. The resolution also sets out the timing for reporting to the Health Assembly.	
3. Budgetary implications	
(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US\$ 10 000, including staff and activities).	
The life-cycle of this resolution is estimated at 10 years (2010–2019) covering two periods of medium-term strategic plans. The estimated cost to the Secretariat for implementation of the global strategy over the envisaged 10-year period at headquarters, in the regional offices and in relevant country offices is US\$ 10 million. It is further estimated that 55% of this amount can be subsumed within current and future budgets.	

- (b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US\$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).**

A total of US\$ 2 million are needed, of which US\$ 1 million are required for implementing and monitoring the recommendations at the regional and country levels.

- (c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?**

No.

4. Financial implications

- How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?**

Significant efforts will be put into active resource mobilization as one of the priority action areas, particularly at the initial stage of implementation of the resolution.

5. Administrative implications

- (a) Implementation locales (indicate the levels of the Organization at which the work will be undertaken, identifying specific regions where relevant).**

Normative work will largely be performed at headquarters, but implementation and monitoring will also involve the regional offices and relevant country offices.

- (b) Can the resolution be implemented by existing staff? If not, please specify in (c) below.**

No.

- (c) Additional staffing requirements (indicate additional required staff – full-time equivalents – by levels of the Organization, identifying specific regions where relevant and noting necessary skills profile).**

Two additional staff will be required at headquarters, one in the professional category and one in the general service category. An expert in food law with regulation expertise will be required for normative development.

- (d) Time frames (indicate broad time frames for implementation of activities).**

The time frame will be 2010–2019, with reporting linked to the progress report on the global strategy for the prevention and control of noncommunicable diseases and its associated action plan. The first report will be submitted to the Sixty-fifth World Health Assembly through the Executive Board at its 130th session.

Mr PRASAD (India), speaking on behalf of the Member States of the South-East Asia Region, said that the growing health and economic challenges of noncommunicable diseases, such as cardiovascular disease, diabetes, cancers and chronic lung diseases, accounted for an estimated 54% of the 14.7 million annual deaths and nearly half the Region's total disease burden. There was mounting evidence of a progressive socioeconomic divide: in terms of, first, exposure to noncommunicable disease factors and, secondly, access to basic health services by people at risk of, or already suffering from, noncommunicable diseases. Efforts should be made to develop and implement workable, low-cost solutions for prevention and control; to prioritize community-based interventions; and to enhance capacity both inside and outside the health sector. Such efforts would need support from the international community. Unfortunately, official development assistance specifically to support low- and middle-income countries in building sustainable institutional capacity to address noncommunicable diseases remained insignificant.

Availability of cheap and good-quality medicines and diagnostic facilities were crucial in fighting noncommunicable diseases. He therefore requested the Secretariat to help to prepare training modules; to provide support in the drafting of public health laws to incorporate best practices from other countries; to facilitate a reduction in the price of medicines such as insulin; and to help in

facilitating research into new non-toxic medicines. He noted the progress made in implementing the global strategy since 2008 and the efforts made by the Secretariat to underline the importance of noncommunicable diseases in United Nations forums and to link them with the Millennium Development Goals. Those efforts should be continued and the necessary advocacy pursued in order to enable Member States to play an active role when the issue was discussed at the United Nations General Assembly.

Mr JHUGROO (Mauritius) said that the action plan for control and prevention of noncommunicable diseases, adopted in 2008, provided a solid foundation for Member States. In Mauritius, surveys of noncommunicable disease had been carried out every five years, and the most recent, in 2009, had shown that Mauritius continued to have one of the highest rates of diabetes in the world: nearly 24% of the population aged 25–74. Cardiovascular diseases and cancer were also on the rise, and there was a high prevalence of risk factors such as obesity and overweight, lack of physical activity, alcohol and tobacco consumption and unhealthy diet. Measures that had been implemented included: regulation of the amount of saturated fat in cooking oil; increased taxes on tobacco products; systematic screening for breast and cervical cancers in women aged 30–60 years; health promotion and education in the community. In addition, physical activity clubs with late opening hours and school health clubs had been established.

Legislation had included public health regulations on tobacco and alcohol; a ban on soft drinks in all educational establishments; and regulations on the foods sold in school canteens. With further measures also to be implemented, he said that his Government looked forward to continuing support from and collaboration with the Secretariat and to containing the steep rise in noncommunicable diseases. Mauritius had hosted an International Conference on Diabetes and Associated Diseases (Port Louis, 12–14 November 2009), and he thanked the Secretariat for its support.

Mr LARSEN (Norway) said that the burden of noncommunicable diseases was spread over all WHO regions and constituted a major health challenge. However, 80% of the resultant deaths would occur in low- and middle-income countries, further widening the health gaps between and within countries, and would be the main threat to health and development in the coming years. There was a need to better understand how the various risk factors influenced the disease burden and on how to deal with them, with an emphasis on developing countries. Member States needed tools, technical assistance and information. Noncommunicable diseases must be included on the development agenda and, in that regard, the recent adoption by the United Nations General Assembly of resolution 64/265 calling for a high-level meeting on the issue was an important step.

The practice of unhealthy diet, a main risk factor for noncommunicable diseases, was acquired in childhood and worsened throughout life; it should be tackled at an early age. In most parts of the world, prevalence of childhood obesity was increasing rapidly; an estimated more than 42 million children under the age of five were overweight or obese, and nearly 35 million of them lived in developing countries. Globally, food marketing to children was extensive and widespread; mostly it promoted foods with a high content of fat, sugar or salt. As a follow-up to resolution WHA60.23 on prevention and control of noncommunicable diseases, the Secretariat had developed a set of recommendations on the marketing of foods and nonalcoholic beverages to children. The Executive Board at its 126th session in January 2010 had taken note of the recommendations.¹

The set of recommendations was a new and powerful tool; it would guide efforts by Member States to design and strengthen policies on marketing to children. It aimed to reduce the impact of marketing of foods and non-alcoholic beverages high in saturated fats, *trans*-fatty acids, free sugars, or salt. In support of the recommendations, Norway had proposed the draft resolution. Following consultations with Member States, he proposed that the word “all” should be deleted from subparagraph 2(1).

¹ See document EB126/2010/REC/2, summary record of the eighth meeting.

Dr DOGBE (Togo), speaking on behalf of the Member States in the African Region, approved the report. The principal risk factors for noncommunicable diseases were well known; if the use of tobacco, unhealthy diet, a sedentary lifestyle and alcohol abuse were eliminated, at least 80% of all cardiovascular diseases, strokes and diabetes and 40% of cancer cases would be avoided. In the African Region, noncommunicable diseases had not received sufficient attention in public health policies and programmes. Tracking and evaluation mechanisms needed to be established or strengthened in order to assess the effectiveness of actions taken, particularly in the area of disease management.

With the support of the Regional Office for Africa epidemiological surveys had been carried out in 24 of the 46 countries of the Region and cancer registries had been established in four. Based on the results of those surveys, some Member States had begun awareness-raising activities on noncommunicable diseases and to develop control programmes. Initiatives had been undertaken to strengthen the capacities of health systems including training in visual screening for cervical cancer; and a WHO package of measures for the prevention and management of the principal noncommunicable diseases at the primary health care level was being piloted in two Member States.

Efforts continued in the field of health promotion: the WHO Framework Convention on Tobacco Control was being implemented in certain Member States, some of which had already legislated against smoking in public places; awareness-raising campaigns had also been carried out to reduce the harmful use of alcohol. However, all the Member States of the Region faced the major challenge of mobilizing additional resources to maintain institutional capacity and to build capacity in research and health promotion.

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

The meeting rose at 21:05.

EIGHTH MEETING

Thursday, 20 May 2010, at 9:15

Chairman: Dr M. MUGITANI (Japan)

later: Mr U. SCHOLTEN (Germany)

1. THIRD REPORT OF COMMITTEE A (Document A63/63)

Dr MISHRA (India), Rapporteur, read out the draft third report of Committee A.

The report was adopted.¹

Mr Scholten took the Chair.

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

Strategies to reduce the harmful use of alcohol: Item 11.10 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R11, and A63/13)

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. She wholeheartedly supported the text contained in resolution EB126.R11. The Board had recommended the adoption of a draft global strategy to reduce the harmful use of alcohol and she urged all Member States to support the draft resolution in the wording in which it was presented.

The draft global strategy would contribute to a healthier world. The harmful use of alcohol was the world's third leading risk factor for premature death and disability and consequently a major challenge to global health, with significant repercussions on social and human development. She also supported the objectives and guiding principles contained in the draft strategy.

The policy options for Member States were sufficiently flexible to take account of national and regional differences and the specificities of the different parties concerned while placing overall emphasis on public health. She welcomed the focus on the need to overcome social disparities within and between countries; the guiding principles aimed at reducing the harmful use of alcohol; and the highlighting of the consequences, such as domestic violence against women and children. She confirmed that the draft global strategy corresponded to the best practices identified in the European Union's strategy on alcohol adopted in 2006 and reflected in the conclusions unanimously adopted by European Union health ministers in December 2009. She stressed effective monitoring of implementation. A global strategy was the first step in reaching an agreement on objectives and on how to move forward. Invaluable guidance was contained in the draft global strategy to support the implementation through effective intersectoral policies at all levels. Comparative information on

¹ See page 321.

consumption, harmful effects and on the implementation of policies would be needed in order to measure progress; it was therefore important for WHO to continue to develop global information systems and thus contribute to a better understanding of the repercussions of the harmful use of alcohol and how to limit them.

Mr PINO ALVAREZ (Cuba), expressing Cuba's support for the draft resolution, said that reducing the harmful use of alcohol was especially important considering the possible effects on human health and society. Cuba had been active in the formulation of the draft global strategy, drawing on experience of implementing a national policy on alcohol abuse: therefore, a comprehensive education policy was essential. He urged all Member States to focus on education when formulating their national policies on alcohol abuse. The Executive Board had reached a firm consensus on the draft global strategy and relevant resolution, demonstrating the flexibility and commitment of the many Member States that had participated in the negotiations and the considerable efforts of the Secretariat in developing the draft resolution, which he commended for rapid adoption by the Health Assembly.

Dr BLOOMFIELD (New Zealand) said that the harmful use of alcohol was a global public health concern and he commended the Member States and the Secretariat for having developed a balanced, non-prescriptive strategy that would become an important instrument for global public health. Effective implementation would need the continued support of the many stakeholders involved in developing the strategy. That would require commitment and resources and he encouraged Member States to consider how they could best contribute to the effort. He supported the draft global strategy and the draft resolution.

Mr MENESES GONZÁLEZ (Mexico) supported the draft global strategy and was confident of its effective basis for establishing national policies for alcohol abuse. His Government was elaborating a national strategy; developing policies to protect the health of the most vulnerable groups; and encouraging changes in cultural attitudes and behaviours towards healthy lifestyles. Based on the scientific evidence available, Mexico would adopt best practices in the formulation of its policies for prevention, promotion and intervention to combat the harmful use of alcohol.

Ms BLACK (Canada) said that Canada had actively participated in the negotiations leading to the draft global strategy, which it supported; Canada also commended the efforts of the Secretariat.

Mrs SMIRNOVA (Russian Federation) commended the Secretariat on the quality of the draft global strategy, which was based on best practices drawn from the Member States. Alcohol abuse had an impact on morbidity and mortality worldwide and was also the cause of many diseases, accidents and other problems. Her Government had formulated a national policy that provided for measures to reduce alcohol consumption and in particular beer consumption. It included commercial measures to regulate the sale and consumption of alcohol; social measures; and programmes to encourage and promote the adoption of healthy lifestyles, sport and exercise. All formed part of a single, wider strategy to promote a healthier society.

Dr RAMSAMMY (Guyana), speaking on behalf of the member countries of the Caribbean Community, welcomed the progress made on the draft global strategy. Caribbean Community members had taken action at the national and regional levels. At the national level, measures included policies to ensure consistency between public health policy goals and intervention measures; delivering public education and programmes to change behaviour, in order to raise awareness among young people and vulnerable groups about the dangers of alcohol misuse; enhanced campaigns and penalties to prevent drink-driving that also included breathalyser legislation.

At the regional level, he recalled the adoption of the Port-of-Spain Declaration (2007), entitled "Uniting to stop the epidemic of chronic noncommunicable diseases", which called for coordinated

policy approaches by regional institutions with respect to noncommunicable diseases, many of which had alcohol as a causal factor. All stakeholders, civil society, economic operators, the broader private sector, regional and international organizations were involved. Self-regulation and co-regulation bodies had also been established with new codes of practice for the marketing, advertising and promotion of alcohol. The member countries of the Caribbean Community unequivocally supported the draft global strategy and he urged the Health Assembly to support the resolution without amendment.

Dr BIRINTANYA (Burundi), speaking on behalf of the 46 Member States of the African Region, said that the numerous health problems related to the harmful use of alcohol posed a major obstacle to the achievement of the Millennium Development Goals. Within the African Region, the detrimental effects of alcohol abuse were much more prevalent in the sub-Saharan area, with 2.2% of deaths and 2.5% of disability-adjusted life years attributable to alcohol. Recent studies had shown that, in the African Region overall, the prevalence of alcohol-related mortality was rising. Evidence indicated that the harmful effects of alcohol were a causal factor in diseases such as tuberculosis, pneumonia, tuberculosis/HIV coinfection and other communicable and noncommunicable diseases. The situation was being exacerbated by intensive advertising, sponsored by alcohol producers, which encouraged the harmful use of alcohol and undermined policies and initiatives to reduce alcohol misuse.

Member States had participated in consultations to strengthen strategies at the international and regional levels. The Regional Committee for Africa at its fifty-eighth session had adopted document AFR/RC58/3 on measures to reduce the harmful use of alcohol and the African Region would also shortly be considering its own regional strategy. In that connection, he requested the Secretariat to pay particular attention to less developed countries in general and to Africa in particular, with respect to information and awareness-raising campaigns, capacity building and technical support when required; establishing databases and appropriate regulatory mechanisms; and prohibiting or restricting the marketing of alcohol. He commended the draft resolution for adoption by the Health Assembly.

Dr GÜRSÖZ (Turkey) said that the serious public health threat posed by alcohol abuse necessitated effective policies to reduce alcohol consumption, through strengthened global and regional information systems, stakeholder cooperation, attention to specific national and cultural aspects; adolescents in particular should be informed about the potentially harmful effects to health and the social consequences.

He drew attention to the positive results achieved by WHO in reducing tobacco consumption following years of persistent efforts and said that, if the Organization were to implement similar measures to overcome the challenge of alcohol consumption, those would be equally successful. WHO was on the brink of a breakthrough in finding effective ways to combat a serious public health threat: the draft global strategy should guide the preparation of successful country programmes and action plans. Member States would look forward to the Director-General's biennial reports on progress in reducing the harmful use of alcohol. He fully supported the draft resolution.

Dr KHADRA (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the harmful use of alcohol had implications for the individuals concerned, their families, friends and society as a whole. It incurred varied health problems, including cardiovascular disease and hepatitis, and led to low productivity in the workplace. Religion and culture were influences on the consumption of alcohol, which was tending to increase among young people. Efforts to reduce consumption should include education and awareness-raising rather than only legislative measures. He welcomed the Secretariat's wide consultations in preparing the draft global strategy and recalled that regional consultations had been held in Cairo in April 2009. No single strategy could be equally effective in all countries in view of differences in religious and cultural contexts, financial resources and international commitments. Member States should implement policies appropriate to their own circumstances. However, steps taken to promote safer consumption

should provide for some control on marketing and sales. The draft resolution could further strengthen efforts made to reduce the harmful use of alcohol.

Professor BISHOP (Australia) said that the text of the draft global strategy was the product of a transparent process. It provided a balanced and evidence-based package of public health measures for Member States to consider in developing their own national and regional strategies to reduce the harmful use of alcohol, and should be adopted without further amendment.

Dr XIAO Donglou (China), thanking the Secretariat for its efforts to draw up the draft global strategy to reduce the harmful use of alcohol, noted that China had been actively involved in the consultations. The report provided an objective and comprehensive analysis of the challenges and opportunities. China agreed with the objectives of the draft global strategy and with the policy options and interventions aimed at reducing the harmful use of alcohol. Strategic interventions should be tailored to the specific circumstances of each country, and he was pleased to note that technical support would be provided to low- and middle-income countries.

His Government was in favour of stronger enforcement of legislative measures to reduce drink-driving. It would welcome the control or prohibition of marketing of alcoholic beverages to children and young people, as well as efforts to reduce the illegal and informal production of alcohol. It attached great importance to reducing the harmful use of alcohol and had published a series of regulations on alcohol control, in particular regarding sale and circulation, in order to ensure effective policy implementation. China would further strengthen the surveillance of alcohol consumption and its effects. It would provide WHO with relevant information and increase exchanges of experience in order to achieve the aims and objectives of the global strategy.

Mrs REITENBACH (Germany) said that the harmful and hazardous consumption of alcohol had a major impact on the health of the population, and generated considerable costs, not only for health systems but for the economy as a whole. The reduction of alcohol-related harm played an essential role in Germany's policies on drugs and addiction. Attention must be focused on risk groups and those who indulged in harmful alcohol use, in particular young people.

She welcomed the draft global strategy and commended the comprehensive consultation process that had taken place. As highlighted in the strategy, States must observe their own national, religious and cultural characteristics to ensure acceptance of the measures introduced. Significant measures outlined in the strategy had already been implemented in her country. She highlighted the importance of effective measures that targeted education and prevention and emphasized support for the initiative to expand and strengthen community action. Local networks for alcohol prevention could provide a crucial means of access to young people at risk of harmful alcohol consumption.

Mr PUJOLS (Dominican Republic) expressed full support for the draft resolution and the draft global strategy, which set out clear options to meet concerns associated with the harmful use of alcohol. The draft global strategy had been analysed fully by the Executive Board at its session in January as part of a transparent process that sought to achieve consensus and should be approved without change. The Secretariat was to be commended for its collaborative efforts throughout the process.

Professor FREEMAN (South Africa) said that the negative consequences of alcohol misuse had been ignored for too long. In his country, a recent behaviour survey had shown that 29% of high-school students had engaged in binge drinking the previous month, an increase of 6% in six years. Noting that the disease burden from harmful use of alcohol was increasing, he said that South Africa had the highest recorded prevalence of fetal alcohol syndrome. An indisputable link also existed between drinking and involvement in high-risk sexual behaviour, and action must be taken on the important risk factors for infection with HIV. He welcomed the stewardship shown by WHO on the issue and supported the immediate adoption of the global strategy.

Dr KANOKWAROON WATANANIRUN (Thailand), speaking on behalf of the Member States of the South-East Asia Region, commended all those who had been involved in the development of the draft global strategy. Annex 1 of the report, concerning the effectiveness of interventions to reduce harmful use of alcohol, confirmed that price and taxation, control of the physical availability of alcohol, random breath-testing and a regulatory framework to control marketing were among the most cost-effective approaches.

Education programmes, irrespective of how well they were designed, performed poorly. However, the alcohol industry tried to convince policy-making bodies not to use effective interventions, but to use education programmes and a system of self-regulation. That was an approach that protected business interests to the detriment of the public. Subparagraph 45(d) of the draft global strategy, which referred to self-regulatory actions and initiatives as effective ways to prevent and reduce harmful use of alcohol, might send a wrong signal to Member States, and she requested clarification of the evidence for the approach advocated in that subparagraph.

She requested the Secretariat to review the structures in place in WHO and the resources used to manage effectively the problems associated with the harmful use of alcohol. She had calculated that, in terms of morbidity and mortality, WHO spent about nine to eleven times less on alcohol-related problems than on other conditions. Despite the fact that it was one of the leading global health risks, the harmful use of alcohol appeared to be a neglected problem in WHO. She called for a sincere commitment from WHO to evidence-based decisions for resource allocation; adequate human and financial resources for alcohol-related issues would be concrete proof of that commitment. She suggested that alcohol-related health problems should be made the subject of World Health Day in 2012.

The impact of globalization was increasingly evident in low- and middle-income countries. While freer markets brought lower prices, greater availability and powerful marketing practices, the draft strategy did not adequately address the impact of free trade agreements on alcohol-related harm. She supported the draft resolution, but suggested that the words “and ensure the adequate support of financial and human resources at all levels” should be inserted after “to give sufficiently high organizational priority” in subparagraph 4(1).

Mr ADAM (Israel) said that the harmful use of alcohol had a serious effect on public health and on young people in particular. The Secretariat and Member States faced a major challenge in reducing the harmful use of alcohol, and he commended the efforts of the Secretariat in developing the text before the Committee. Israel was implementing a recently adopted strategy to reduce the harmful use of alcohol, which was consistent with the draft global strategy. He supported the draft resolution and the draft global strategy, which would begin a global process for awareness-raising and action.

Mr JHUGROO (Mauritius) said that the harmful use of alcohol constituted an increasing public health problem in his country where more than 19% of adult males and 2% of adult females were heavy drinkers. Mauritius had adopted a dual strategy of primary prevention and legislation that included an intensive campaign of health education in health centres, the workplace and schools. Statistics showed that consumption of alcoholic drinks had fallen significantly since regulations to ban the advertising, promotion and sponsorship of alcohol had entered into force in March 2009. His country’s experience suggested that regulation was more effective than awareness-raising. Noting that the alcohol lobby in his country was strong and found ways to circumvent the regulatory framework, he said that his Government would formulate a comprehensive action plan to reduce the harmful use of alcohol. Mauritius fully supported the draft resolution.

Mr BULL (Norway) said that alcohol was one of the main risk factors for disease across all regions, and contributed to somatic diseases, accidents and problems related to mental health as well as social problems. Some of the most effective policy options outlined in the global strategy were structural measures. Such measures could be very cost-effective but also more challenging politically given the potential conflict of interests involved. However, as the burden of noncommunicable

diseases was likely to increase in the future, those political challenges would have to be addressed by the international health community. Norway had already used structural measures, such as excise duties and regulation of accessibility, and those health effects could be seen on the level of alcohol-related diseases in his country. International cooperation, in particular on lifestyle issues, was increasingly important. The European Union's alcohol strategy had highlighted the importance of comparative information for measuring progress made; comparative instruments should therefore be developed to facilitate implementation of the global strategy. He thanked all those involved for their efforts to reach common ground on the draft global strategy.

Dr INNIS (Barbados) said that harmful use of alcohol was a major contributor to the global burden of disease. The draft global strategy, which he welcomed, provided Member States with varied policy options and interventions that could be implemented according to national circumstances. It recognized that developing countries required technical support to establish and strengthen national policies and infrastructures for the prevention of harmful use of alcohol, and made provision for the Secretariat to offer various kinds of support for that purpose. He looked forward to the adoption of the draft resolution and of the draft global strategy.

Mr HOHMAN (United States of America) expressed support for the draft global strategy and the draft resolution, which he hoped would be adopted without change. He commended the work done on the issue by the Executive Board, and in particular by the co-chairs of the drafting group.

Dr AL OUUFFI (Bahrain) said that the harmful use of alcohol posed considerable economic, social and health challenges for societies. In his country, drink-driving was an offence and the production of alcohol was regulated. Free medical and health services were provided for those with alcohol-related problems and specialized units existed for rehabilitation. Awareness-raising initiatives were also undertaken in schools. Bahrain would cooperate closely with the Secretariat in order to achieve the aims and objectives of the draft global strategy, and looked forward to its adoption.

Mr AL-TAAE (Iraq) said that, although alcohol consumption was not a problem in Iraq, his country still took preventive measures, consolidated within primary health care and control of noncommunicable disease to combat the misuse of drugs and tobacco. WHO was called upon to address such issues within the framework of its activities to strengthen health and promote healthy lifestyles, and enhance the capacity of individuals and institutions to achieve sustainable social development.

Dr AL HAMAD (Kuwait) expressed support for the draft global strategy. She drew attention to the importance of social mobilization and the concept of common responsibility in dealing with the mental, physical, social and economic effects of the harmful use of alcohol. Strategies developed must take into account social factors, including religious beliefs.

Professor ADITAMA (Indonesia) said that increased alcohol consumption among young people was a concern and legal frameworks would be important in restricting the sale and distribution of alcohol. The education and information programmes included in the draft global strategy were essential to raise awareness of the risks, promote effective interventions and to mobilize public opinion in favour of effective alcohol policies.

Ms RAO (India), emphasizing the serious effects of the harmful use of alcohol on public health, said that the age of initiation of alcohol consumption in her country had dropped significantly over the previous 20 years; that was a concern given the current demographic profile. In collaboration with state, national and international partners, strategies were needed that focused on: health promotion; prevention through education; health impacts and treatment; and availability of alcohol. Further, awareness of the harmful use of alcohol should be raised in the media and among community leaders.

Like most countries, India did not have national legislation on the reduction of harmful use of alcohol other than in the areas of drink-driving and advertising. Moreover, practices such as surrogate advertising were being employed to circumvent attempts to ban the direct advertising of alcohol. Regarding paragraph 27 under Area 5 of the draft global strategy, the degree of regulation of alcohol availability at state level would depend on existing international obligations. A comprehensive global response was needed and WHO should therefore consider replicating the model used in achieving consensus to combat tobacco use, namely the WHO Framework Convention on Tobacco Control. She commended the Secretariat on its work in developing the draft global strategy.

Dr GAMARRA (Paraguay), recognizing the many health risks of harmful use of alcohol, commended the work undertaken in developing the draft global strategy and supported the draft resolution. Traffic accidents were a major cause of mortality in the 15–39 year age group and were frequently linked to alcohol use. A global strategy would facilitate the elaboration of national plans and mobilization of resources and would carry greater weight through its adoption by consensus by an international organization.

Dr SEAKGOSING (Botswana), commending the Secretariat's comprehensive report, said that his Government was committed to reducing the harmful use of alcohol through a multisectoral approach. It had launched a national alcohol campaign in 2009 and had introduced a 30% alcohol levy to raise campaign funds related to public education with emphasis on youth; rehabilitation; law enforcement; and restrictions on advertising in relation to sports. A national alcohol policy would be approved in 2010 and public education would continue in areas such as road safety and the consequences of alcohol consumption. Legislation would regulate traditional brews for commercial use and prohibit illicit brewing; traffic legislation would provide for stiffer penalties; and the alcohol industry was being more tightly regulated. The Head of State was committed to the national campaign against alcohol abuse, and activities were specially coordinated within the Ministry of Health. Botswana supported the draft resolution.

Dr NDYANABANGI (Uganda) said that, in 2006, WHO had listed Uganda as the Member State with the highest per capita consumption of alcohol. Informal production of alcohol was a major challenge and had recently resulted in 80 deaths in a two-week period. Uganda therefore welcomed the draft global strategy and urged its adoption and implementation. Uganda was developing a multisectoral policy related to the use of alcohol with a view to strengthening legislation, which was already consistent with the draft global strategy. Uganda requested WHO to provide technical and financial support to developing countries to ensure successful implementation of the strategy.

Dr TAKEI (Japan), expressing support for the draft global strategy, paid tribute to the work done by the Executive Board and the Secretariat. It was important to take into account social and cultural differences between countries in the elaboration of evidence-based and cost-effective national policies to implement the strategy. Japan's health strategy for the twenty-first century incorporated a multisectoral approach to the harmful use of alcohol.

Mr DE ALBUQUERQUE E SILVA (Brazil) supported the draft global strategy, which had resulted from difficult concessions and compromises and represented a significant breakthrough. Implementation would therefore require increased dialogue and understanding. In the context of the serious public health effects of the harmful use of alcohol, adoption of the draft global strategy would be most timely. Brazil therefore supported the draft resolution.

Dr UGARTE UBILLUZ (Peru) said that consumption of alcohol was a serious public health problem in Peru; 10% of the adult population exhibited some degree of dependence on alcohol, and consumption was rising among young people and women. Regulation was needed to curb aggressive advertising of alcoholic drinks. Peru would strengthen legislation to control the illegal production of

alcoholic drinks using toxic colouring, and methyl and industrial alcohol. It was also promoting healthy lifestyles and expanding measures to reduce traffic accidents. He therefore urged support for the draft resolution.

Mr WATERBERG (Suriname) said that a recent survey showed that many children in Suriname started consuming alcohol from the age of 12 or even younger. Traffic accidents related to alcohol use were also a major problem. Suriname therefore supported the draft resolution.

Dr MONDESIR (Saint Lucia) said that harmful use of alcohol increased the burden of noncommunicable disease and the number of traffic accidents; it was a leading cause of death in Saint Lucia. The cost to families and the financial implications for the social and health sectors were considerable. He supported the draft resolution and endorsed the recommendation that interventions in the implementation of the global strategy should be tailored to national circumstances.

Professor ANONGBA DANHO (Côte d'Ivoire) said that the production, sale, distribution and consumption of alcohol in his country had been regulated since 1964. The legislation sought to strike a balance between a dynamic industrial and economic activity and the need to protect consumers from toxicity and harmful use, with a special focus on young people. However, public health considerations conflicted with economic interests and with the cultural practices and demands of social groups. He commended WHO's action, welcomed the support for national public health policies recommended in the draft global strategy, and supported the draft resolution.

Dr Shu-Ti CHIOU (Chinese Taipei) endorsed the draft global strategy and the draft resolution. Outlining the legislation in Chinese Taipei aimed at controlling the harmful use of alcohol, she said that alcohol sales were prohibited from outlets where buyer identification was not possible, such as vending machines, or by mail and electronic order. Underage drinking and drink-driving were also offences and penalised.

New legislation was being aligned with the draft global strategy to regulate advertising, impose tax levies and require labelling for health warnings. The capacity of health services to implement and monitor interventions would be strengthened. The public health sector was collaborating with other government departments and nongovernmental organizations to raise public awareness about drink-driving, and community development projects were being conducted in aboriginal communities. Chinese Taipei looked forward to further international collaboration in technical meetings, to implementing the strategy and to countering challenges from groups with vested interests.

Dr CHEN (World Medical Association), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance (comprising the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association), welcomed the draft global strategy that should contribute to the global goal of reducing the harmful use of alcohol and urged its adoption by the Health Assembly. However, it should give greater attention to the role of health professionals, since that was pivotal in terms of education, advocacy and research as well as in the prevention and treatment of the harmful use of alcohol. As indicated by the delegate of Thailand, limits should be placed on the role of parties with a vested interest in the production and sale of alcohol and alcoholic products, so that policies and programmes at all levels were developed on the basis of public health interests, independent of commercial influence. Member States were urged to ensure the allocation of adequate resources for implementation of the global strategy, in particular in low- and middle-income countries with high or rising alcohol consumption.

Mr KADURU (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the medical student members of the Federation, like other young people, were affected by the harmful use of alcohol and believed that an effective global

strategy would reduce that burden. Of the total number of years lived with disability attributable to alcohol, 34% were experienced by persons aged 15–29 years and 31% by those aged 30–44 years, compared with 22% by those aged 45–59 years. Harmful use of alcohol also made a significant contribution to violence and unprotected sex among young people. Effective public health strategies to reduce harmful use of alcohol should take into account cultural and religious values and avoid the influence of manipulative marketing practices on the part of the alcohol industry; the draft global strategy should indicate ways of protecting young people from such practices. Medical school curricula should be reviewed to ensure the inclusion of problems caused by the harmful use of alcohol. He urged the adoption and effective implementation of the draft global strategy.

Mr HACKER (CMC – Churches' Action for Health) speaking at the invitation of the CHAIRMAN, said that his organization was collaborating with the Global Alcohol Policy Alliance, an international coalition of nongovernmental organizations, and with WHO and governments to reduce the harm from alcohol use. The draft global strategy was based on strong evidence in relation to pricing, availability and marketing of alcoholic beverages. It recognized the important role of civil society in creating political will, and acknowledged the need for health-sector leadership within a multisectoral approach. He urged Member States to adopt the draft global strategy.

Dr ALWAN (Assistant Director-General) thanked delegates for their support and commended the commitment, constructive collaboration and flexibility shown by the Board members during consideration of the draft global strategy at the 126th session of the Executive Board. He agreed with the delegate of Brazil that the successful outcome represented a breakthrough after two years of negotiation. He agreed with the delegate of Spain that it was vital to upgrade information; the Secretariat would continue to maintain and strengthen the global information system on alcohol and health. Regional information systems had also been developed in four WHO regions in the previous two years. Furthermore, indicators on alcohol and health had been included in the core indicators for monitoring and surveillance of noncommunicable diseases. The Secretariat was currently finalizing the first report on the global status of noncommunicable diseases, which would contain information on alcohol and health. As mentioned by the delegate of Burundi, effective implementation would be a considerable challenge. Headquarters and the regional offices would make every effort to mobilize sufficient resources to strengthen support for Member States. He had noted the recommendation made by Thailand that increased resources should be found for the alcohol and health programme within WHO. However, assessed contributions currently provided only one fifth of the overall budget allocations and it was becoming increasingly difficult to fund new programmes. Nevertheless, steps would be taken to mobilize extrabudgetary resources for that programme and for the prevention and control of noncommunicable diseases. Adoption of the draft global strategy should encourage donors.

The CHAIRMAN asked the Secretary to read out the proposed amendments to the text recommended by the Board in resolution EB126.R11.

Ms VESTAL (Assistant Secretary) said that the delegate of Thailand had proposed that paragraph 4(1) should be amended by inserting the words “and ensure the adequate support of financial and human resources at all levels” after the word “priority”.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA63.13.

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3) (continued from the sixth meeting, section 2)

Mr DE ALBUQUERQUE E SILVA (Brazil), supported by Mr ARSLAN (Bangladesh), requested that discussion of the agenda item be postponed to the ninth meeting of Committee A as informal consultations on the issue were continuing.

Professor ORHII (Nigeria) said that more time for further discussions was needed, so that the Member States of the African Region could consolidate their position on the issue.

Professor JOOMA (Pakistan), speaking on behalf of the Member States of the Eastern Mediterranean Region, and emphasizing a focus on protecting people's health, said that it was important to agree on a definition for the term "counterfeit" and to distinguish between substandard, spurious and falsified medicines and those considered counterfeit from an intellectual property perspective.

It was vital that the International Medical Products Anti-counterfeiting Taskforce should work within the scope of an intergovernmental mandate. The Taskforce played a major role in ensuring the quality and efficacy of medical products and national drug regulatory authorities should be strengthened with the help of WHO. Furthermore, WHO should not be party to commercial interests; the intense competition between innovators and generic companies in the pharmaceutical marketplace should not be discussed at the international level as it was a matter for quality laboratories and standard-setting bodies.

He proposed that an intergovernmental working group should be established to consider and resolve the contentious issues.

Professor ORHII (Nigeria) said that the concerns of the Member States of the African Region were related to the effects of counterfeit medicines on public health, rather than to patents and definitions of the term "counterfeit": there were no manufacturers of brand or generic products in the Region. A strong framework within WHO was required to prevent counterfeiting of medicines, especially in the case of Member States in the African Region, where existing systems were weak. Therefore, further regional discussions were required.

The CHAIRMAN suggested that discussion of the issue should be postponed to the ninth meeting of Committee A.

It was so agreed.

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

Prevention and control of noncommunicable diseases: implementation of the global strategy: Item 11.9 of the Agenda (Document A63/12) (continued from seventh meeting, section 3)

The CHAIRMAN drew attention to a draft resolution on the marketing of food and non-alcoholic beverages to children, proposed by the delegate of Norway, which had been introduced at the previous meeting.

Mr KOVALEVSKIJ (Russian Federation), expressing support for the draft resolution, emphasized that prevention of noncommunicable diseases could only be achieved through targeting of individual population groups.

Research had shown the link between poor or unhealthy working conditions and the prevention and control of noncommunicable diseases. Therefore, synergy was required between the global plan of action on workers' health and the action plan to implement the global strategy for the prevention and

control of noncommunicable diseases. Cooperation was necessary to introduce international and national measures for occupational health and safety services, access to which was enjoyed by few workers throughout the world. He would have liked to see mention made of specific types of noncommunicable diseases, such as occupational diseases, in the section of the Secretariat's report on obstacles to implementation. Occupational diseases should be included on the agenda for discussion at future conventions on noncommunicable diseases.

Mr AL-TAAE (Iraq) said that programmes for the early detection of hypertension and diabetes mellitus had been introduced in primary health care centres throughout his country. Future planning included greater integration of primary health care centres with secondary and tertiary care centres and the consolidation of the patient referral system. The establishment of eye care centres in the community had improved primary eye care throughout the country; and mental health care had been included within primary health care.

Efforts related to the fulfilment of Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) in Iraq had focused on the integration of surveillance systems for communicable disease with those for noncommunicable diseases. Activities related to cancer, including prevention, early detection and care, had also been strengthened. The Secretariat should assist Member States in capacity building and research into the control of risk factors for noncommunicable diseases.

Dr GOUYA (Islamic Republic of Iran) said that policies on noncommunicable disease should not divert attention from the prevention and control of communicable diseases. They should focus on reducing the risk to the population as a whole, as well as individual susceptibility.

Risk factor surveillance had been established in his country six years earlier: it covered individuals between the ages of 15 and 64 years and monitored risk factors such as obesity, smoking and physical activity. Comprehensive programmes for health promotion, patient care and the prevention of the most common noncommunicable diseases, such as cardiovascular diseases, hypertension, diabetes mellitus and cancer, had also been implemented.

Dr ABUDHER (Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean Region, commended the efforts of the Director-General, particularly in relation to the adoption of United Nations General Assembly resolution 64/265 on the prevention and control of noncommunicable diseases. WHO was playing a leading role on the issue and the adoption of that resolution would bolster political commitment and establish a link between the Millennium Development Goals and the control and prevention of noncommunicable diseases.

The incidence of noncommunicable diseases, such as cardiovascular diseases, diabetes mellitus and cancer, was increasing rapidly in the Region, mainly as a result of changes in lifestyle and social and economic conditions. Noncommunicable diseases currently accounted for 50% of the disease burden in the Region, and that figure was expected to rise to 60% by 2020. In addition to the challenges associated with globalization, such as changes in dietary habits and an increasingly sedentary lifestyle, many countries in the Region also faced destabilization, occupation and war.

In February 2008, health ministers from the 11 Member States of the Region had committed themselves to reducing the incidence of noncommunicable diseases by 2% each year. Furthermore, a ministerial meeting on noncommunicable diseases held in Doha in May 2009 had endorsed an initiative to integrate evidence-based indicators for noncommunicable diseases into the monitoring and evaluation of achievement of the Millennium Development Goals in 2010. At the fifty-sixth session of the Regional Committee for the Eastern Mediterranean in October 2009, a regional strategy for cancer control had been adopted.

He emphasized that any efforts to reduce the burden of noncommunicable diseases would need the integration of programmes into primary health care systems together with the involvement of the private sector and civil society.

Dr IMAMEGIOĞLU (Turkey) commended the report and progress achieved in the implementation of the global strategy for the prevention and control of noncommunicable diseases, particularly with regard to raising the priority accorded to those diseases under objective 1 of the action plan. The adoption of United Nations General Assembly resolution 64/265 on the issue would play a vital role in reducing the burden of noncommunicable diseases in the world.

The health-care agenda in Turkey had shifted towards noncommunicable diseases as a result of the socioeconomic and lifestyle changes, and the ageing of the population. A central objective of the strategic plan for the period 2010–2014 was the reduction of costs related to the treatment of noncommunicable diseases through early diagnosis, effective treatment and improved management.

He expressed support for the report's recommendations on the marketing of food and non-alcoholic beverages to children, which were in line with the valuable European Charter on Counteracting Obesity and Turkey's own programme for obesity and control. Childhood obesity was an emerging epidemic that would contribute significantly to the burden of ill health unless appropriate remedial steps were taken. He supported the draft resolution.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The recent dramatic increase in preventable noncommunicable diseases called for strong political commitment and effective implementation of the action plan for the global strategy at all levels. The European Union welcomed the first Forum of the Global Noncommunicable Disease Network held on 24 February 2010 and the General Assembly's decision to convene a high-level Summit in September 2011 on the prevention and control of noncommunicable diseases.

She welcomed the high priority attached by WHO to the issue of the marketing of unhealthy foods and non-alcoholic beverages to children. The European Union had already established directives relating to unfair commercial practices and audiovisual media services; those aimed to develop codes of conduct in relation to inappropriate commercial communication aimed at children. Member States should give high priority to the challenges, and the relevant initiatives must be properly monitored and evaluated. Strategies and mechanisms should address the key determinants of the issue, including lifestyle and underlying social and environmental factors. Close interaction with the findings and initiatives set out in the report of the Commission on Social Determinants of Health was a prerequisite for progress.

A cross-sectoral approach was needed to reduce the burden of disease and premature death. It must not be left to the health sector alone. Public health considerations must be integrated into all relevant policies. WHO must do more to strengthen sustainable health systems, particularly in developing countries and based on responsible leadership; universal coverage; "health in all" policies; fair financing; and a focus on primary health care centred on the patient. Health systems should meet the needs of the large population groups that were either suffering from noncommunicable diseases or were at risk of contracting such diseases in the future. The elderly needed special attention in order to ensure healthy ageing. The European Union sought to further contribute to the universal coverage of basic and quality health care through comprehensive health systems. It would also enhance its role in global health through increasing the coherence of external and internal policies for universal and equitable coverage of health services.

As the report emphasized, the provision of technical support to Member States for capacity building was essential for the success of the initiative. The European Union considered that capacity building was one of WHO's most important tasks for the coming years.

The Director-General should strongly support actions designed to prevent and control noncommunicable diseases by promoting health, addressing risk factors, and strengthening health systems. Allocation of sufficient resources in future budgets should reflect the magnitude of the disease burden represented by noncommunicable diseases.

Professor ADITAMA (Indonesia) said that, like other developing countries, Indonesia faced a triple burden in health care with prevalence of existing communicable diseases; increasing prevalence of noncommunicable diseases; and emerging infectious diseases. In the area of noncommunicable diseases, the main causes of mortality in Indonesia were cardiovascular disease. In 2007 the Minister of Health had established a specific directorate for cardiovascular disease, cancer, endocrine and metabolic diseases and chronic degenerative problems, including common risk factors, and trauma and accidents. Indonesia would actively participate in the monitoring and evaluation of the global strategy for the prevention and control of noncommunicable diseases, with the support of WHO and the international community.

Dr BALACHANDRAN (Malaysia) said that, in line with WHO mandates, his country had strengthened its prevention and control of noncommunicable disease through implementation of its national strategic plan. Much more remained to be done and Member States should continue to prioritize the issue in their national and political agendas.

Professor BISHOP (Australia) said that prevention programmes should address the determinants of noncommunicable disease, especially tobacco control, hypertension and cholesterol control. Chronic noncommunicable diseases, especially cancer, cardiovascular disease, mental ill health, respiratory diseases and diabetes represented a major challenge for Australia's health and hospital system and were responsible for more than 80% of the burden of disease and injury in the country. In response, his Government was making significant reforms to its health system.

Smoking was a leading cause of preventable death and disease and his Government had announced new measures that included a 25% increase in tobacco excise; the introduction of plain packaging of tobacco products from 1 January 2012; restrictions on advertising on the Internet; and significant funding for campaigns targeted at the members of disadvantaged groups in particular. Those measures supplemented existing bans on advertising, bans in restaurants and bars, and restrictions at point of sale. Australia looked forward to sharing lessons learnt in dealing with noncommunicable diseases through WHO mechanisms, such as the Global Noncommunicable Disease Network.

Dr GEHRMANN (Germany) said that global health could not be improved without addressing the health problems associated with noncommunicable diseases. Germany welcomed the emphasis placed on the prevention of irresponsible marketing of foods and non-alcoholic beverages to children under the age of 12, and the corresponding recommendations set out in the Annex to the report. Germany's health ministry was working on a code of conduct in cooperation with ministries of food, agriculture and consumer protection, economics and technology and industry. Food marketing should be restricted according to age and not according to ingredients, since it was more difficult for young children to resist commercial incentives than it was for adolescents and adults. The engagement of parents together with nursery and elementary schools all played an important role in nutrition and health education from an early age and the promotion of healthy lifestyles for children and adolescents, including healthy diets and physical activity.

Dr PHILIPS (Trinidad and Tobago) wished to place on record his Government's commitment to according the highest priority to the prevention and control of noncommunicable diseases. His country had tabled a resolution on behalf of the member countries of the Caribbean Community on the convening of a high-level meeting of the United Nations General Assembly with the participation of Heads of State and Government in September 2011. The United Nations General Assembly had adopted resolution 64/265 at its meeting on 13 May 2010. That had been a historic moment signalling the intention of the international community to accord high priority to a problem that threatened to undermine the development goals of all Member States.

Trinidad and Tobago had taken legislative measures on tobacco control and drink-driving. During the past six years, taxes on alcohol and tobacco had been increased periodically.

Noncommunicable diseases were rapidly becoming a major health challenge for all countries, especially small island developing States, with potentially catastrophic social and economic consequences. Noncommunicable diseases accounted for more than 60% of all deaths globally and 70% in the countries of the Caribbean Community. The case for action, through integrated multisectoral approaches to prevention and control, was compelling. National programmes must be based on evidence, and noncommunicable disease progress indicators should be integrated in the Millennium Development Goals. International cooperation programmes should strengthen and harmonize data collection systems at the national, regional and international levels.

Welcoming the recent adoption of the United Nations General Assembly resolution 64/265, he urged Member States to lend support to the resolution under consideration. With commitment and consistency of purpose, the international community could roll back the pervasive prevalence of noncommunicable diseases.

Dr PUSKA (Finland) emphasized that the burden of global noncommunicable disease represented an important threat to public health and had damaging social and economic impact. However, under the WHO global strategy, prevention was possible. He urged concerted action at all levels.

He emphasized certain priority areas in the action plan: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol; support for national strategies; and emphasis on the role of both primary health care and public health infrastructure based on the principle of health in all policies. The recommendations on the marketing of food and non-alcoholic beverages to children would usefully contribute to measures needed to curb the prevalence of childhood obesity.

He welcomed the recent decision of the United Nations General Assembly to hold a high-level meeting on noncommunicable diseases, which called for WHO's leadership, solid background work and close cooperation with other stakeholders. He strongly supported the statement by the delegate of Spain concerning necessary resources: the budget allocated by WHO to the programme for noncommunicable disease was not proportionate to the magnitude of the problem.

Finland would contribute to the WHO programme and would share its successful experiences in prevention and control. He confirmed the value of the principles and recommendations contained in the WHO strategy and action plan.

Dr XIAO Donglou (China) commended the strategy adopted by WHO, the objectives attained in 2009 and 2010, and the way in which future trends had been assessed. He fully supported the efforts made by WHO in seeking to limit the damage caused by noncommunicable diseases. Governments must be made more aware of the need to take steps to combat the scourge, and WHO should exert its influence on public health strategies in order to ensure that targets would be met. Indicators linked to the control of noncommunicable diseases should rapidly be included in the Millennium Development Goals.

In China with the development of the economy the health of the population had generally improved; however, it suffered from the burden of noncommunicable diseases, and 77% of mortality could be linked to cancer, cardiovascular disease or chronic respiratory diseases. China was taking steps to combat that burden. including intersectoral cooperation on policies; public awareness campaigns about healthy lifestyles; the support at community level to control cardiovascular disease, diabetes and cancer; and the enhancement of cooperation and contact with WHO and other relevant international bodies.

Dr SEAKGOSING (Botswana) said that Botswana had made prevention and control of noncommunicable diseases the subject of a five-year strategic plan that included strengthened partnerships. He thanked WHO and other stakeholders for their support in developing the national health policy. His country's health facilities offered an integrated service of screening, treatment and education on cancer diabetes, hypertension and cardiovascular conditions. The Botswana National Cancer Registry was responsible for the surveillance of cancers and was a useful source of information

for policy direction and for national and international researchers. He urged WHO to finalize the protocols for Survey 3 of the WHO STEPwise approach to surveillance so that countries could conclude the three surveys and gather information on common risk factors for noncommunicable diseases that could form a basis for relevant interventions.

Vice Admiral BENJAMIN (United States of America) said that, as Surgeon-General of the United States, she recognized that noncommunicable diseases contributed significantly to mortality and morbidity worldwide and represented an increasing proportion of the disease burden in developing countries. The issue affected both developing and developed countries and the United States continued to support WHO's action plan for implementing the global strategy, with the inclusion and shared responsibility of all stakeholders. She commended the progress WHO had made in implementing the action plan. The recommendations contained in the Annex to the report concerning the marketing of food and non-alcoholic beverages to children should play a significant role in helping Member States to promote healthier patterns of eating with a view to the reduction of childhood obesity. That was a priority for her Government, and in particular for the First Lady, who had raised awareness of childhood obesity and the importance of healthy eating.

She was pleased to note that the stakeholder consultation process implemented by the Secretariat had resulted in considerable improvement in the structure and content of the recommendations, which set forth policy objectives recognized by the United States Congress and the Government. The United States was addressing the pressing problem of obesity in many ways. The National Institutes of Health had established an Obesity Research Task Force which had developed a strategic plan for obesity research with the contribution of external experts and health advocacy organizations. The United States' investments in obesity research and strategic planning would benefit WHO in implementing global strategies for the prevention and control of obesity and other noncommunicable diseases. The United States Federal Trade Commission, together with the Food and Drug Administration, the Centers for Disease Control and Prevention, and the Department of Agriculture were developing standards for the marketing of foods to children in the United States. The proposed standards had been presented in December 2009 at a workshop hosted by the United States Federal Trade Commission, and were to be submitted to Congress in July 2010. She welcomed the reference in the recommendations to a range of implementation mechanisms. There was a shared responsibility for tackling the growing obesity epidemic, which meant that governments, industry and nongovernmental actors and individuals all had roles to play. No stakeholder should be left out.

She supported the draft resolution, with the proposed amendment.

The meeting rose at 12:10.

NINTH MEETING

Thursday, 20 May 2010, at 14:35

Chairman: Dr M. MUGITANI (Japan)

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

Prevention and control of noncommunicable diseases: implementation of the global strategy: Item 11.9 of the Agenda (Document A63/12) (continued)

Ms NUKU (New Zealand) said that many useful activities relating to the prevention and control of noncommunicable diseases had been outlined in the report on the implementation of the action plan of the global strategy. However, Member States needed to prioritize their actions, and donor countries must increase funding and support for WHO and the developing countries. Those actions were essential for continued progress towards existing health-related Millennium Development Goals; in that context, she welcomed the recently adopted United Nations General Assembly resolution 64/265, and the decision to convene a high-level meeting of the General Assembly in September 2011 on the prevention and control of noncommunicable diseases.

She commended the Secretariat and the contribution of stakeholders on the recommendations concerning the marketing of food and non-alcoholic beverages to children, contained in the Annex to the report and which included the underlying issue of unhealthy diet and provided clear, non-prescriptive guidance for Member States. Her country's experience with self-regulation of marketing to children had been positive, and the measures had been strengthened in recent years.

Dr AL-JALAHMA (Bahrain), commending WHO's progress in implementing the global strategy on noncommunicable diseases, said that his Government's strategy to control noncommunicable diseases was a health priority, based on the global and regional strategies and conducted in partnership with civil society through social initiatives.

Bahrain had adopted anti-tobacco legislation that complied with the WHO Framework Convention on Tobacco Control, had banned advertising of tobacco products, and prohibited smoking in enclosed spaces. It had established a strategy on nutrition and physical exercise; a national cancer registry; specialist clinics to treat chronic disease. Having established a link between obesity and poor nutrition, the authorities encouraged children to avoid high-fat and sweetened foods. Bahrain therefore supported the draft resolution.

Dr NALINEE SRIPAUNG (Thailand), commending the report, said that, although in 2008 noncommunicable diseases had accounted for 63% of global mortality, comparatively few resources were generally set aside for them, even by WHO. The unacceptable dual burden of under-nutrition and over-nutrition among children and infants posed a serious challenge to the global community and to the next generation. Like many countries, Thailand was facing an alarming surge in over-nutrition, coupled with the re-emergence of problems relating to micronutrition such as iodine deficiency. Greater affordability, availability and aggressive marketing of energy-dense foods were major causes of growing obesity in developing countries. She supported the draft resolution as amended.

Ms OCHIENG (Switzerland), commending the work undertaken by the Secretariat on the recommendations, said that the varied and different risk factors relating to the prevention and control of noncommunicable diseases required a multisectoral approach, notably in regard to Objective 3.

Member States should adopt approaches suited to their national circumstances. She welcomed United Nations General Assembly resolution 64/265 and supported the draft resolution as amended.

Dr ASIN-OOSTBURG (Suriname) said that in Suriname six of the leading causes of mortality were noncommunicable diseases; furthermore, in 2009 preventable illnesses such as myocardial infarction, chest pain, ill-regulated diabetes mellitus and asthma had also resulted in significant costs in hospitalization. Implementation of a comprehensive and integrated national strategy on prevention and control was an important condition for reducing the morbidity and mortality that resulted from noncommunicable diseases.

In March 2010, with support and guidance from WHO, PAHO and regional experts, Suriname had hosted a meeting with key stakeholders to further develop the national strategic approach to noncommunicable diseases, building on the Port of Spain Declaration (2007).

In building national capacity, greater emphasis should be placed on the leadership role of health ministries in identifying and fostering partnerships within and outside the health sector. Her country looked forward to WHO's continued technical support.

Mrs WAXMAN (Israel) said that heart disease was the prime cause of mortality in Israel and that more than 62% of the population were overweight. The prevalence of risk factors of chronic diseases was higher among lower socioeconomic groups, and a new strategy to address prevention and treatment of noncommunicable disease had been developed by the ministries of health, sports and education.

She commended WHO's response to chronic diseases and its focus on prevention, and welcomed progress on the implementation of the WHO Framework Convention on Tobacco Control and the Global Strategy on Diet, Physical Activity and Health. Effective targeting of obesity should continue to be a major element of WHO's work on the prevention of chronic diseases. Commending WHO on its multistakeholder consultation process in developing the guidelines, she expressed support for the draft resolution.

Dr MISHRA (Nepal), endorsing the statement made by the delegate of Thailand, said that in order to reduce the high incidence of noncommunicable diseases in the South-East Asia Region, health education from an early age must play a prominent role in the school curriculum; that should include physical exercise in schools; and raising awareness of healthy eating practices and the risk factors of noncommunicable diseases.

Mr EL MENZHI (Morocco), commending the report, said that in his country much had been done to implement the plan of action and the global strategy through intersectoral policies and measures to control noncommunicable diseases. Efforts to combat cancer included the establishment of cancer screening centres, with a capacity to screen tens of thousands per year. He appealed to the Secretariat to support countries through national epidemiological studies and fundraising for that purpose.

Ms KRISTENSEN (Denmark) said that WHO must accord the highest priority to the common global task of tackling noncommunicable diseases. Denmark's national action programme emphasized prevention by targeting the determinants of chronic conditions, including social inequity in health. The health-care system itself aimed to deliver evidence-based care to all people with chronic diseases. The services provided for disease management must be of high and uniform quality and limit the impact of economic and staffing problems through the activation of patients' resources and through their capacity for self-management. She encouraged Member States to implement similar action plans adapted to their national requirements, when addressing the problems posed by chronic noncommunicable diseases. She strongly supported the draft resolution.

Dr EMILIA KASSIM (Brunei Darussalam) said that in her country noncommunicable diseases had become more prevalent than communicable diseases; the four main contributors to rates of adult mortality were cancer, coronary heart disease, cerebrovascular diseases and diabetes mellitus. Sedentary lifestyle had become an issue. The risk factors of noncommunicable diseases, such as obesity, inactivity and tobacco smoking, could be greatly influenced by changes in individual lifestyle. The national health strategy had therefore focused on the promotion of a healthy lifestyle, in addition to the treatment of noncommunicable diseases, in order to educate the population and empower it to take responsibility for its own health. She welcomed WHO's guidance in the implementation of national health programmes and looked forward to participating in relevant regional and subregional networks.

Dr RI Il Yong (Democratic People's Republic of Korea) commending the progress made towards the global strategy, said that various activities were being implemented under the national strategic plan for prevention and control of noncommunicable diseases. General practitioners had been involved in a survey of risk factors that had generated data for the development of noncommunicable disease control and prevention programmes; the results had been transmitted to the Regional Office for South-East Asia. His Government was committed to successful implementation of the global strategy and agreed that prevention and control were integral to the protection and promotion of public health.

Dr MUKONKA (Zambia) said that his country was at a stage of epidemiological transition: the incidence of noncommunicable diseases had increased but the prevalence of communicable diseases remained high. Continued urbanization and globalization had intensified high-risk factors which, in turn, had caused the increase in hypertension, diabetes, obesity and heart disease nationwide. Zambia had established a specific unit for noncommunicable disease at the Ministry of Health with a separate budget to deal with such diseases. The WHO STEPwise approach was used for assessment of the prevalence of noncommunicable diseases; and surveillance had improved as part of the WHO Integrated Disease Surveillance and Response.

Zambia had also developed greater advocacy through wide-ranging awareness campaigns; a strengthened school health programme; and collaboration with partners, nongovernmental organizations and disease-specific associations. However, additional financial support and multisectoral strategies were required and he therefore requested the Health Assembly to re-examine its funding and overall approach to managing noncommunicable diseases in order to find sustainable solutions.

Dr AL-NISSEF (Kuwait), commending the Regional Office for the Eastern Mediterranean for support in tackling noncommunicable diseases, as well as the Health Ministers' Council for the Gulf Cooperation Council States for its cooperation, said that his country had implemented various related programmes and policies, notably the Kuwait Declaration to combat Diabetes (2007).

There had been a national increase in rates of tobacco-related diseases, hypertension, obesity and diabetes across the country, and national activities to combat noncommunicable diseases included reinforcement of the health-care system; promotion of a healthy lifestyle (Objectives 2, 3 and 5 of the global strategy); and risk-factor studies, resulting in a database on noncommunicable diseases (Objective 4). He supported the draft resolution and looked forward to the attainment of targets for the health-related Millennium Development Goals.

Mrs FALETOESE SU'A (Samoa), commending the global strategy, said that the collective efforts of the Regional Office and the Member States of the Western Pacific Region to implement the 2008 regional strategy had made a significant contribution to Samoa's strategy and policies in the prevention and control of noncommunicable diseases.

Dr GAMARRA (Paraguay) said that Paraguay's strategic plan for prevention and control of noncommunicable diseases included innovative policies based on the WHO Framework Convention

on Tobacco Control. The plan was implemented under the framework of free and equal health care for all; provision of primary health care, with family health as the starting-point, and covered social factors such as education, housing, employment and poverty alleviation. She encouraged all Member States to support the global strategy for prevention and control of noncommunicable diseases.

Mr SAMIEI (International Atomic Energy Agency), said that the Agency had long been involved in the fight against cancer. In collaboration with WHO, it had initiated programmes in more than 100 developing countries, and enabled Member States to establish cancer centres. Under its Programme of Action for Cancer Therapy, the Agency had established a number of model demonstration sites in order to enable Member States to build capacity. Commending WHO's leadership role in bringing to the attention of the world the increasing impact of noncommunicable diseases on low- and middle-income countries, he pledged the Agency's continued support for WHO's work to implement its global strategy for the prevention and control of noncommunicable diseases, and cancer in particular.

Dr Shu-Ti CHIOU (Chinese Taipei) said that Chinese Taipei assigned priority to the prevention and control of noncommunicable diseases. It provided free periodic screening for major chronic diseases and their determinants, and persons identified as high risk were treated accordingly under the national health insurance scheme. With regard to risk factors, Chinese Taipei had promulgated the Tobacco Hazards Prevention and Control Act and would aim to promote healthy nutrition through statutory regulations on the marketing of foods and non-alcoholic beverages to children, together with strengthened education in nutrition. In its monitoring system on major noncommunicable diseases, Chinese Taipei intended to place greater emphasis on inequity in incidence and control. In the face of a mounting obesity epidemic, a weight-loss campaign launched in Taipei City would be replicated in other cities. She supported the draft resolution.

Dr SHANTINATH (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said that oral health was an essential component of general health and well-being. Oral diseases shared risk factors and determinants common to other chronic diseases, which resulted in, for instance, dental caries, periodontal disease and cancer of the mouth and throat. Resolution WHA60.17, adopted in 2007, had been the first resolution on oral health in decades, and she urged Member States to support oral health activities within WHO.

Dental caries, although entirely preventable, was the world's most common noncommunicable disease. Tooth loss was preventable, yet the absence of teeth and poor oral health compromised the quality of life for many elderly persons, who were overlooked on national health agendas. Her Federation, together with the WHO Global Oral Health Programme and the International Association for Dental Research, planned a conference on the oral health of the vulnerable elderly in May 2011. She urged Member States to commit resources to oral health as an essential element in preventing and controlling noncommunicable diseases.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the global burden of noncommunicable diseases, including haemoglobinopathies such as thalassaemia and sickle-cell disease, continued to increase. In 2006, resolutions WHA59.20 on sickle-cell anaemia and EB118.R1 on thalassaemia and other haemoglobinopathies had urged Member States to develop and implement national programmes for the prevention and management of those diseases.

With appropriate prevention services in place, such disorders could be effectively avoided; national resources thus saved could be redirected to improving health care and quality of life of patients. Benefiting from recent advances in science and medicine, the opportunity must be seized to integrate basic improvements for the prevention and control of genetic and congenital disorders into the health systems of all affected countries. The Federation fully supported the action plan for the global strategy for the prevention and control of noncommunicable diseases.

Ms FELTON (International Diabetes Federation), speaking at the invitation of the CHAIRMAN and on behalf of the International Union Against Cancer, the Union Against Tuberculosis and Lung Disease, the World Heart Foundation and the Framework Convention Alliance for Tobacco Control, said that, despite WHO's commendable progress in implementing the global strategy, the social and economic burden that noncommunicable diseases placed on vulnerable countries was still largely ignored. Cardiovascular disease, diabetes, cancer and chronic respiratory disease were responsible for 60% of deaths worldwide, some 80% of which occurred in low- and middle-income countries. In those countries, noncommunicable diseases were responsible for the deaths of 8.1 million people below the age of 60, and held back development; and yet, less than 1% of total investment in official development assistance for health was spent in the area of noncommunicable diseases.

At the United Nations General Assembly summit in September 2011, actions would be discussed to counter the growing threat posed by noncommunicable diseases. Her Federation and the organizations she represented pledged their support to WHO in catalysing the process. Member States should invest in the pre-summit consultations in order to ensure that the summit produced a concrete action plan and accountability measure; to support the inclusion of an item to consider adding indicators on noncommunicable diseases to Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) in the provisional agenda of the 2010 Millennium Development Goals Review Summit; to ensure that noncommunicable diseases formed part of the discussions on successor goals to the Millennium Development Goals; and to address the availability and affordability of essential medicines for people living with noncommunicable diseases in low- and middle-income countries.

The integration of the prevention and control of noncommunicable diseases into national and global development agendas was a priority and needed international donors' support. Her Federation and the organizations she represented were already implementing the action plan for the global strategy. With strong WHO leadership, the epidemic could be considerably curtailed.

Dr RAASHID (Alzheimer's Disease International), speaking at the invitation of the CHAIRMAN, said that Alzheimer's disease and other dementias were emerging as one of the major health issues of the century. The prevalence of dementia cases was expected to double over the next 20 years. For persons aged over 60 it was the second leading cause of years lived with disability. And yet, owing to lack of awareness and the mistaken assumption that it was a normal part of ageing, it was often not recognized that dementia was a terminal condition and often linked to other chronic diseases. WHO should declare dementia as a global health priority. She welcomed the inclusion of dementia as a mental health priority in the WHO Mental Health Gap Action Programme, which, however, needed to be funded and implemented in all the Member States without delay. Her organization's World Alzheimer's Report (2009) showed that the prevalence of dementia worldwide was higher than previously estimated and that it placed a heavy burden on individuals, families and society. The problem could only increase as life expectancy continued to rise.

There was no cure for dementia but important work should include removing the stigma surrounding the disease to support families and caregivers; and training the workforce to study prevention methods and develop a new research agenda. Those solutions could form the basis of national dementia strategies. Dementia care needed to be integrated into improvements in primary health care in low- and middle-income countries. Her organization was in discussions with WHO on a joint action plan and the support of Member States would be needed for national implementation of those actions, with the assistance of existing national Alzheimer's associations.

Ms WEBBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the report but was concerned that health and development were held back by emerging epidemics of noncommunicable diseases. Effective implementation of the global strategy required investment, training and support for skilled nurses and other health personnel working in health teams within functioning health systems. Nurses delivered cost-effective services in the prevention and control of noncommunicable disease.

The Council had integrated such prevention and control into its programme areas, had elaborated guidance for nurses, was establishing partnerships with other groups such as the International Diabetes Federation, and supported the integration of essential preventive health care into health policies. She reaffirmed her organization's continued commitment to partnership with WHO and to the contribution of nursing to improving health worldwide.

Ms KELLETT (Corporate Accountability International), speaking at the invitation of the CHAIRMAN, said that 2010 marked the fifth anniversary of the WHO Framework Convention on Tobacco Control, the world's first public-health and corporate accountability treaty. Interference by the tobacco industry remained the single greatest threat to implementation of the treaty's lifesaving measures. That had been demonstrated recently by the chief executive of a leading tobacco company who had assured the shareholders that the company did not intend to comply with the guidelines of the Framework Convention; she recalled that the guidelines, which recognized the fundamental conflict of the tobacco industry with public health policies, had been unanimously adopted. She therefore urged Member States to renew their commitment to increased funding for implementation of the treaty, and vigilance over its enforcement. Her organization would continue to monitor and expose the tobacco industry, and provide support for the implementation of the Framework Convention.

The WHO recommendations on the marketing of foods to children were a commendable step towards curbing the irresponsible marketing of foods high in fat, sugar and salt to children. The recommendations reinforced the importance of Member States as the key stakeholder in policy setting, given the ineffectiveness of the food industry's self-regulatory and voluntary approaches. She therefore urged Member States to enact statutory regulations as the most effective means of implementing those recommendations.

Ms RUNDALL (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, welcoming the draft resolution, said that in order to implement the recommendation to ensure that settings such as schools and nurseries were free from the marketing of unhealthy foods, it should be clearly indicated that the logos and brand names of companies in the food industry were strongly discouraged. Bans on direct advertising must not simply result in more extensive and subtle forms of marketing. The issue of infant feeding had shown how companies could build trust in a brand and then an entire product range, through marketing and messaging that included the sponsoring of education materials. Children had the right to protection from exploitation and to an education free of such commercial influence.

She also welcomed the recommendation that governments should be the key stakeholders in policy development and was in favour of enforced regulatory measures. The inclusion in the recommendations of the phrase "independently of any other measures taken" (in paragraph 24) was a vital safeguard, as was the call for independent monitoring of voluntary measures. Her organization would willingly assist Member States in establishing enforcement, monitoring and reporting mechanisms.

Dr ARANA (Consumers International), speaking at the invitation of the CHAIRMAN, said that the recommendations provided an important step towards protecting children from the marketing of foods that led to overweight and obesity and the growth in noncommunicable diseases. Welcoming the reaffirmation of the key role that governments should play in developing the policy framework, including the setting of clear definitions, he said that those should include all forms of marketing communication; extend to teenagers and younger children; and target all energy-dense food high in fat, sugar and salt. The code developed by the European Network aimed to reduce marketing pressure on children and contained specific definitions that would enhance implementation of the recommendations.

He urged Member States to entrust the Secretariat with the mandate needed to develop technical support for nutrient profiling and for monitoring the marketing of foods to children, and thus ensure a basis of public health criteria without conflicts of interest. It should also be given a mandate to address

concerns about cross-border marketing and the uniform implementation of the recommendations. He supported the draft resolution, particularly the need for a progress review in two years' time.

Mrs BILINSKA (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that her organization supported implementation of the global strategy through its role in the Noncommunicable Diseases Network. She sought the broader involvement of patients in the implementation of the global strategy at national level, as illustrated in Peru by the training of cancer patients to actively manage their condition, or as exemplified in Uganda by a patients' organization that was raising awareness of health issues through radio and drama. The contribution of patient groups was essential in finding solutions to meet the practical needs of patients.

A patient-centred approach was crucial to solutions for noncommunicable diseases; individuals and communities should have a stronger role in the design and delivery of health care. She supported the prioritization of health literacy initiatives to empower patients and involve them in their own health. In addition, resources must be increased and the right investments made for adequate prevention and control of the burden of noncommunicable diseases.

Dr ALWAN (Assistant Director-General) thanked the delegates and the representatives of nongovernmental organizations for their comments on progress in implementing the global strategy. In particular, he thanked the delegations of Norway and other Member States for their active engagement in preparing the draft resolution and the recommendations on the marketing of foods and non-alcoholic beverages to children, key tools in the fight against childhood obesity and consequently noncommunicable diseases. He thanked the delegation of the Russian Federation for its generous offer to help to organize the international high-level conference on noncommunicable diseases and healthy lifestyles to be held in 2011.

He drew attention to the important role played by the member countries of the Caribbean Community and more than 70 other Member States that had sponsored the landmark United Nations General Assembly resolution 64/265. Close collaboration with Member States would continue in order to implement that resolution. Work was already under way on a global status report on noncommunicable diseases, which would contribute to monitoring those diseases and their risk factors, as called for in the General Assembly resolution. The first report was due for completion by the end of 2010, and updated reports would be published every three years. Reiterating the Organization's commitment to achieving each of the six objectives of the action plan, he looked forward to reporting back to the Sixty-fifth World Health Assembly in 2012.

The CHAIRMAN invited the Secretary of the Committee to read out the proposed amendment.

Ms VESTAL (Secretary) said that Norway had proposed deletion of the word "all" in paragraph 2(1) which would read: "to take necessary measures to implement the recommendations on the marketing of foods and non-alcoholic beverages to children, while taking into account existing legislation and policies, as appropriate".

The CHAIRMAN said that, in the absence of any objections, he took it that the Committee wished to approve the draft resolution.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA63.14.

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3)
(continued from the eighth meeting, section 2)

Ms RAO (India), noting that there remained wide divergence of views on how to proceed with the topic despite two days of discussion, said that it had been impossible to reconcile the three proposed draft resolutions. Following informal consultations, the Member States of the South-East Asia Region had prepared a draft decision which she submitted for the Committee's consideration. Under the heading "Substandard/spurious/falsely-labelled/falsified/counterfeit medical products" it read:

"The Sixty-third World Health Assembly,

DECIDES to establish an open-ended intergovernmental working group comprising Member States;

REQUESTS the Director-General to facilitate the work of an intergovernmental working group;

DECIDES that the working group will examine the following issues: (1) measures to ensure access to quality, safe, efficacious and affordable medical products; (2) the relationship between WHO and IMPACT; (3) prevention and control of medical products of compromised quality, safety and efficacy, such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products, from a public-health perspective, excluding trade and intellectual property considerations; (4) issues raised in the proposals in documents A63/A/Conf.Paper No.4 Rev.1, A63/A/Conf.Paper No.5 and A63/A/Conf.Paper No.7;

DECIDES that the working group shall make specific recommendations in relation to the above issues and report to the Sixty-fourth World Health Assembly through the 128th session of the Executive Board."

The aim of the decision was to provide a way forward on an issue on which the Committee had already spent too much time and which affected all Member States in equal measure. The menace of medicine of compromised quality and safety, far from being specific to Africa, was global in scale. It was related to regulatory systems and systems of governance and was thus the responsibility of sovereign Governments. She therefore urged all Member States to accept the decision to establish an intergovernmental working group, which was a democratic mechanism for addressing the concerns, fears and needs of all parties.

The CHAIRMAN suggested that the proposed decision should be distributed as a conference paper in all languages for consideration at the next meeting.

It was so decided.

The agenda item was suspended.

(For resumption of the discussion, see below.)

Tuberculosis control: progress and long-term planning; prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis: Item 11.11 of the Agenda (Document A63/14)

Dr MISHRA (Nepal), speaking on behalf of the Member States of the South-East Asia Region, home to some 40% of the world's poorest people and one third of people with tuberculosis in the world, said that they were committed to addressing the huge burden of tuberculosis. National programmes for tuberculosis-control in the Region were performing well with provision of high-quality drugs. As a result, new cases of multidrug-resistant tuberculosis had been maintained at a low 2.8%. However, the overall number of tuberculosis cases remained high. Failure to pay urgent attention to ensuring a more effective response to tuberculosis and HIV in the Region could reverse the progress achieved in reducing the prevalence of tuberculosis and regional and global mortality, which in turn would substantially increase the costs of tuberculosis control.

The Region was proud of its achievements and acknowledged the significant resources that had been made available through the Global Fund to Fight AIDS, Tuberculosis and Malaria and other development partners. The WHO Prequalification Programme, which facilitated access to quality, safe and efficacious tuberculosis medicines, should be maintained. Further efforts were required in respect of the enforcement of regulations, with the provision of first- and second-line anti-tuberculosis drugs; building capacity in human resources, introducing new diagnostic tools and researching new tuberculosis drugs.

Mrs FALETOESE SU'A (Samoa) expressed support for the Organization's work in combating all forms of tuberculosis, especially its efforts to achieve universal access to diagnosis, treatment and care. Noting the continuing emergence of multidrug-resistant tuberculosis and extensively resistant tuberculosis, she said that nurses and midwives had a key role in achieving targets, especially through patient-centred approaches such as the DOTS strategy. All health-care professionals, including nurses and midwives, should be involved in developing policies and ensuring patient-centred care.

Ms KHUMALO (Swaziland) noted with concern that the global tuberculosis burden appeared to be worsening, with 9.4 million new cases in 2008, and the majority of those in developing countries. The emergence of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis in sub-Saharan Africa contributed to increased mortality rates. Swaziland was striving to increase its detection rate from 68% to 78%, and to further strengthen management and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis through follow-up care in the community; her country was committed to strengthening laboratory services in order to improve diagnosis and to ensuring a reliable and uninterrupted supply of anti-tuberculosis drugs. She urged the Organization and development partners to ensure full implementation of the Stop TB Strategy and the Global Plan to Stop TB 2006–2015.

Dr SALMAN AL-SAYYAD (Bahrain) said that Bahrain nationals had accounted for 18% of cases of pulmonary tuberculosis and 31% of cases of non-pulmonary tuberculosis in his country in 2009, while three cases of multidrug-resistant tuberculosis, had been recorded in 2006, one in 2007 and one in 2008, whereas none had been recorded in 2009. There were no recorded cases of extensively multidrug-resistant tuberculosis. Bahrain had set the goal of a 20% reduction in the incidence of tuberculosis by 2012. To that end, it had introduced various primary and secondary health-care measures. Those included the review and updating of national tuberculosis guidelines, laws and policies relating to tuberculosis; strengthening of epidemiological screening; improved coordination between the national programme for tuberculosis control and the national AIDS programme; and the strengthening of laboratory testing for multidrug-resistant tuberculosis and extensively multidrug-resistant tuberculosis. Bahrain fully supported WHO's efforts to control tuberculosis and had adopted the WHO guidelines for controlling tuberculosis in general and extensively multidrug-resistant tuberculosis in particular.

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

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3) (resumed)

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union, requested clarification of the status of the three draft resolutions on counterfeit medical products.

The CHAIRMAN confirmed that the matter would be discussed at a later meeting, together with the draft decision submitted by the delegate of India.

Mr DE ALBUQUERQUE E SILVA (Brazil), supported by Dr CHIRIBOGA (Ecuador), said that the draft decision proposed by the delegate of India on behalf of the Member States of the South-East Asia Region and supported by the Union of South American Nations was additional to the three draft resolutions remaining on the table. Discussion of that draft decision was still possible even though it had not yet been translated into the other five official languages.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union and supported by Mr TAYLOR (United States of America), said that the new draft decision was the outcome of informal consultations among certain delegations and could not be discussed before other delegations had had the opportunity to consider it. She suggested that the earlier proposal to establish a drafting group might now be taken up so that all interested delegations had time to reach agreement.

Mr DE ALBUQUERQUE E SILVA (Brazil) said that it was not necessary to establish a drafting group since the newly proposed draft decision dealt simply with procedure. Furthermore, all delegations would be able to accept the language of the draft decision, which was the outcome of informal consultations in which Member States from all regions had participated. The procedural decision required could be taken at the following meeting, once the draft was available in all six official languages.

Mr GOPINATHAN (India), supported by Dr GAMARRA (Paraguay), said that he fully agreed with the previous speaker but that an immediate preliminary discussion of the issues raised in the draft decision, namely the blueprint for a road map to establish an open-ended working group, and the points on which its work should focus, would inform the discussion due to take place at the next meeting.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union and reiterating her earlier arguments, said that the establishment of a drafting group therefore remained the best option for reaching agreement.

Mr GOPINATHAN (India) said that there was nothing left to draft. He proposed that concerned delegations should hold informal discussions on the draft decision so as to make more productive use of the time to be devoted to its consideration once it was available in all six official languages.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union, said that any discussion of the draft decision must be a formal one that included all interested delegations.

The CHAIRMAN said that the planned discussion of the draft decision, once it had been translated in all languages, would constitute a formal process. In the interim, the suggestion by the delegate of Brazil offered a realistic approach with which he agreed. Interested delegations were

therefore invited to discuss the draft decision informally during the time available before the Committee's next meeting.

(For continuation of the discussion, see the summary record of the eleventh meeting, section 1.)

The meeting rose at 16:50.

TENTH MEETING

Thursday, 20 May 2010, at 18:00

Chairman: Dr M. MUGITANI (Japan)

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

Tuberculosis control: progress and long-term planning; prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis: Item 11.11 of the Agenda (Document A63/14) (continued from the ninth meeting)

Professor KULZHANOV (Kazakhstan), endorsing the report on tuberculosis control, identified areas of tuberculosis control that warranted particular attention: early diagnosis; access to appropriate services; technology transfers to countries with high morbidity and prevalence of multidrug-resistant tuberculosis; and research on new medicines. WHO's determination to step up its work on tuberculosis control was gratifying. In Kazakhstan, prevalence of morbidity and mortality resulting from tuberculosis had declined. However, the prevalence of multidrug resistance, 40% of cases in 2010, made control of the disease very difficult. He thanked WHO, the Global Fund to Fight AIDS, Tuberculosis and Malaria and other partners for support in strengthening services, provision of medicines and training, and improved infrastructure. He looked forward to continued support as further means to achieve Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases).

Dr GÜRSÖZ (Turkey) recalled that WHO had been involved for many years in tuberculosis control activities, including the setting and monitoring of international goals and establishment of the Stop TB Partnership's Global Plan to Stop TB 2006–2015. Turkey, like other Member States that had achieved the targets set for diagnosis and treatment, shared a responsibility to maintain collaborative efforts. To achieve the goals laid down in the Global Plan to Stop TB 2006–2015 it would be necessary for WHO, its international partners and other stakeholders to step up their efforts to reduce global poverty, strengthen health systems, scale up research and allocate additional resources to tuberculosis control.

Dr MHLANGA (South Africa), speaking on behalf of the Member States of the African Region, welcomed the increased funding allocated to tuberculosis control but noted with concern that a shortfall remained. The upsurge in multidrug-resistant tuberculosis in at least 27 African countries, with six countries having notified at least one case of extensively drug-resistant tuberculosis, threatened efforts to attain the Millennium Development Goals. He agreed with the view expressed recently on behalf of the Coordinating Board of the Stop TB Partnership that Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) should be given the same attention as Goals 4 (Reduce child mortality) and 5 (Improve maternal health) at the high-level plenary meeting, to be held in New York in September 2010. Obstacles to successful control of tuberculosis included: weak health systems; difficulty of ensuring sustainable financing; persistence of stigmatization and discrimination; inadequate coordination; weak linkages between tuberculosis and HIV/AIDS programmes within overall health systems. In response to the call for intensified action to prevent and control tuberculosis, issued during the Fifty-ninth session of the WHO Regional Committee for Africa, Member States had committed themselves to scaling up their efforts to overcome those obstacles.

The eradication of poverty and hunger, and socioeconomic development were prerequisites for the well-being of all countries. The prevalence of multidrug-resistant and extensively drug-resistant tuberculosis persisted because of weaknesses in basic control and management programmes. The search for faster diagnostics and improved medicines should not distract attention from the strict implementation of the DOTS strategy. African health ministers had recommended extending the “Abuja Call for Accelerated Action towards Universal Access to HIV/AIDS, Tuberculosis and Malaria Services” for the period 2010–2015, in line with Millennium Development Goal targets. He called on development partners to guarantee sustainable funding; strengthen laboratory capacity; ensure the availability of medicines against multidrug-resistant and extensively drug-resistant tuberculosis; and build capacity in managing programmes for tuberculosis control.

Dr PAIROJ SAONUAM (Thailand) said that the growing problem posed by multidrug-resistant and extensively drug-resistant tuberculosis emphasized the importance of early laboratory diagnosis and appropriate treatment. However, in many countries laboratory capacity was limited in terms of infrastructure, technologies, human resources and technical skill, and it was crucial to make good such deficiencies. Thailand’s national tuberculosis programme had been certified by WHO as a supranational reference laboratory able to support Member States in improving national capacity. However, in addition to issues related to tuberculosis/HIV coinfections, challenges to health services remained: migrant workers, the prison population and cross-border populations with limited access to health services. Therefore, national programmes, with technical support, needed to find appropriate mechanisms for strengthening screening and treatment in combined tuberculosis/HIV programmes. Epidemiological research should also be increased in order to accurately measure the current burden of multidrug-resistant and extensively drug-resistant tuberculosis.

He commended the work of the Green Light Committee; however, its approval and enrolment processes needed to be speeded up in order to meet the growing demand for quality-assured medicines against multidrug-resistant and extensively drug-resistant tuberculosis.

Mr ADAM (Israel) said that since 1997 the incidence rates of tuberculosis in Israel had been halved and the rates for successful treatment had tripled. The Stop TB Strategy had also been implemented. He had noted the progress made since 1991 towards the international targets for global tuberculosis control and had welcomed the Global Plan to Stop TB 2006–2015, which coincided with the health-related Millennium Development Goals. Nevertheless, a mortality rate of 1.7 million people per year, of whom 200 000 had lived with HIV, was unacceptably high; of the almost nine million new annual cases of tuberculosis infection, 1.8 million failed to receive treatment. Therefore he called on the Secretariat to prepare a further progress report to be submitted to the Sixty-fifth World Health Assembly.

Dr DAKULALA (Papua New Guinea) said that Papua New Guinea was a small, low-income country with a high burden of multidrug-resistant tuberculosis and a generalized epidemic of HIV. Only recently had fixed-dose medicine combinations been supplied by the Global Drug Facility, a Stop TB Partnership project. Since 2007, DOTS coverage had been increased.

Facilities for culture of *Mycobacterium tuberculosis* were available but could not be used for diagnosis and case management because limited resources prevented the authorities from maintaining a sufficient level of biosafety in culture laboratories; that posed a challenge for the national tuberculosis programme. The national health service would benefit from cheaper, simpler diagnostic tools that did not require complicated environmental controls and could work with existing lower levels of biosafety. The report indicated that such tools would soon be available and he asked to be kept informed.

A national priority was to ensure the compliance of patients through support in the community even though the private sector was small and most health services were provided by the Government or through the Church. His country urgently needed support in obtaining quality-assured medicines to

counter multidrug-resistant tuberculosis, possibly through the mechanism of the Green Light Committee.

Ms USIKU (Namibia), commending the report, said that the disease burden of tuberculosis remained high in her country despite an estimated case detection rate of 84% compared with the international target of 70%. Coverage of DOTS programmes was expanding with the support of partners. Nevertheless, Namibia had declared tuberculosis a national emergency: figures for 2009 had included 275 cases of multidrug-resistant tuberculosis and 17 cases of extensively drug-resistant tuberculosis. A lack of resources to manage those cases was compounded by specific needs to control infection in the health facilities that accommodated patients with multidrug-resistant and extensive-drug resistant tuberculosis. She appealed to WHO to provide urgently needed technical support.

Dr AL SHATI (Kuwait) said that the global burden of tuberculosis was unacceptably high. The situation needed to be reviewed and the findings published in a follow-up report. His government's strategy to tackle tuberculosis included: the establishment of a dedicated committee and effective detection and notification systems; strengthening of laboratory diagnostic capacity; provision of treatment to all those affected using the DOTS approach; involvement of national and international experts in a follow-up programme; and awareness-raising through cooperation with civil society. He looked forward to a continued spirit of cooperation in order to allow the Millennium Development Goal targets to be met and the Stop TB Strategy to be fully implemented.

Mr AL-TAAE (Iraq) said that Iraq had adopted the DOTS strategy for tuberculosis control. In 2009, case detection rates had reached 46% and treatment success rates had attained 88%. Public-private partnerships had been pursued in order to fulfil the indicator targets and standards set by WHO. However, further support from WHO was required in the following areas: building capacity in the detection, laboratory testing and treatment of multidrug-resistant and extensively drug-resistant tuberculosis; increasing support for World TB Day activities in schools, colleges, health institutions and local communities; and incorporating tuberculosis control activities in primary health-care services and health promotion. He urged WHO to ensure that tuberculosis control activities were included in community-based initiatives and conformed to the principles of sustainable development.

Dr GOUYA (Islamic Republic of Iran) said that efforts to control tuberculosis should not be confined to health ministries and treatment initiatives and that interventions should be assessed in terms of socioeconomic determinants. Effective prevention and control of HIV/tuberculosis coinfection, and multidrug-resistant and extensively drug-resistant tuberculosis was through rigorous treatment programmes, reliable diagnostic services and through quality-assured, second-line antituberculosis medicines. WHO might enlist the support from the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to provide such medicines free of charge, as had been done for leprosy. The medicines could be purchased directly from the manufacturers and distributed within a framework that included surveillance.

Dr XIAO Donglou (China) supported the proposals contained in the report. His Government had adopted a series of policies and measures to further strengthen efforts to prevent and treat tuberculosis. The proportion of cases detected and treated under the DOTS strategy had reached the targets set in the national plan and globally. Nationwide surveys of the tuberculosis epidemic and evaluation of existing strategies would provide scientific evidence for the Government's new tuberculosis prevention plans. However, the challenges posed by multidrug-resistant tuberculosis, HIV/tuberculosis coinfection and high rates of infection in particular groups of people at risk were of particular concern. Following the Beijing "Call for Action" on Tuberculosis control and patient care (2009), his Government had carried out research on coinfection; participated in cooperative projects, such as those of the Global Fund to Fight AIDS, Tuberculosis and Malaria; and enhanced the existing prevention measures and treatment programmes for migrants and the prison population. He thanked

WHO, the World Bank and the Global Fund for their support. In order to assist those Member States with a high burden of disease, the Secretariat might focus on raising resources to tackle multidrug-resistant tuberculosis; providing training for the relevant personnel; and enhancing technological support.

Ms GIBB (United States of America) said that her Government was committed to working with the international community for the prevention and treatment of tuberculosis in countries most affected by the disease, and to achieving the targets set out in the Stop TB Partnership's Global Plan to stop TB, 2006–2015. Both the United States Agency for International Development and the Centers for Disease Control and Prevention were members of the Coordinating Board of the Stop TB Partnership; together with the National Institutes of Health and the United States President's Emergency Plan for AIDS Relief, they also participated in technical working groups within the Stop TB Partnership.

It was incumbent on Member States and the Secretariat to work together to ensure that all tuberculosis patients had access to the best possible care. That included continued improvements to the quality of care based on DOTS; curtailing the emergence of multidrug-resistant tuberculosis; and increased investment in research on new medicines, diagnostic equipment and vaccines.

In 2008, in response to the urgent need to control the spread of tuberculosis, the United States had legislated to substantially increase funding for treatment and control, amounting to US\$ 4000 million over five years. In addition to support for the targets of the Global Plan to Stop TB, the legislation had set targets to successfully treat 4.5 million new smear-positive tuberculosis patients and to diagnose and treat 90 000 cases of multidrug-resistant tuberculosis. The President of the United States had further indicated his support for tuberculosis control when he had announced the Global Health Initiative in May 2009.

Continued collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria was crucial for the sustainable financing of progress towards attainment of the health-related Millennium Development Goals, including those relating to tuberculosis. The United States was the leading bilateral donor to the Global Fund and also provided technical assistance to ensure the effectiveness of its grants.

Dr EVSEENKO (Russian Federation), noting the report, said that, although tuberculosis clearly remained a global threat, evidence from the Global Plan to Stop TB indicators suggested that collective efforts were producing results, namely the gradually declining incidence of the disease and the improving treatment success rates. He emphasized the coordinating role of WHO in preventing the spread of multidrug-resistant tuberculosis, setting international standards and providing technical support to Member States and overall monitoring. He noted that resources for implementation of tuberculosis control were increasing and were highest in the European Region, mostly for the Russian Federation.

In his country, efforts were under way to improve monitoring of tuberculosis, to provide modern equipment, including equipment for more rapid diagnosis, and to achieve full coverage of bacterial studies for multidrug-resistant tuberculosis. Treatment models for multidrug-resistant tuberculosis, specific to his country's needs, were being introduced; financing of tuberculosis control, including the provision of second-line medicines, would be increased. His country stood ready to collaborate in the use of technologies with other Member States.

Dr KASSIM (Brunei Darussalam) welcomed the increase in the proportion of tuberculosis cases treated successfully and the reduction in mortality as a result of DOTS programmes. However, she also noted that most of the targets in the Stop TB Partnership Global Plan for 2006, 2007 and 2008 had not been achieved. The initiatives supported by WHO and other stakeholders were to be commended, in particular the work of the WHO Global Task Force on TB Impact Measurement. She looked forward to WHO's continued leadership in the area, and to the Secretariat's provision of technical

support to Member States, including the identification of barriers to progress and the search for appropriate solutions.

Mr HAGE CARMO (Brazil) said that, with the support of the national Stop TB Partnership initiative, and the Global Fund to Fight AIDS, Tuberculosis and Malaria, some 90 institutions in his country were involved in tuberculosis control. Results included a 20% reduction in the annual mortality rate over recent years; and prevalence of multidrug-resistant tuberculosis remained fairly low. Progress would be consolidated by expanding coverage of treatment and care through the family health programme; implementing the DOTS strategy; and improving laboratory diagnosis in order to speed up case detection and treatment.

Dr SEAKGOSING (Botswana) noted that one third of the new tuberculosis cases in 2008 had been reported from the African Region and that a significant percentage of those were tuberculosis/HIV coinfections. In Botswana, tuberculosis morbidity and mortality had risen relentlessly since 1990 as a result of the HIV epidemic. The rate of 76% for tuberculosis/HIV coinfection was high; furthermore, the proportion of tuberculosis patients with access to antiretroviral drugs was low. Activities for tuberculosis prevention and control were guided by a five-year strategic plan. Advocacy, communication and social mobilization for tuberculosis prevention and control had improved through support from the Global Fund; and from other partners, especially in the areas of monitoring and evaluation. The number of recorded cases had increased but mortality rates had declined, especially among new, smear-positive cases.

In his country universal access to HIV testing was offered to tuberculosis patients and the rate for patients tested had reached 64%. Case detection and treatment success rates remained well below target. The rising burden of multidrug-resistant and extensively drug-resistant tuberculosis was a significant challenge. Drug susceptibility testing had been conducted in new patients, treatment guidelines had been published in 2009, and medicines were available free of charge. The Green Light Committee had agreed procurement for limited second-line tuberculosis medicines.

He requested support to strengthen the national health and surveillance systems and build national laboratory capacity. Support was also needed for its application to the Global Drug Facility to ensure an uninterrupted supply of first-line medicines.

Dr CHAUHAN (India) suggested that the WHO Prequalification Programme should be strengthened so that a greater number of pharmaceutical manufacturers, and finished pharmaceutical products used in national programmes, completed the prequalification process.

Dr MULYONO (Indonesia) said that, in Indonesia, the prevalence and mortality rates of tuberculosis had declined significantly since the 1990s. The country had achieved the 70% target for case detection rates and the 85% target for treatment success rates. Prevalence of multidrug-resistant tuberculosis was 2% in new patients and tuberculosis was the most prevalent opportunistic infection in people with HIV/AIDS. Indonesia was therefore conducting a pilot DOTS plus project and was implementing the DOTS strategy carefully. It was also undertaking operational research. Tuberculosis remained a priority in communicable disease control programmes; Member States should be encouraged to participate actively in implementing the Global Plan.

Dr GAMARRA (Paraguay), drawing attention to paragraph 12 of the report, said that the control of multidrug-resistant tuberculosis and strengthening of research were essential for the achievement of the tuberculosis-related Millennium Development Goals. With the support of international partners, Paraguay was extending the Stop TB Strategy nationwide. It had a network of diagnostic laboratories and was working to reduce the time taken between notification and incorporation of data into national statistics. The Ministry of Health was providing free treatment in a bid to improve access and avoid the development of multidrug resistance to tuberculosis. The testing of tuberculosis patients for HIV infection, which had been introduced in 2009 with guidelines for

implementation, would be extended to 16 regions. Patients with multidrug-resistant tuberculosis were receiving medicines, through procurement by the Green Light Committee and with support from the Global Fund.

Dr Feng-Yee CHANG (Chinese Taipei) said that in 2006 Chinese Taipei had launched a programme aimed at halving the burden of tuberculosis in 10 years. Activities included the implementation of the DOTS strategy, a project on multidrug-resistant tuberculosis, surveillance and the establishment of a database. Over the previous four years, incidence of tuberculosis and mortality rates had been substantially reduced and coverage under the DOTS strategy was currently 100%. Coverage rates of 85% had been achieved for treatment of multidrug-resistant tuberculosis and had resulted in increased case detection and treatment success rates. Chinese Taipei would continue to undertake measures for prevention and control of tuberculosis in line with the Global Plan.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the importance WHO was giving to tuberculosis control. The emergence of multidrug-resistant and extensively drug-resistant tuberculosis was a reminder that quality-assured care delivered by informed, trained and supported health-care personnel was essential in tackling complex public health problems. His organization played a vital role in addressing the pressing challenges that included case detection; implementing WHO's policies on infection and tuberculosis control in health-care facilities; improving integrated tuberculosis and HIV care; and supporting universal access to diagnosis, treatment and care for all forms of the disease. In partnership with the pharmaceutical industry, national nurses associations and ministries of health, the Council was building global capacity in the prevention, detection, treatment and care of all forms of tuberculosis through an approach to training that had so far been successfully extended to more than 18 000 nurses.

Dr NAKATANI (Assistant Director-General) welcomed the support expressed for WHO's policies and programmes and for the Stop TB Partnership, whose secretariat WHO hosted and supported. Multidrug-resistant and extensively drug-resistant tuberculosis and coinfection with tuberculosis and HIV were complex challenges that required more costly interventions and, as the delegates of South Africa and Thailand had pointed out, required sustainable funding, secure supplies of medicines, appropriately trained human resources and new technologies. Tuberculosis incidence had declined since 2004. It was essential to maintain the current momentum and to achieve the tuberculosis-related Millennium Development Goals and targets.

In reply to the delegate of Israel, he said that the Secretariat would provide a further progress report in 2012. In response to the delegate of Thailand, he said that work was under way to reform the Green Light Committee mechanism in order to speed up the provision of second-line tuberculosis medicines. However, the process was sometimes hampered by a lack of national capacity, so efforts were needed to strengthen health systems and policies that required support from sectors other than health. In response to the delegates of China and Papua New Guinea, he indicated that WHO was supporting technology transfer for laboratory diagnosis through the Stop TB Partnership's Global Laboratory Initiative. The delegates of China and the Islamic Republic of Iran had asked about funding; the Secretariat was continuing to work with Member States to mobilize the necessary international and domestic resources for the control of tuberculosis and its multidrug-resistant forms in particular, and to make applications for support from the Global Fund. With regard to the WHO Prequalification Programme, currently 38 products from seven manufacturers, four of them from India, had completed the procedure. The Secretariat was aware of the need to provide quality-assured medicines and would try to step up its efforts in that area. Finally, he reminded Member States that tuberculosis control should continue to be underpinned by careful implementation of the orthodox DOTS strategy.

The Committee noted the report.

International recruitment of health personnel: draft global code of practice: Item 11.5 of the Agenda (Document A63/8 and A63/INF.DOC./2) (continued from the first meeting, section 3)

The CHAIRMAN said that the drafting group set up at the first meeting of the Committee to prepare a draft resolution on the draft global code of practice on the international recruitment of health personnel, and to revise the draft global code set out in document A63/8, had achieved consensus. He thanked all those concerned for their hard work, in particular the chairman, Dr Viroj Tangcharoensathien of Thailand.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), speaking as chairman of the drafting group on the draft global code of practice on the international recruitment of health personnel, said that the drafting group had held extensive and constructive discussions. It had been difficult to formulate the code because human resources for health varied widely in different Member States, ranging from countries experiencing critical shortages, as indicated in *The world health report 2006*; to those with difficulties in human-resource productivity; and those that were making a net gain through international recruitment. The group had nevertheless reached consensus and was pleased to submit the draft resolution incorporating the revised draft global code, which read:

The Sixty-third World Health Assembly,

Having considered the revised draft global code of practice on the international recruitment of health personnel, annexed to the report by the Secretariat on the international recruitment of health personnel: draft global code of practice contained in document A63/8,

1. ADOPTS, in accordance with Article 23 of the Constitution, the WHO Global Code of Practice on the International Recruitment of Health Personnel, hereafter the "WHO Global Code", annexed to the present resolution;
2. DECIDES that the first review of the relevance and effectiveness of the WHO Global Code shall be made by the Sixty-eighth World Health Assembly;
3. REQUESTS the Director-General:
 - (1) to give all possible support to Member States, as and when requested, for the implementation of the WHO Global Code;
 - (2) to cooperate with all stakeholders concerned with the implementation and monitoring of the WHO Global Code;
 - (3) to rapidly develop, in consultation with Member States, guidelines for minimum data sets, information exchange and reporting on the implementation of the WHO Global Code;
 - (4) based upon periodic reporting, to make proposals, if necessary, for the revision of the text of the WHO Global Code in line with the first review, and for measures needed for its effective application.

ANNEX

**REVISED WHO GLOBAL CODE OF PRACTICE ON THE
INTERNATIONAL RECRUITMENT OF HEALTH PERSONNEL***Preamble*

The Member States of the World Health Organization:

PP1 Recalling resolution WHA57.19 in which the World Health Assembly requested the Director-General to develop a voluntary code of practice on the international recruitment of health personnel in consultation with all relevant partners;

PP2 Responding to the calls of the Kampala Declaration adopted at the First Global Forum on Human Resources for Health (Kampala, 2–7 March 2008) and the G8 communiqués of 2008 and 2009 encouraging WHO to accelerate the development and adoption of a code of practice;

PP3 Conscious of the global shortage of health personnel and recognizing that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services;

PP4 Deeply concerned that the severe shortage of health personnel, including highly educated and trained health personnel, in many Member States, constitutes a major threat to the performance of health systems and undermines the ability of these countries to achieve the Millennium Development Goals and other internationally agreed development goals;

PP5 Stressing that the WHO Global Code of Practice on the International Recruitment of Health Personnel be a core component of bilateral, national, regional and global responses to the challenges of health personnel migration and health systems strengthening;

THEREFORE:

The Member States hereby agree on the following articles which are recommended as a basis for action.

Article 1 – Objectives

The objectives of this Code are:

- (1) to establish and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel;
- (2) to serve as a reference for Member States in establishing or improving the legal and institutional framework required for the international recruitment of health personnel;
- (3) to provide guidance that may be used where appropriate in the formulation and implementation of bilateral agreements and other international legal instruments;

(4) to facilitate and promote international discussion and advance cooperation on matters related to the ethical international recruitment of health personnel as part of strengthening health systems, with a particular focus on the situation of developing countries.

Article 2 – Nature and scope

2.1 The Code is voluntary. Member States and other stakeholders are strongly encouraged to use the Code.

2.2 The Code is global in scope and is intended as a guide for Member States, working together with stakeholders such as health personnel, recruiters, employers, health-professional organizations, relevant subregional, regional and global organizations, whether public or private sector, including nongovernmental, and all persons concerned with the international recruitment of health personnel.

2.3 The Code provides ethical principles applicable to the international recruitment of health personnel in a manner that strengthens the health systems of developing countries, countries with economies in transition and small island states.

Article 3 – Guiding principles

3.1 The health of all people is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states. Governments have a responsibility for the health of their people, which can be fulfilled only by the provision of adequate health and social measures. Member States should take the Code into account when developing their national health policies and cooperating with each other, as appropriate.

3.2 Addressing present and expected shortages in the health workforce is crucial to protecting global health. International migration of health personnel can make a sound contribution to the development and strengthening of health systems, if recruitment is properly managed. However, the setting of voluntary international principles and the coordination of national policies on international health personnel recruitment are desirable in order to advance frameworks to equitably strengthen health systems worldwide, to mitigate the negative effects of health personnel migration on the health systems of developing countries and to safeguard the rights of health personnel.

3.3 The specific needs and special circumstances of countries, especially those developing countries and countries with economies in transition that are particularly vulnerable to health workforce shortages and/or have limited capacity to implement the recommendations of this Code, should be considered. Developed countries should, to the extent possible, provide technical and financial assistance to developing countries and countries with economies in transition aimed at strengthening health systems, including health personnel development.

3.4 Member States should take into account the right to the highest attainable standard of health of the populations of source countries, individual rights of health personnel to leave any country in accordance with applicable laws, in order to mitigate the negative effects and maximize the positive effects of migration on the health systems of the source countries. However, nothing in this Code should be interpreted as limiting the freedom of health personnel, in accordance with applicable laws, to migrate to countries that wish to admit and employ them.

3.5 International recruitment of health personnel should be conducted in accordance with the principles of transparency, fairness and promotion of sustainability of health systems in developing countries. Member States, in conformity with national legislation and applicable international legal

instruments to which they are a party, should promote and respect fair labour practices for all health personnel. All aspects of the employment and treatment of migrant health personnel should be without unlawful distinction of any kind.

3.6 Member States should strive, to the extent possible, to create a sustainable health workforce and work towards establishing effective health workforce planning, education and training, and retention strategies that will reduce their need to recruit migrant health personnel. Policies and measures to strengthen the health workforce should be appropriate for the specific conditions of each country and should be integrated within national development programmes.

3.7 Effective gathering of national and international data, research and sharing of information on international recruitment of health personnel are needed to achieve the objectives of this Code.

3.8 Member States should facilitate circular migration of health personnel, so that skills and knowledge can be achieved to the benefit of both source and destination countries.

Article 4 – Responsibilities, rights and recruitment practices

4.1. Health personnel, health professional organizations, professional councils and recruiters should seek to cooperate fully with regulators, national and local authorities in the interests of patients, health systems, and of society in general.

4.2 Recruiters and employers should, to the extent possible, be aware of and consider the outstanding legal responsibility of health personnel to the health system of their own country such as a fair and reasonable contract of service and not seek to recruit them. Health personnel should be open and transparent about any contractual obligations they may have.

4.3 Member States and other stakeholders should recognize that ethical international recruitment practices provide health personnel with the opportunity to assess the benefits and risks associated with employment positions and to make timely and informed decisions.

4.4 Member States should, to the extent possible under applicable laws, ensure that recruiters and employers observe fair and just recruitment and contractual practices in the employment of migrant health personnel and that migrant health personnel are not subject to illegal or fraudulent conduct. Migrant health personnel should be hired, promoted and remunerated based on objective criteria, such as levels of qualification, years of experience and degrees of professional responsibility on the basis of equality of treatment with the domestically trained health workforce. Recruiters and employers should provide migrant health personnel with relevant and accurate information about all health personnel positions that they are offered.

4.5 Member States should ensure that, subject to applicable laws, including relevant international legal instruments to which they are a party, migrant health personnel enjoy the same legal rights and responsibilities as the domestically trained health workforce in all terms of employment and conditions of work.

4.6 Member States and other stakeholders should take measures to ensure that migrant health personnel enjoy opportunities and incentives to strengthen their professional education, qualifications and career progression, on the basis of equal treatment with the domestically trained health workforce subject to applicable laws. All migrant health personnel should be offered appropriate induction and orientation programmes that enable them to operate safely and effectively within the health system of the destination country.

4.7 Recruiters and employers should understand that the Code applies equally to those recruited to work on a temporary or permanent basis.

Article 5 – Health workforce development and health systems sustainability

5.1 In accordance with the guiding principle as stated in Article 3 of this Code, the health systems of both source and destination countries should derive benefits from the international migration of health personnel. Destination countries are encouraged to collaborate with source countries to sustain and promote health human resource development and training as appropriate. Member States should discourage active recruitment of health personnel from developing countries facing critical shortages of health workers.

5.2 Member States should use this Code as a guide when entering into bilateral, and/or regional and/or multilateral arrangements, to promote international cooperation and coordination on international recruitment of health personnel. Such arrangements should take into account the needs of developing countries and countries with economies in transition through the adoption of appropriate measures. Such measures may include the provision of effective and appropriate technical assistance, support for health personnel retention, social and professional recognition of health personnel, support for training in source countries that is appropriate for the disease profile of such countries, twinning of health facilities, support for capacity building in the development of appropriate regulatory frameworks, access to specialized training, technology and skills transfers, and the support of return migration, whether temporary or permanent.

5.3 Member States should recognize the value both to their health systems and to health personnel themselves of professional exchanges between countries and of opportunities to work and train abroad. Member States in both source and destination countries should encourage and support health personnel to utilize work experience gained abroad for the benefit of their home country.

5.4 As the health workforce is central to sustainable health systems, Member States should take effective measures to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country, including areas of greatest need, and is built upon an evidence-based health workforce plan. All Member States should strive to meet their health personnel needs with their own human resources for health, as far as possible.

5.5 Member States should consider strengthening educational institutions to scale up the training of health personnel and developing innovative curricula to address current health needs. Member States should undertake steps to ensure that appropriate training takes place in the public and private sectors.

5.6 Member States should consider adopting and implementing effective measures aimed at strengthening health systems, continuous monitoring of the health labour market, and coordination among all stakeholders in order to develop and retain a sustainable health workforce responsive to their population's health needs. Member States should adopt a multisectoral approach to addressing these issues in national health and development policies.

5.7 Member States should consider adopting measures to address the geographical maldistribution of health workers and to support their retention in underserved areas, such as through the application of education measures, financial incentives, regulatory measures, social and professional support.

Article 6 – Data gathering and research

6.1 Member States should recognize that the formulation of effective policies and plans on the health workforce requires a sound evidence base.

6.2 Taking into account characteristics of national health systems, Member States are encouraged to establish or strengthen and maintain, as appropriate, health personnel information systems, including health personnel migration, and its impact on health systems. Member States are encouraged to collect, analyse and translate data into effective health workforce policies and planning.

6.3 Member States are encouraged to establish or strengthen research programmes in the field of health personnel migration and coordinate such research programmes through partnerships at the national, sub-national, regional and international levels.

6.4 WHO, in collaboration with relevant international organizations and Member States, is encouraged to ensure, as much as possible, that comparable and reliable data are generated and collected pursuant to paragraphs 6.2 and 6.3 for ongoing monitoring, analysis and policy formulation.

Article 7 – Information exchange

7.1 Member States are encouraged to, as appropriate and subject to national law, promote the establishment or strengthening of information exchange on international health personnel migration and health systems, nationally and internationally, through public agencies, academic and research institutions, health professional organizations, and subregional, regional and international organizations, whether governmental or nongovernmental.

7.2 In order to promote and facilitate the exchange of information that is relevant to this Code, each Member State should, to the extent possible:

- (a) progressively establish and maintain an updated database of laws and regulations related to health personnel recruitment and migration and, as appropriate, information about their implementation;
- (b) progressively establish and maintain updated data from health personnel information systems in accordance with Article 6.2; and
- (c) provide data collected pursuant to subparagraphs (a) and (b) above to the WHO Secretariat every three years, beginning with an initial data report within two years after the adoption of the Code by the Health Assembly.

7.3 For purposes of international communication, each Member State should, as appropriate, designate a national authority responsible for the exchange of information regarding health personnel migration and the implementation of the Code. Member States so designating such an authority, should inform WHO. The designated national authority should be authorized to communicate directly or, as provided by national law or regulations, with designated national authorities of other Member States and with the WHO Secretariat and other regional and international organizations concerned, and to submit reports and other information to the WHO Secretariat pursuant to subparagraph 7.2(c) and Article 9.1.

7.4 A register of designated national authorities pursuant to paragraph 7.3 above shall be established, maintained and published by WHO.

Article 8 – Implementation of the Code

8.1 Member States are encouraged to publicize and implement the Code in collaboration with all stakeholders as stipulated in Article 2.2, in accordance with national and subnational responsibilities.

8.2 Member States are encouraged to incorporate the Code into applicable laws and policies.

8.3 Member States are encouraged to consult, as appropriate, with all stakeholders as stipulated in Article 2.2 in decision-making processes and involve them in other activities related to the international recruitment of health personnel.

8.4 All stakeholders referred to in Article 2.2 should strive to work individually and collectively to achieve the objectives of this Code. All stakeholders should observe this Code, irrespective of the capacity of others to observe the Code. Recruiters and employers should cooperate fully in the observance of the Code and promote the guiding principles expressed by the Code, irrespective of a Member State's ability to implement the Code.

8.5 Member States should, to the extent possible, and according to legal responsibilities, working with relevant stakeholders, maintain a record, updated at regular intervals, of all recruiters authorized by competent authorities to operate within their jurisdiction.

8.6 Member States should to the extent possible encourage and promote good practices among recruitment agencies by only using those agencies that comply with the guiding principles of the Code.

8.7 Member States are encouraged to observe and assess the magnitude of active international recruitment of health personnel from countries facing critical shortage of health personnel, and assess the scope and impact of circular migration.

Article 9 – Monitoring and institutional arrangements

9.1 Member States should periodically report the measures taken, results achieved, difficulties encountered and lessons learned into a single report in conjunction with the provisions of Article 7.2(c).

9.2 The Director-General shall keep under review the implementation of this Code, on the basis of periodic reports received from designated national authorities pursuant to Articles 7.3 and 9.1 and other competent sources, and periodically report to the World Health Assembly on the effectiveness of the Code in achieving its stated objectives and suggestions for its improvement. This report would be submitted in conjunction with Article 7.2(c).

9.3 The Director-General shall:

(a) support the information exchange system and the network of designated national authorities specified in Article 7;

(b) develop guidelines and make recommendations on practices and procedures and such joint programmes and measures as specified by the Code; and

(c) maintain liaison with the United Nations, the International Labour Organization, the International Organization for Migration, and other competent regional and international organizations as well as concerned nongovernmental organizations to support implementation of the Code.

9.4 The WHO Secretariat may consider reports from stakeholders as stipulated in Article 2.2 on activities related to the implementation of the Code.

9.5 The World Health Assembly should periodically review the relevance and effectiveness of the Code. The Code should be considered a dynamic text that should be brought up to date as required.

Article 10 – Partnerships, technical collaboration and financial support

10.1 Member States and other stakeholders should collaborate directly or through competent international bodies to strengthen their capacity to implement the objectives of the Code.

10.2 International organizations, international donor agencies, financial and development institutions, and other relevant organizations are encouraged to provide their technical and financial support to assist the implementation of this Code and support health system strengthening in developing countries and countries with economies in transition that are experiencing critical health workforce shortages and/or have limited capacity to implement the objectives of this Code. Such organizations and other entities should be encouraged to cooperate with countries facing critical shortages of health workers and undertake to ensure that funds provided for disease-specific interventions are used to strengthen health systems capacity, including health personnel development.

10.3 Member States either on their own or via their engagement with national and regional organizations, donor organizations and other relevant bodies should be encouraged to provide technical assistance and financial support to developing countries or countries with economies in transition, aiming at strengthening health systems capacity, including health personnel development in those countries.

He expressed the hope that the draft resolution and revised draft global code would meet with the approval of the Committee.

The draft resolution was approved.¹

Viral hepatitis: Item 11.12 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R16, and A63/15)

The CHAIRMAN introduced the item and drew attention to the draft resolution contained in document A63/15.

Dr AL SHATI (Kuwait) welcomed the inclusion of the subject of viral hepatitis on the agenda of the Health Assembly and supported the draft resolution, in particular the proposal to designate a World Hepatitis Day. Health-care workers were especially at risk of contracting viral hepatitis and studies should be conducted to establish whether health-workers could continue working after having contracted the disease.

Hepatitis prevention measures would be enhanced through the setting of targets and information provided to health personnel. His Government's prevention activities had focused on hepatitis B in children and training included safe injection practices for health-care workers. Comprehensive surveillance of viral hepatitis was conducted by the Ministry of Health, and guidelines for treatment and prevention were in place. Efforts were being made to achieve the target set by the Regional Office for the Eastern Mediterranean in 2009 to reduce the prevalence rate of viral hepatitis in children. All the relevant recommendations contained in Health Assembly resolutions had been fulfilled and the

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA63.16.

Ministry of Health was working with civil society to control the disease. Kuwait would continue to work with the Secretariat to achieve the goals set.

Dr AL-SAYYAD (Bahrain), commending the Secretariat for work done in combating viral hepatitis, said that in his country the issue had serious implications and economic costs for the health system. Surveillance and prevention measures were essential. The incidence rate for hepatitis A had been reduced in Bahrain from 35 per 100 000 in 2004 to 9 per 100 000 in 2009. However, the rate of detection of new cases of hepatitis B and C remained the same since the inclusion of these two diseases in the epidemiological surveillance programme since 1998. Annual incidence rates for hepatitis B virus ranged from 500 to 700 per year and for hepatitis C virus from 200 to 300 cases.

Immunization to control hepatitis B had been introduced in 2004 and also for children against hepatitis A. There were follow-up and prevention measures regarding liver health and training health-care workers to treat all forms of hepatitis. Efforts were being made to reduce the level of chronic viral hepatitis infections; to strengthen follow-up activities and referral for patients with hepatitis B and C; updating the national control plan for viral hepatitis A, B and C; and providing free treatment and care for people infected with hepatitis C virus. He supported the draft resolution.

Mr AL-TAAE (Iraq) said that solid progress had been made in his country in the clinical diagnosis of all forms of hepatitis. Prevalence rates of hepatitis B and E were high and particular attention was being paid to prevention of hepatitis B in early childhood. The Ministry of Health was keen to coordinate its activities with all organizations that were working in the area of health; and to implement WHO's recommendations in health-care settings, including training and prevention programmes in the practice of safe injections.

Ms SONG Kyung-Min (Republic of Korea) said that hepatitis B had been a major public health problem in her country. Hepatitis B vaccine had been introduced into the national immunization programme in 1995, which had been reinforced with a separate programme to prevent perinatal transmission of hepatitis B virus in 2002. Her country had been certified by the Western Pacific Region as having achieved the goal of hepatitis B control in 2008.

She expressed support for the comprehensive approach to prevention and control of viral hepatitis set out in the report; for the draft resolution; and for the designation of a World Hepatitis Day. WHO should be the catalyst for sharing information on the prevention and treatment of viral hepatitis, including measures to prevent transfusion-related transmission of the disease. Her country would be pleased to share its experience of the control of viral hepatitis.

Dr KASSIM (Brunei Darussalam) said that, given the high global health burden resulting from viral hepatitis, the current focus on the disease was timely. Viral hepatitis was a debilitating disease with varying presentation, disease etiology and global distribution. The successful control and prevention measures taken to date were to be commended; however, the report also highlighted the need to consolidate and coordinate those measures through the development of a comprehensive strategy. She urged support for the elaboration of a draft strategy and adoption of the draft resolution.

Dr ALMARZOOQI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that viral hepatitis was a significant health problem with high costs of treatment: consideration of the issue was timely. Projects for viral hepatitis control had been effective but there was still insufficient coordination at the international level; a global strategy was required as well as more work on prevention in order to strengthen international efforts to control transmission. His country had prioritized a prevention strategy: immunization for children had achieved a national coverage rate of 94%. It was also monitoring rates of incidence and had introduced programmes for immunization of pregnant women.

In 2009, the Region had adopted a strategy to combat hepatitis B which included the immunization of children under five years of age. Her Region supported the draft resolution and called

on the Secretariat to continue to provide technical support and guidelines to developing countries as well as to develop an effective international strategy for control of hepatitis in all health-care settings.

Mrs TZIMAS (Germany) welcomed the draft resolution and stressed that a prevention approach was key to reducing incidence. Availability of epidemiological data was not sufficient in all contexts and yet surveillance was essential in order to develop evidence-based and efficient interventions. Therefore, she proposed to amend the resolution by inserting the word “surveillance” before “prevention” in subparagraph 3(1).

Mr EL MENZHI (Morocco) said that viral hepatitis posed similar challenges to those of HIV/AIDS, although it had not received the same level of attention. He strongly supported the draft resolution as it would serve to improve the global prevention and control of viral hepatitis. However, he would prefer another date to be designated for World Hepatitis Day since the one proposed coincided with a holiday period. Donors should allocate resources for hepatitis control and an international fund for hepatitis control should be established. He called on the pharmaceutical industry to lower the costs of medicines in order to facilitate access to treatment. A global strategy, with well defined goals, should be elaborated for hepatitis control.

Dr PAIROJ SAONUAM (Thailand) welcomed the report on viral hepatitis and the draft resolution to which he proposed several amendments. In the fourth preambular paragraph, the words “advocacy to both governments and populations” should be replaced by “advocacy to governments, all parties and populations”; in the fifth preambular paragraph, the phrase “access to affordable treatments as well as an integrated approach to the management of the disease” should be re-worded to read: “access to affordable prevention and control measures as well as an integrated approach to the appropriate treatment and care of the disease”; in subparagraph 2(1), the words “and to strengthen laboratory capacity, where necessary” should be inserted after “surveillance system”; at the end of subparagraph 2(2), the words “blood systems” should be replaced by “blood products”; at the end of subparagraph 2(3), the words “including migrant and vulnerable populations” should be added after “population affected by viral hepatitis”; in subparagraph 2(9) the phrase “related to preventive, diagnostic and treatment activities” should be replaced by “in order to assess progress towards reducing the burden from viral hepatitis and to guide evidence-based strategy for policy decisions”; in subparagraph 3(3), the phrase “global and regional” should be inserted before “economic impact”; and subparagraphs 3(5) and (6) should be integrated into a new subparagraph (5), which would read:

“to invite international organizations, financial institutions and other partners to give support and assign resources in strengthening of surveillance systems, prevention and control programmes, diagnostic and laboratory capacity, and management of viral hepatitis to developing countries in an equitable, most efficient and suitable manner;”

He expressed support for holding World Hepatitis Day on 28 July in order to honour Professor Baruch Blumberg who had discovered the hepatitis B virus.

Dr MELNIKOVA (Russian Federation) said that viral hepatitis represented a significant burden for the health systems of many countries, especially those with limited resources. She agreed that WHO should adopt an integrated strategy for prevention and control. The main elements to prevention and control of viral hepatitis, which were outlined in the report, had been successfully implemented in her country, including those concerned with the treatment of hepatitis B virus/HIV and hepatitis C virus/HIV coinfections. The most effective preventive measure had been the mass vaccination against hepatitis B, with coverage of more than 50 million people. Vaccination had reduced incidence rates for hepatitis B to sporadic levels in most regions of the country. A single donor database that included registers of blood donors was being developed. In order to ensure safe clinical transfusion practices, all blood supplies were screened for markers of hepatitis B and C virus infection. Great efforts were made, including allocation of additional resources, to provide antiviral medicines for the treatment of patients with chronic hepatitis B and C virus infection and those coinfecting with HIV. Awareness-

raising campaigns had been conducted and a prevention strategy for mother-to-child transmission had been put in place. Efforts were being made to prevent infections through contaminated blood among the most vulnerable sections of the population. Effective measures were still required for practices such as sharps waste management; use of non-reusable syringes for immunization; and ensuring the supply of safe food and water. Following the identification of an escape mutant of hepatitis B virus, an international system would be needed to monitor mutant forms of hepatitis A, B, C and E viruses; that element should be included in the draft global strategy for prevention of viral hepatitis. She supported the draft resolution and the designation of a World Hepatitis Day.

Dr MULYONO (Indonesia) noted that the dramatic reduction in hepatitis B virus transmission in many endemic countries was the result of vaccination at birth and other vaccination strategies. However, prevalence of viral infection was highest in developing countries where the treatment needed to delay progression to chronic cirrhosis and liver cancer was not readily available and resulted in alarming rates of mortality. Furthermore, the treatment itself was complicated by the toxicity of medicines, antiviral resistance, virus mutation and the need for long-term follow-up. Health Assembly resolutions on immunization, safe blood supplies and safe injection had resulted in only minimal progress; the current draft resolution sought to improve on that state of affairs by its call for comprehensive prevention and control of viral hepatitis and seeking to raise awareness of efforts to that end through the designation of a World Hepatitis Day on 28 July.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that preventive immunization and treatment could significantly reduce morbidity and mortality caused by viral hepatitis infection and HIV/tuberculosis coinfection. All but one of the States in the Region had integrated hepatitis B virus vaccine into their national immunization programmes. However, available data were insufficient for formulation of strategies to combat hepatitis C, and he urged WHO to mobilize resources and promote the necessary research on prevalence and disease burden in the Region. Efforts to reduce morbidity related to viral hepatitis hinged on the screening of pregnant women and other groups at risk, and cost-effective tests to ensure accurate diagnosis and follow-up of patients. The African Region was home to around 50 million of the world's estimated 450 million carriers of hepatitis B virus but could not afford the medicines and treatment. He therefore requested WHO to appeal to pharmaceutical companies to cut their prices, as had been done for HIV/AIDS. Recalling the declaration adopted at the second "Hepatitis B and C – the African Experience Exchange Conference" (Mauritius, 2–4 April 2009), he urged the Organization to support Africa in strategies for prevention and control of viral hepatitis, sustainable financing for vaccine procurement, unsafe injection, and unsafe blood supplies for transfusion.

Dr XIAO Donglou (China), endorsing the analysis contained in the report, suggested that WHO should propose a global partnership to control and treat infections; that it step up prevention strategies, and prioritize hepatitis B virus vaccination, including the targeted vaccination of high-risk groups, including neonates and young children; and that it enhance health promotion for the control of morbidity related to hepatitis C and E virus. Furthermore, WHO should embark on work in setting standards for medicines for use in viral hepatitis in order to prevent their irrational use and social discrimination.

Dr MULESHE (Kenya) said that his country had integrated hepatitis vaccination into the national immunization programme for children under five years of age, and its laboratories routinely screened for markers of hepatitis B and C virus infection. However, support was required to scale up existing capacity to manufacture test kits; to introduce antenatal hepatitis B virus screening into public health facilities; and to increase coverage of hepatitis B vaccination among all health-care workers.

Expressing support for the resolution, he proposed several amendments. A new preambular paragraph should be inserted before paragraph 1, to read: "Further recognizing the need for universal coverage for safe injection practices as promoted through the WHO Safe Injection Global Network".

In paragraph 1 the phrase “or such other day or days as individual Member States decide” should be inserted after “28 July” so as to ensure consistency with subparagraph 2(10). A new subparagraph 2(11) should be added to read: “to promote total injection safety at all levels of national health-care systems”; a new subparagraph 3(7) should be added to read: “to strengthen the WHO Safe Injection Global Network”. The current subparagraphs 3(7) and 3(8) would need to be renumbered accordingly.

Ms VALLINI (Brazil) endorsed the report’s assertion that viral hepatitis was a serious global health problem. With no available vaccine for hepatitis C virus, around 80% of those infections became chronic and potentially fatal. Infection was linked to complex cultural, socioeconomic and environmental factors; measures for prevention and control required the involvement of governments, communities, health workers, civil society and other partners. The designation of a World Hepatitis Day, in conjunction with campaigns to combat HIV/AIDS and other diseases, would boost national programmes and actions to raise awareness of the problem, and foster public participations. She supported the draft resolution: it would provide a major impetus for national strategies for prevention and control and establish operational guidelines for scientific and technological research and development, and would also facilitate access to the relevant technologies for developing countries and vulnerable population groups.

Dr ACOSTA SAAL (Peru), endorsing the comments made by the delegate of Brazil, drew attention to the plight of the vulnerable indigenous populations of the Amazon rainforests, who were devastated by the rapid spread of hepatitis B virus infection. His Government was overseeing the management of a multisectoral approach to the prevention and control of viral hepatitis, within the framework of joint HIV/AIDS and tuberculosis strategies, and drawing on experience of programmes to control sexually transmitted infections and supported by protocols and guidelines. Although vaccines could be swiftly distributed and extensive campaigns carried out to curb vertical transmission of hepatitis viruses, problems remained with respect to the cost of surveillance in order to determine the extent of infection, and to deal with hepatitis virus carriers whose infections had rapidly developed into cirrhosis and cancer. A major offensive was required. He supported the draft resolution, which would represent the first step in a concerted WHO strategy aimed at future management of the disease.

Professor Pei-Jer CHEN (Chinese Taipei) expressed appreciation for the recommendations contained in the draft resolution on the prevention and control of viral hepatitis, including the designation of a World Hepatitis Day. Chinese Taipei’s long experience in that area had shown that vaccination, effective screening, diagnosis, monitoring and treatment could prevent and control infection, but that sufficient resources and commitment were still needed to sustain momentum. The Secretariat must coordinate action to raise public awareness and education; to overcome the geographical, social and financial inequities in access to health care; to improve the standards of care; and to produce new generations of effective and affordable vaccines. Chinese Taipei continued to promote concerted action among all stakeholders to rid society of viral hepatitis, especially hepatitis B, in the near future.

Mr GORE (International Alliance of Patients’ Organizations), speaking at the invitation of the CHAIRMAN and also as President of the World Hepatitis Alliance and as a hepatitis patient who would be directly affected by the decision to be taken by the Health Assembly, pointed out that many of the 500 million people living with chronic viral hepatitis B and C were not yet ill, despite advanced liver disease, and many were undiagnosed. Before the next Health Assembly, many more would become infected and around one million would die. Published research undertaken by the World Hepatitis Alliance for WHO showed that four out of five responding Member States viewed the disease as an urgent public health issue. He therefore encouraged Member States to approve the draft resolution, which provided a robust and effective framework for viral hepatitis prevention and control. The adoption of a strong resolution would be the first step in tackling the disease in a comprehensive,

global manner and emphasize to partner institutions that WHO considered viral hepatitis to be a global health priority.

Dr FUKUDA (Assistant Director-General) thanked delegates for their comments and suggestions, which indicated the recognition of viral hepatitis as a major public health problem that had perhaps not been given the attention it deserved. The disease had several etiologies and often presented with other infections, such as HIV and tuberculosis, especially in Africa. Although prevention and control activities were often fragmented, some countries had developed strong programmes, and those with good hepatitis B vaccination interventions had achieved gratifying results. In addition to vaccination, blood and injection safety, public and patient education, and provision of medicines should also be taken into account, although the cost of medicines could be a serious obstacle. Delegates had clearly called for a coordinated and integrated approach, and had emphasized the need for surveillance, normative guidance, additional training and guidance for health-care workers, clear goals, further research on hepatitis C and improved access to medicines. There also appeared to be strong support for the designation of a World Hepatitis Day. The Secretariat recognized the need to give greater attention to viral hepatitis and would plan for a more coordinated and focused approach in the future.

The CHAIRMAN suggested that the Secretariat should be requested to prepare a revised text of the draft resolution, taking into account the proposed amendments, and that further consideration of the item should be postponed pending circulation of the revised text.

It was so agreed.

(For approval of the draft resolution, see the summary record of the eleventh meeting, section 1.)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 11.4 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R4, and A63/7) (continued from the fourth meeting, section 1)

The CHAIRMAN drew attention to the revised draft resolution, which included the amendments proposed by the delegations of Jamaica, Papua New Guinea, and Thailand on behalf of the Member States of the South-East Asia Region, and which read:

The Sixty-third World Health Assembly,

PP1 Having considered the report on monitoring of the achievement of the health-related Millennium Development Goals;¹

PP2 Recalling resolution WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals;

PP3 Recalling the outcomes of the major United Nations conferences and summits in the economic, social and related fields, especially those related to global health, in particular the 2005 World Summit Outcome and the commitments made by the international community to attain the Millennium Development Goals and the new commitments made during the United Nations High-level Event on the Millennium Development Goals (New York, 25 September 2008);

PP4 Stressing the importance of achieving the health-related Millennium Development Goals, especially with the objective of ensuring socioeconomic development;

PP5 Concerned by the fact that achievement of the Millennium Development Goals varies from country to country and from goal to goal;

¹ Document EB126/7.

PP6 Welcoming the Ministerial Declaration adopted at the annual ministerial review held by the Economic and Social Council in 2009 on implementing the internationally agreed goals and commitments in regard to global public health;

PP7 Recalling United Nations General Assembly resolution 64/108 (10 December 2009) on global health and foreign policy;

PP8 Recognizing that the Millennium Development Goals are interlinked, and reiterating the Health Assembly's commitment to continued reinvigoration and strengthening of the global partnership for development, as a vital element for achieving these Goals, in particular those related to health, inter alia through capacity building, transfer of technology, sharing of best practices and lessons learnt, South-South cooperation, and predictability of resources;

PP9 Recalling the Monterrey Consensus of March 2002 to "urge developed countries that have not done so, to make concrete efforts towards the target of 0.7% of the gross national product (GNP) as ODA" and "encourage developing countries to build on progress achieved in ensuring that ODA is used effectively to help achieve development goals and targets";

PP10 Reaffirming the commitments by many developed countries to achieve the target of 0.7% of gross national income on official development assistance by 2015 and to reach 0.56% of gross national income for official development assistance by 2010, as well as the target of 0.15% to 0.20% for least developed countries;

PP11 Welcoming increasing efforts to improve the quality of official development assistance and to increase its development impact, such as the Development Cooperation Forum of the Economic and Social Council, the principles contained in the Paris Declaration and the Accra Agenda for Action, and the experience of the International Health Partnership and others, in order to strengthen national ownership, alignment, harmonization and managing for results;

PP12 Noting the work of the Leading Group on Innovative Financing for Development and of the High-level Task Force on Innovative International Financing for Health Systems, the additional pledges made by several countries to increase financing for health, and the announcements made by several countries at the United Nations General Assembly High-level Meeting on Health (New York, 23 September 2009) to achieve universal access to affordable basic health care, including provision of free services for women and children at the point of use where countries choose, and financial mechanisms toward social health protection;

PP13 Expressing concern at the relatively slow progress in attaining the Millennium Development Goals, particularly in sub-Saharan Africa;

PP13bis Expressing deep concern over the weak institutional capacity in health-information systems, the inadequate coverage and poor quality of civil registrations in developing countries which hamper monitoring progress of Millennium Development Goals, this requires significant increased investment in financial and human resources on health-information systems to generate accurate, reliable and timely evidence on achievement of the Goals, gender and geographical disparities; [Thailand on behalf of countries of the South-East Asia Region]

PP14 Expressing deep concern that maternal, newborn and child health and universal access to reproductive health services remain constrained by health inequities, and at the slow progress in achieving Millennium Development Goals 4 and 5 on improving child and maternal health;

PP15 Welcoming the contribution of all relevant partners and progress achieved towards the goal of universal access to prevention, treatment, care and support related to HIV/AIDS;

PP16 Reaffirming WHO's leading role as the primary United Nations specialized agency for health, including its roles and functions with regard to health policy in accordance with its mandate;

PP17 Welcoming WHO's report on women and health¹ as important in advancing women's rights and gender equality, underlining the need to address women's health through comprehensive strategies targeting root causes of discrimination, and stressing the importance of strengthening health systems to better respond to women's health needs in terms of access and comprehensiveness;

PP18 Recognizing that health systems based on the principles of tackling health inequalities through universal access, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health are essential to achieving sustainable improvements in health;

PP19 Recognizing also the growing burden of noncommunicable diseases worldwide, and recalling the importance of preventing infectious diseases that still represent a heavy burden, particularly in developing countries, the adverse impacts of the food, environmental, economic and financial crises on populations, in particular on the poorest and the most vulnerable ones, which may increase the level of malnutrition and reverse the achievement of Millennium Development Goal 1 (Eradicate extreme hunger and poverty) and the health-related Goals and the progress made in the past two decades,

1. URGES Member States:

(1) to strengthen health systems so that they deliver equitable health outcomes as a basis of a comprehensive approach towards achieving Millennium Development Goals 4, 5 and 6, underlining the need to build sustainable national health systems and strengthen national capacities through attention to, inter alia, service delivery, health systems financing, health workforce, health information systems, procurement and distribution of medicines, vaccines and technologies, sexual and reproductive health care and political will in leadership and governance;

(2) to review policies, including those on recruitment, training and retention, that exacerbate the problem of the lack of health workers, and their imbalanced distribution, within countries and throughout the world, in particular the shortage in sub-Saharan Africa, which undermines the health systems of developing countries;

(3) to reaffirm the values and principles of primary health care, including equity, solidarity, social justice, universal access to services, multisectoral action, transparency, accountability, decentralization and community participation and empowerment, as the basis for strengthening health systems, through support for health and development; **taking into account leadership, public policy, universal coverage and service-delivery reforms necessary for strengthening primary health care. [Jamaica]**

(4) to take into account health equity in all national policies that address social determinants of health, and to consider developing and strengthening universal comprehensive social protection policies, including health promotion, infectious and noncommunicable disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;

(4)bis to further commit to investment in and strengthening of the national health-information systems in order to generate accurate, reliable and timely evidence on achievement of the Millennium Development Goals; [Thailand on behalf of countries of the South-East Asia Region]

(5) to renew their commitment to prevent and eliminate maternal, newborn and child mortality and morbidity: through an effective continuum of care, **in particular through interventions that increase rates of exclusive and sustained breastfeeding, [Papua New Guinea]** strengthening health systems, and comprehensive and integrated strategies and programmes to address root causes of gender inequalities and lack of access to

¹ *Women and health: today's evidence tomorrow's agenda*. Geneva, World Health Organization, 2009.

adequate care and reproductive health, including family planning and sexual health; by promoting respect for women's rights; and by scaling up efforts to achieve integrated management of newborn and child health care, including actions to address the main causes of child mortality;

(6) to expand significantly efforts towards meeting the goal of universal access to HIV prevention, treatment, care and support by 2010 and the goal to halt and reverse the spread of HIV/AIDS by 2015;

(7) to maximize synergies between the HIV/AIDS response and strengthening of health systems and social support;

(8) to enhance policies to address the challenges of malaria including monitoring of drug resistance in artemisinin-based combination therapy;

(9) to sustain and strengthen the gains made in combating tuberculosis, and to develop innovative strategies for tuberculosis prevention, detection and treatment, including means of dealing with new threats such as coinfection with HIV, multidrug-resistant tuberculosis or extensively drug-resistant tuberculosis;

(10) to sustain commitments to support the eradication of poliomyelitis; **and measles;**
[Jamaica]

(11) to include best practices for strengthening health services in bilateral and multilateral initiatives addressed to the achievement of the Millennium Development Goals, in particular in South-South cooperation initiatives;

(12) to support developing countries in their national endeavours to achieve the Millennium Development Goals, in particular the health-related Millennium Development Goals, inter alia through capacity building, transfer of technology, sharing of lessons learnt and best practices, South-South cooperation, and predictability of resources;

(13) to fulfil their commitments regarding official development assistance by 2015; **for both levels and its allocation to the least developed countries;** **[Thailand on behalf of countries of the South-East Asia Region]**

(14) **to fulfil and sustain the political and financial commitment of developing country governments in mobilizing adequate budget allocation to health sectors** **[Thailand on behalf of countries of the South-East Asia Region]**

2. REQUESTS the Director-General:

(1) to continue to play a leading role in the monitoring of the achievement of the health-related Millennium Development Goals, including progress towards achieving universal coverage of services essential to these Goals;

(2) within the framework of WHO's Medium-term strategic plan 2008-2013, to continue to cooperate closely with all other United Nations and international organizations involved in the process of achieving the Millennium Development Goals, maintaining a strong focus on efficient use of resources based on the respective mandates and core competencies of each, avoiding duplication of efforts and fragmentation of aid, and promoting the coordination of work among international agencies;

(3) to provide support to Member States in their efforts to strengthen their health systems, address the problem of the lack of health workers, reaffirm the values and principles of primary health care, address the social determinants of health, and strengthen their public policies aimed at fostering full access to health and social protection, including improved access to quality medicines required to support health care for, inter alia, the most vulnerable sectors of society;

(4) to foster alignment and coordination of global interventions for health system strengthening, basing them on the primary health care approach, in collaboration with Member States, relevant international organizations, international health initiatives, and

other stakeholders in order to increase synergies between international and national priorities;

(5) to articulate and present to the Health Assembly as part of its action plan for the renewal of primary health care, the actions that the Secretariat envisages will strengthen its support for the realization of Millennium Development Goals 4, 5 and 6;

(6) to work with all relevant partners in order to achieve high immunization coverage rates with affordable vaccines of assured quality;

(7) to lead the work with all relevant partners to help to ensure that action on the health-related Millennium Development Goals is one of the main themes of the United Nations Millennium Development Goals High-level Plenary Meeting, 20–22 September 2010;

(8) to continue to collect and compile scientific evidence needed for achieving health-related Millennium Development Goals and to disseminate it to all Member States;

(9) to continue to submit annually a report on the status of progress made, including on main obstacles and ways to overcome them, in achievement of the health-related Millennium Development Goals, through the Executive Board, to the Health Assembly;

(10) to promote the development of robust and reliable health-information systems in order to ensure the collection and compilation of quality data for accurate measurement and tracking of achievement of Millennium Development Goals; [Jamaica]

(11) 3. INVITES to call upon [Thailand on behalf of countries of the South-East Asia Region] concerned organizations of the United Nations system, international development partners and agencies, international financial institutions, nongovernmental organizations and private sector entities to continue their support and consider further support to countries, particularly in sub-Saharan Africa, for the development and implementation of health policies and national health development plans, consistent with internationally agreed health goals, including the Millennium Development Goals.

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, said that, following wide consultations, he proposed several further amendments. First, with the agreement of the delegation of Thailand, preambular paragraph 13bis should be amended to read: “Expressing deep concern over the weak institutional capacity in health-information systems, the inadequate coverage and poor quality of civil registrations in developing countries, which hampered monitoring progress of Millennium Development Goals”. The amendment to subparagraph 1(3) proposed by Jamaica was acceptable. Subparagraph 1(4)bis should be amended to read: “to further commit to increased investment in financial and human resources and to strengthening the national health-information systems in order to generate accurate, reliable and timely evidence on achievement of the Millennium Development Goals”. That proposal had been agreed to by the delegation of Thailand, on behalf of countries of the South-East Asia Region. In subparagraph 1(5), the additional wording proposed by Papua New Guinea, namely “in particular through interventions that increase rates of exclusive and sustained breastfeeding”, should be moved to the end of the paragraph. In subparagraph 1(10), the additional wording “and measles” proposed by Jamaica should be amended to read “and the efforts to eliminate measles”. The amendment to subparagraph 1(13) proposed by Thailand had been withdrawn with the agreement of that delegation. The new subparagraph 1(14) proposed by Thailand was acceptable. New subparagraph 2(10) proposed by Jamaica should be amended, with that delegation’s agreement, to read: “to assist Member States in the development of reliable health-information systems to provide quality data for monitoring and evaluation of the Millennium Development Goals”.

A new paragraph 2 should be inserted, with the support of the delegation of Thailand, with wording based on the existing subparagraph 2(11), and which would read: “INVITES concerned organizations of the United Nations system, international financial institutions, and calls upon international development partners and agencies, nongovernmental organizations and private sector entities to continue their support and consider further support to countries, particularly in sub-Saharan

Africa, for the development and implementation of health policies and national health development plans, consistent with internationally agreed health goals, including the Millennium Development Goals". The existing paragraph 2 should be renumbered accordingly.

He thanked all contributors to the draft resolution, which was of great importance for the United Nations high-level plenary review of the Millennium Development Goals, to be held in September 2010, and urged its adoption by consensus in order to send a strong signal of WHO's commitment to the achievement of the Goals.

Ms STEEN (Norway) paid tribute to the efforts of Member States in preparing the draft resolution, which she supported. She proposed, however, that it should be amended further by the addition of a new preambular paragraph, 12bis, to read: "Welcoming the important initiative of the United Nations Secretary-General and the work on the Joint Action Plan to improve health of women and children and his invitation to all Member States to engage".

Dr MHLANGA (South Africa) supported that amendment.

Dr NAKORN PREMSRI (Thailand) said that all the proposed amendments were acceptable.

Ms BULLINGER (Switzerland), Dr MMBANDO (United Republic of Tanzania) and Dr DAULAIRE (United States of America) supported the amendments proposed by the delegates of Norway and Spain.

Mr KIESSLER (Papua New Guinea) supported the amendments proposed by the delegate of Spain.

The draft resolution, as amended, was approved.¹

The CHAIRMAN drew attention to a revised draft resolution on the WHO HIV/AIDS strategy for 2011–2015, under the same agenda item, which took into account the amendments proposed in the previous discussion and which read:

The Sixty-third World Health Assembly,

PP1 Considering that the HIV epidemic still constitutes one of the foremost challenges to health and development, both in countries with generalized epidemics and in regions with concentrated epidemics affecting most at-risk groups, such as men who have sex with men, sex workers and injecting drug users;

PP2 Noting that globally HIV is the major cause of mortality among women of reproductive age and was responsible for the death of 280 000 children in 2008, thereby undermining efforts to achieve Millennium Development Goals 4 and 5;

PP3 Recognizing that the significant gains made in prevention and treatment of HIV/AIDS need to be ~~protected~~ **sustained [Thailand on behalf of countries of the South-East Asia Region]** and expanded for Millennium Development Goal 6 to be achieved, including the urgent need to strengthen targeted prevention measures and achieve universal access to antiretroviral treatment, within a framework of respect for human rights, gender ~~equality~~ **equity [Thailand on behalf of countries of the South-East Asia Region]**, and the reduction of stigma and discrimination;

PP3bis Further recognizing the need to strengthen the linkages between prevention and treatment of HIV/AIDS in order to achieve Millennium Development Goals 4 and 5; [USA]

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA63.15.

PP4 Recalling that WHO's work on HIV/AIDS has been guided by a series of strategies endorsed by several World Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

PP5 Considering that the WHO "3 by 5" strategy, launched in 2003, which focused on expanding access to antiretroviral treatment, was developed in the context of the Global Health Sector Strategy for HIV/AIDS (2003–2007), endorsed by the Fifty-sixth World Health Assembly (WHA56.30);

PP6 Recalling that in 2006 the UN adopted the target of Universal Access to HIV prevention, treatment and care by 2010, and WHO developed the Universal Access Plan 2006–2010, welcomed by the Fifty-ninth World Health Assembly, which has guided WHO's work since then;

PP7 Recognizing the need for countries to **sustain commitment to addressing the HIV/AIDS epidemic at all levels, including the highest political level, and to [USA]** be supported in their efforts to expand the scope, improve the effectiveness and ensure the sustainability of their HIV responses so that they may achieve the Millennium Development Goals;

PP8 Noting that a sustainable HIV response requires ~~robust~~ **comprehensive [Thailand on behalf of countries of the South-East Asia Region]** health systems and for HIV to be integrated into other health services, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis prevention and control, ~~harm-reduction~~ **comprehensive prevention and treatment programmes [USA]** for drug users and primary health care, particularly; **noting that sustaining these efforts is challenging [Thailand on behalf of countries of the South-East Asia Region]** in light of the global financial crisis;

PP9 Recognizing that antiretroviral treatment programmes take a major share of total national AIDS spending in most countries, which warrants immediate attention to review and improve the performance of those programmes through early recruitment, ensuring highest adherence to medications, limiting drug resistance, and minimizing risk behaviours and safeguarding the level of national spending on HIV prevention and control measures; **[Thailand on behalf of countries of the South-East Asia Region]**

PP10 Expressing deep concern that the financing of HIV programmes in most developing countries relies on external financial resources contributed by donors and global health initiatives, with limited national financial resources, thereby hampering the financial sustainability of HIV programmes, and lack of donor harmonization creates fragmentation and inefficiencies in programme implementation; **[Thailand on behalf of countries of the South-East Asia Region]**

1. URGES Member States:

(1) to reaffirm their commitment to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals, in particular the goal to halt and begin to reverse the spread of HIV/AIDS, malaria and other major diseases and to the agreements dealing with HIV/AIDS reached at all major United Nations conferences and summits, including the 2005 World Summit and its statement on treatment, and the goal of achieving universal access to reproductive health by 2015, as set out at the International Conference on Population and Development;

(1bis) to increase governments' financial commitment to HIV/AIDS programme financing and to take steps towards donor harmonization while safeguarding expenditure on prevention interventions; [Thailand on behalf of countries of the South-East Asia Region]

(2) to incorporate, ~~based on national in their specific contexts,~~ **[Thailand on behalf of countries of the South-East Asia Region]** the policies, strategies, programmes and interventions as **[Thailand on behalf of countries of the South-East Asia Region]** tools recommended by WHO in order to implement **effective [Thailand on behalf of**

countries of the South-East Asia Region] HIV prevention measures, [Thailand on behalf of countries of the South-East Asia Region] early diagnosis, prevention, [Thailand on behalf of countries of the South-East Asia Region] treatment and care; and take further steps towards minimizing social stigmatization and discrimination which hamper access to prevention, treatment and care; [Thailand on behalf of countries of the South-East Asia Region]

(3) to consider, whenever necessary, using ~~use~~ [Spain] existing administrative and legal ~~means~~ mechanisms [Thailand on behalf of countries of the South-East Asia Region] in order to promote access to affordable and cost-effective [Thailand on behalf of countries of the South-East Asia Region] prevention, [USA] [Spain] treatment and ~~care~~ diagnostic technologies; [USA] [Spain]

(4) to integrate HIV/AIDS services [Thailand on behalf of countries of the South-East Asia Region] into other key services, including those for maternal, neonatal and child health, sexual and reproductive health, tuberculosis, ~~harm reduction~~ comprehensive prevention and treatment programmes for injecting drug users [USA] and primary health care, to ensure sustainability and maximize efficiencies and effectiveness;

(5) to monitor closely and evaluate HIV/AIDS programmes by ensuring the completeness, accuracy and reliability of the data and use that information to improve programme efficiency; [Thailand on behalf of countries of the South-East Asia Region]

2. REQUESTS the Director-General:

(1) to take [Thailand on behalf of countries of the South-East Asia Region] the lead in convening [Thailand on behalf of countries of the South-East Asia Region] a broad consultative processes [Thailand on behalf of countries of the South-East Asia Region] to develop a WHO HIV/AIDS Sstrategy for 2011–2015 which will guide WHO's support to Member States, be aligned with broader strategic frameworks, including the Millennium Development Goals, primary health care ~~PHC~~ and the UNAIDS Outcome Framework, and which builds on the five strategic directions of the Universal Access Plan, and takes into consideration the changing international public health architecture, and reflect the Paris ~~Principles for~~ Declaration on [Thailand on behalf of countries of the South-East Asia Region] Aid Effectiveness;

(2) to encourage [Spain] ~~ensure that the knowledge arising from~~ and promote the translation of [USA] research results be translated [USA] into efficient public health policies for HIV/AIDS, in accordance with the Global Strategy on Public Health, Innovation and Intellectual Property (WHA61.21); [USA]

(3) to submit to the Sixty-fourth World Health Assembly through the WHO Executive Board a WHO HIV/AIDS Sstrategy for 2011–2015 for its ~~endorsement~~ consideration. [USA]

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, proposed several amendments to the revised text of the draft resolution. In preambular paragraph 3, the word “equality” should remain and should not be replaced by “equity” as proposed by Thailand. At the end of preambular paragraph 6, the phrase “keeping in mind the outcomes of the Second Independent Evaluation of UNAIDS” should be added. In preambular paragraph 7, “so that they may” should be replaced by “to enable them to”. In preambular paragraph 8, the opening part of the paragraph should be amended to read : “Noting that a sustainable HIV response requires integration into comprehensive health systems; the phrase “and for HIV to be integrated into other health services” should be deleted; and at the end of preambular paragraph 8 the phrase “aligned with the *WHO, UNODC, UNAIDS Technical Guide* for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users” should be added. In preambular paragraph 9, “safeguarding” should be replaced by “enhancing”. The last part of preambular paragraph 10, after “global health initiatives”,

should be replaced by “with space for improvement in their adherence to aid effectiveness commitments; limited national financial resources hamper the financial sustainability of HIV programmes; the lack of donor harmonization creates fragmentation and inefficiencies in programme implementation”. Subparagraph 1(1bis) should be amended to read: “to increase governments’ commitment to HIV/AIDS programmes and to take steps towards donor harmonization and adherence to aid effectiveness commitments”. In subparagraph 1(2) “interventions as” should be replaced by “interventions and”. In subparagraph 1(4) the words “other key services” should be replaced by “comprehensive health and other relevant sector strategies”. Finally, in subparagraph 2(1) “be aligned” should be replaced by “in line with UNAIDS guiding policies, including the Outcome Framework and aligned”; and the words “and the UNAIDS Outcome Framework” after “primary health care” should be deleted.

Mr MCIFF (United States of America) agreed that in preambular paragraph 3, the word “equality” should be retained. In preambular paragraph 3bis, the words “and maternal and child health” should be inserted after “HIV/AIDS”. As the inclusion in preambular paragraph 8 of a reference to the *WHO, UNODC, UNAIDS Technical Guide*, as proposed by the delegate of Spain, removed the need to replace “harm reduction” with “comprehensive prevention and treatment programmes”, he therefore proposed that the words “harm reduction” be reinstated in that paragraph and also in subparagraph 1(4). In preambular paragraph 9, the word “safeguarding” should be retained. He supported the amendment to preambular paragraph 10 proposed by the delegate of Spain. The last part of preambular paragraph 10, beginning with the words “and lack of donor harmonization” should be deleted. In subparagraph 1(1bis), the last part of the amendment proposed by the delegate of Spain, which was otherwise acceptable to his delegation, should be amended to read: “and to take steps to accelerate donor harmonization and aid effectiveness commitments”.

In reply to a request from Dr NAKORN PREMSRI (Thailand), Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, proposed that paragraph 1(1bis) be amended to read: “to increase governments’ commitment to enhancing attention to HIV/AIDS programmes and to take steps towards donor harmonization and adherence to aid effectiveness commitments.”

Mr DOKEKIAS (Congo) said that the French language version of the draft resolution was not complete.

(For approval of the draft resolution, see the summary record of the eleventh meeting, section 1.)

The meeting rose at 21:10.

ELEVENTH MEETING

Friday, 21 May 2010, at 9:20

Chairman: Dr M. MUGITANI (Japan)

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

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3) (continued from the ninth meeting)

The CHAIRMAN said that, in addition to the three draft resolutions already presented, the Committee had before it a draft decision on substandard/spurious/falsely-labelled/falsified/counterfeit medical products proposed by the delegations of Ecuador, on behalf of the Union of South American Nations, and India, on behalf of the Member States of the South-East Asia Region. The text of the draft decision read:

The Sixty-third World Health Assembly,

1. DECIDES to establish an open-ended intergovernmental working group on substandard, spurious, falsely-labelled, falsified, counterfeit medical products comprising Member States;
2. REQUESTS the Director-General to facilitate the work of the intergovernmental working group;
3. DECIDES that the intergovernmental working group will examine the following:
 - (1) measures to ensure access to quality, safe, efficacious and affordable medical products;
 - (2) the relationship between WHO and the International Medical Products Anti-Counterfeiting Taskforce;
 - (3) prevention and control of medical products of compromised quality, safety and efficacy such as substandard, spurious, falsely-labelled, falsified, and counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations;
 - (4) issues raised in the proposals in documents A63/A/Conf.Paper No.4 Rev.1, A63/A/Conf.Paper No.5 and A63/A/Conf.Paper No.7;
4. DECIDES that the working group shall make specific recommendations in relation to the issues set out in paragraph 3 above and report to the Sixty-fourth World Health Assembly through the Executive Board, at its 128th session on progress in implementing this resolution.

He also drew attention to a draft resolution on spurious/falsely-labelled/falsified/counterfeit medical products proposed by the delegations of Spain, on behalf of the European Union, and Switzerland, which read:

The Sixty-third World Health Assembly,

Recognizing the current work WHO is doing to ensure the safety, quality and efficacy of medicines,

1. DECIDES to request the Director-General to hold consultations with Member States and regional economic integration organizations on the following issues:
 - (1) WHO's role on measures to ensure quality, safety and efficacy of medical products;
 - (2) WHO's relationship with the International Medical Products Anti-Counterfeit Taskforce;
 - (3) WHO's role in prevention and control of medical products of compromised quality, safety and efficacy such as spurious, falsely-labelled, falsified and counterfeit medical products exclusively from a public health perspective.

2. FURTHER DECIDES to request the Director-General to make specific recommendations in relation to the above issues and to report to the Sixty-fourth World Health Assembly through the Executive Board at its 128th session.

As a result of extensive discussions and informal consultations, the Committee therefore currently had before it five proposals. How did the Committee wish to proceed? Options included further discussion with a view to formulating a single consensus text, or deferring consideration of the item to the Executive Board at its session in January.

Mr DESIRAJU (India) said that the draft decision submitted by his delegation and that of Ecuador, and the draft resolution proposed by the delegations of Spain and Switzerland were similar. However, the former called for the establishment of an open-ended intergovernmental working group, whereas the text proposed by the delegations of Spain and Switzerland requested the Director-General to hold consultations. Many Member States had indicated their intention to participate in the consultations, which should be guided by the Members, rather than institutionally led. As indicated in subparagraph 3(4) of the draft decision his delegation was proposing, the intergovernmental working group would examine the proposals made in the three existing draft resolutions. Further consideration of the issue should not be deferred to the meeting of the Executive Board in January as a decision was within reach of the Health Assembly. He suggested that interested parties should consult further outside the meeting with a view to formulating an acceptable text.

Mr NDIMENI (South Africa) said that the African group had a vested interest in the issue, and would be interested in participating in the consultations.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the Member States of the European Union, said that she would welcome more time for consultations as delegations were so close to an agreement. The Secretariat should appoint a chairman to lead the consultations, who should not represent any particular region.

Dr CHIRIBOGA (Ecuador) agreed that additional consultations at the present juncture would be useful.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to suspend consideration of the item pending the conclusion of informal consultations which would be chaired by a Member State and open to all interested delegations.

It was so agreed.

(For approval of the draft decision, see the summary record of the twelfth meeting, section 1.)

Infant and young child nutrition: Item 11.6 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R5 and A63/9) (continued from the fifth meeting, section 2)

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

The Sixty-third World Health Assembly,

PP1 Having considered the report on infant and young child nutrition;¹

PP2 Recalling resolutions **WHA34.22, [Swaziland]** WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA49.15 and WHA54.2 on infant and young child nutrition and WHA59.11 on nutrition and HIV/AIDS;

PP3 Conscious that achieving the Millennium Development Goals will require the reduction of maternal and child malnutrition;

PP4 Aware that worldwide malnutrition accounts for 11% of the global burden of disease, leading to long-term poor health and disability and poor educational and developmental outcomes; that worldwide **186** million children are **stunted**² (**WHO Secretariat**) and 20 million suffer from the most deadly form of severe acute malnutrition each year; and that nutritional risk factors, including underweight, suboptimal breastfeeding and vitamin and mineral deficiencies, particularly of vitamin A, iron, iodine and zinc, are responsible for 3.9 million deaths (35% of total deaths) and 144 million disability-adjusted life years (33% of total disability-adjusted life years) in children less than five years old;

PP5 Aware that countries are faced with increasing public health problems posed by the double burden of malnutrition (both undernutrition and overweight), with its negative later-life consequences;

PP6 Acknowledging that 90% of stunted children live in 36 countries and that children under two years of age are most affected by undernutrition;

PP6 bis Recognizing that promotion of commercial foods for infants and young children continues to undermine progress in optimal infant and young child feeding; [Kuwait]

PP7 Mindful of the challenges posed by the HIV/AIDS pandemic and the difficulties in formulating appropriate policies for infant and young child feeding, and concerned that food assistance does not meet the nutritional needs of young children infected by HIV;

PP7 bis Concerned that in emergencies, many of which occur in countries not on track to attain Millennium Development Goal 4 and include situations created by the effects of climate change, infants and young children are particularly vulnerable to malnutrition, illness and death; [Swaziland]

PP7 ter Recognizing that national emergency preparedness plans and international emergency responses do not always cover protection, promotion and support of optimal infant and young child feeding; [Swaziland]

PP7 quarter Expressing deep concern over evidence showing high and increasing incidence of violations of the International Code of Marketing of Breast-milk Substitutes by some infant food manufacturers and distributors with regard to promotion targeting mothers and health-care workers; [Thailand]

PP7 quinquies Expressing further deep concern over the ineffectiveness of voluntary measures to enforce compliance with the International Code of Marketing of Breast-milk Substitutes; [Thailand]

PP8 Aware that inappropriate feeding practices and their consequences are major obstacles to attaining sustainable socioeconomic development and poverty reduction;

¹ Document EB126/9.

² *World Health Statistics*, May 2010.

PP9 Concerned about the vast numbers of infants and young children who are still inappropriately fed and whose nutritional status, growth and development, health and survival are thereby compromised;

PP10 Mindful of the fact that implementation of the global strategy for infant and young child feeding and its operational targets requires strong political commitment and a comprehensive approach, including strengthening of health systems and communities **with particular emphasis on the Baby-friendly Hospitals Initiative [Swaziland]**, and careful monitoring of the effectiveness of the interventions used;

PP11 Recognizing that the improvement of ~~breast~~ **infant and young child [USA]** feeding practices could **contribute to saving [USA]** annually the lives of about one million children under five years of age and that each year the deaths of more than half a million such children could be prevented by adequate and timely complementary feeding along with continual breastfeeding for up to two years or beyond;

PP12 Aware that multisectoral food and nutrition policies are needed for the successful scaling up of evidence-based safe and effective nutrition interventions;

PP13 Recognizing the need for comprehensive national policies on infant and young child feeding that are well integrated within national strategies for nutrition and child survival;

PP14 Convinced that it is time for governments, civil society and the international community to renew their commitment to promoting the optimal feeding of infants and young children and to work together closely for this purpose;

PP15 Convinced that strengthening of national nutrition surveillance is crucial in implementing effective nutrition policies and scaling up interventions,

1. URGES Member States:

(1) to increase political commitment **in order to prevent and reduce** ~~ing~~ **[USA]** malnutrition in all its forms;

(2) to strengthen and expedite the implementation of the global strategy for infant and young child feeding with emphasis on giving effect to the **aim and principles of the [USA] International Code of Marketing of Breast-milk Substitutes, adopted in resolution WHA34.22, and the implementation of the Baby-friendly Hospital Initiative; [Swaziland, Côte d'Ivoire]**

(2) bis to develop and/or strengthen legislative measures to control the marketing of breast-milk substitutes; [Thailand]

(2) ter to end all forms of promotion of foods for infants and young children and in particular the use of nutrition and health claims; [Palau, South Africa]

(3) to develop or review current policy frameworks addressing the double burden of malnutrition **including childhood obesity [Kuwait] and food security [Congo]** and allocate adequate human and financial resources to ensure their implementation;

(4) to scale up interventions to improve infant and young child nutrition **in an integrated manner [USA] with [Kuwait] including:** the protection, ~~and~~ **promotion and support [Kuwait]** of breastfeeding and timely, safe and appropriate complementary feeding **as core interventions [Kuwait];** the implementation of **interventions for the prevention and management of [Kuwait, USA] supplementary and therapeutic feeding interventions prevention and for** severe malnutrition; and the **targeted [USA]** control of vitamin and mineral deficiencies;

(4) bis to implement the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009, in order to address the infant feeding dilemma for HIV-infected mothers and their families while ensuring protection, promotion and support of exclusive and sustained breastfeeding for the general population; [Swaziland]

(4) ter to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief

Staff and Programme Managers¹ on infant and young child feeding in emergencies, which includes the protection, promotion and support for optimal breastfeeding, and the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria; [Swaziland, Congo]

(5) to include the strategies referred to in subparagraph 1(4) above in comprehensive maternal and child health services and support the aim of universal coverage and principles of primary health care, including strengthening health systems as outlined in resolution WHA62.12;

(6) to strengthen nutrition surveillance systems and improve use and reporting of agreed Millennium Development Goals indicators in order to monitor progress;

(7) to implement the WHO Child Growth Standards by their full integration into child health programmes;

(8) to implement the measures for prevention of malnutrition as specified in the WHO strategy for community-based management of severe acute malnutrition,² most importantly improving water and sanitation systems and hygiene practices to protect children against communicable disease and infections; [Nigeria]

2. CALLS UPON ~~the food industry~~ **infant food manufacturers and distributors [Thailand] to observe fully comply with their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions and enhance their corporate social responsibilities; [Thailand, Kuwait, Swaziland, Botswana]**

3. REQUESTS the Director-General:

(1) to strengthen the evidence base on effective and safe nutrition actions to counteract the public health effects of the double burden of malnutrition, and to describe good practices for successful **implementation;**

(2) to mainstream nutrition in all WHO's health policies and strategies and confirm the presence of essential nutrition actions, **including integration of the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009, [Swaziland]** in the context of the reform of primary health care;

(3) to continue and strengthen **the existing mechanisms, especially the United Nations Standing Committee on Nutrition, for [Brazil]** collaboration with other United Nations agencies and international organizations involved in the process of ensuring improved nutrition including clear identification of leadership, division of labour and outcomes;

(4) to support Member States, on request, in expanding **their** nutritional interventions related to the double burden of malnutrition, monitoring and evaluating impact, strengthening or establishing effective nutrition surveillance systems, and implementing the WHO Child Growth Standards, **and the Baby-friendly Hospital Initiative. [Swaziland]**

(5) to support Member States in their efforts to develop and/or strengthen legislative measures to control marketing of breast-milk substitutes; [Thailand]

~~(5)~~ to develop a **clear and [Libyan Arab Jamahiriya]** comprehensive implementation plan on infant and young child nutrition **with a targeted budget [Libyan**

¹ Available online at <http://www.enonline.net/resources/6>.

² Community-based management of severe acute malnutrition: a joint statement by the World Health Organization, the World Food Programme, the United Nations System Standing Committee on Nutrition and the United Nations Children's Fund. Geneva, WHO, 2007.

Arab Jamahiriya], which includes direct and indirect interventions addressing the underlying causes of malnutrition, [Nigeria], including the primacy of exclusive and sustained breastfeeding [Swaziland] as a critical component of a global multisectoral nutrition framework, free of conflicts of interest, [Swaziland] for preliminary discussion at the Sixty-fourth World Health Assembly and for final delivery at the Sixty-fifth World Health Assembly, through the Executive Board and after broad consultation with Member States, and which must be linked to related global efforts to address the causes of malnutrition, such as the Comprehensive Framework on Agriculture and Food Security and Sanitation and Water for All. [Nigeria]

Dr HAMAD (Kuwait) asked whether the word “breast” was to be deleted in the first line of the eleventh preambular paragraph, and proposed that the beginning of subparagraph 1(2) be amended to read “to regulate all forms of promotion”.

Dr BLOOMFIELD (New Zealand) said that he still had concerns about some of the amendments, and requested information on the outcome of the informal consultations led by the delegation of Peru. He suggested that, in view of the large number of amendments made, the Committee might wish to establish a drafting group, with a clear time limit, to finalize the text, rather than discussing each proposed amendment in turn.

Mr CHOCANO BURGA (Peru) said that informal discussions had been held the previous day to consider the amendments proposed, and agreement had been reached in some areas. He suggested that the Committee go through each amendment in turn with a view to reaching an acceptable text.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain) said that the preference of the European Union would be to go through the text amendment by amendment. However, she did not oppose further informal discussions.

Ms BILLINGS (Canada) expressed appreciation of the efforts made to reach an agreement. She wished to make some additional amendments to the text that would maintain the ability to promote nutritious food, while limiting advertising on non-nutritious food and moving away from legislation.

Dr THAKSAPHON THAMARANGSI (Thailand), supported by Dr HAMAD (Kuwait), expressed support for further informal discussions, which should be limited in time.

Dr BLOOMFIELD (New Zealand) said that any additional consultations should be undertaken within the framework of a formal drafting group chaired by a Member State.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to suspend the item pending the outcome of further consultations, to be chaired by New Zealand.

It was so agreed.

(For approval of the draft resolution, see the summary record of the twelfth meeting, section 1.)

Monitoring of the achievement of the health-related Millennium Development Goals: Item 11.4 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R4, and A63/7) (continued from the tenth meeting)

In response to a request by the CHAIRMAN, Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, repeated the amendments to the draft resolution on the WHO HIV/AIDS strategy for 2011–2015 that he had proposed during the previous meeting.

Mr MCIFF (United States of America) said that in the third preambular paragraph the word “equality” should be retained. He proposed that in preambular paragraph 3bis the phrase “and maternal and child health” should be inserted after “HIV/AIDS”. He supported the proposed addition to the sixth preambular paragraph. In the eighth preambular paragraph he welcomed the proposal to include a reference to the *WHO, UNODC, UNAIDS Technical Guide* and would therefore accept the words “harm reduction” and withdraw his delegation’s earlier proposal to replace those words with “comprehensive prevention and treatment programmes”. In the ninth preambular paragraph he did not favour the replacement of “safeguarding” by “enhancing”. In the tenth preambular paragraph he supported the first part of the proposed amendment but would prefer to keep the tone positive by deleting the phrase “The lack of donor harmonization creates fragmentation and inefficiencies in programme implementation” from that amendment. In subparagraph 1(1)bis he supported the proposed amendment in principle but proposed that “towards” should be replaced by “to accelerate”; donors were already trying to harmonize their activities but should be encouraged to increase their efforts. He proposed that there should be an additional reference to the *WHO, UNODC, UNAIDS Technical Guide* in subparagraph 1(4), in which case the United States would withdraw its proposal to replace “harm reduction” with “comprehensive prevention of treatment programmes” in that subparagraph. He endorsed the other amendments proposed by the delegate of Spain.

Dr NAKORN PREMSRI (Thailand) said that Thailand supported the draft resolution, as amended by the delegates of Spain and the United States of America.

Ms STEEN (Norway) welcomed the proposal to include the reference to the *WHO, UNODC, UNAIDS Technical Guide* in the draft resolution and the proposal to retain the words “harm reduction”. She suggested an alternative to the proposal by the United States of America to replace “endorsement” by “consideration” in subparagraph 2(3), namely that “endorsement” should be replaced with “consideration and possible endorsement”.

Mr MCIFF (United States of America) said that he could accept Norway’s proposal concerning subparagraph 2(3).

The draft resolution, as amended, was approved.¹

Birth defects: Item 11.7 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R6, and A63/10) (continued from the seventh meeting, section 1)

The CHAIRMAN invited the Committee to continue its consideration of the draft resolution on birth defects, which was a revision of the resolution recommended in EB126.R6 proposed by the delegations of the Libyan Arab Jamahiriya, Mexico, Myanmar (on behalf of the countries of the South-East Asia Region), Thailand, United Kingdom of Great Britain and Northern Ireland and the United States of America, and which read:

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA63.19.

The Sixty-third World Health Assembly,

PP1 Having considered the report on ~~B~~birth defects;¹

PP2 Concerned by the high number of stillbirths and neonatal deaths occurring worldwide and by the large contribution of neonatal mortality to under-five mortality;

PP3 Recognizing the importance of birth defects as a cause of stillbirths and neonatal mortality;

PP4 Mindful that effective interventions to prevent birth defects including provision of appropriate community genetic services within the primary health care are available that can be integrated into maternal, reproductive and child health services **as well as interventions to limit exposure to risk factors for birth defects [Myanmar on behalf of countries of the South-East Asia Region];**

PP5 Concerned by the inadequate coverage of maternal, newborn and child health interventions and the barriers to access to health services that still exist in countries with the highest burden of maternal, newborn and child deaths;

PP6 Aware that the attainment of Millennium Development Goal 4 (Reduce child mortality) will require accelerated progress in reducing neonatal mortality including prevention and management of birth defects;

PP6bis Recognizing that the lack or inadequacy of vital registration systems in developing countries, and inaccurate records of the causes of death, are major barriers to estimating the size of public health problems attributable to birth defects; [Thailand]

PP7 Recalling resolution WHA58.31, in which the Health Assembly, calling for universal coverage of maternal, newborn and child health interventions, urged Member States to commit resources and to accelerate national action to build a seamless continuum of care for reproductive, maternal, newborn and child health; and resolution WHA57.13 in which it was recognized that genomics has a significant contribution to make in the area of public health;

PP8 Recognizing that the prevalence of birth defects varies between communities, and that insufficient epidemiological data may hamper effective and equitable management;

PP9 Recognizing the diversity of causes and determinants of congenital disorders, including preventable factors such as infections or nutritional factors, vaccine-preventable diseases, consumption of alcohol, tobacco and drugs, and exposure to chemical substances, notably pesticides;

PP10 Deeply concerned that birth defects are not still recognized as priorities in public health;

PP11 Concerned by the limited resources dedicated to prevention and management of birth defects **before and after birth [Libyan Arab Jamahiriya]** in particular in middle- and low-income countries;

PP12 Welcoming the report on birth defects,

1. URGES Member States:

(1) to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of birth defects as a cause of child morbidity and mortality;

(2) to set priorities, commit resources, and develop plans and activities for integrating effective interventions that include comprehensive guidance, information and awareness raising to prevent birth defects, and care for children with birth defects into existing maternal, reproductive and child health services and social welfare for all individuals ~~who need them~~ **and effective interventions to prevent tobacco and alcohol use during pregnancy; [Myanmar on behalf of countries of the South-East Asia Region];**

¹ Document EB126/10.

- (3) to promote the application of internationally recognized standards regulating the use of chemical substances in the air, water and soil;
- (4) to increase coverage of effective prevention measures **including vaccination against rubella, folic acid supplementation, programme addressing tobacco and alcohol use among pregnant women and women who are trying to conceive through [Thailand]**, health education programmes that include ethical, legal and social issues associated with birth defects for the general population and high-risk groups, and by fostering the development of parent-patient organizations and establishing appropriate community genetic services;
- (5) to record surveillance data on birth defects as part of national health information systems **and to link to other surveillance systems where relevant to enable causal investigations [United Kingdom of Great Britain and Northern Ireland];**
or
- (5) **to strengthen civil registration and surveillance systems in order to capture accurate epidemiological data on birth defects and birth defect risk factors as part of a national health-information system, and to develop a national birth defect registry, where feasible for continued care and support to individuals affected by birth defects; [Thailand]**
or
- (5) **to develop and strengthen surveillance systems for birth defects within the framework of national health information systems in order to have information available for taking decisions on prevention and control of these birth defects and on health promotion; [Mexico]**
- (6) to develop expertise and to build capacity on the prevention of birth defects and care of children with birth defects;
- (7) to strengthen research and studies on etiology, diagnosis and prevention of major birth defects and to promote international cooperation in combating with them;
- (7bis) to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with congenital birth defects; [USA]**
- (8) to take all necessary measures to ensure the full enjoyment by children with disabilities of all human rights and fundamental freedoms on an equal basis with other children and give priority to the child's well-being and support and facilitate families in their child-care and child-raising efforts;
- (9) to raise awareness among all relevant stakeholders, including government officials, health professionals, civil society and the public, about the importance of newborn screening programmes and their role in identifying infants born with birth defects;
- (10) to support families who have children with birth defects and associated disabilities, and ensure that appropriate habilitation and support is provided to children with disabilities;

2. REQUESTS the Director-General:

- (1) to promote the collection of data on the global burden of mortality and morbidity due to birth defects, and to consider broadening the groups of congenital abnormalities included in the classification when the International Statistical Classification of Diseases and Related Health Problems (Tenth Revision) is revised;
- (2) to continue to collaborate with the International Clearinghouse for Birth Defects Surveillance and Research in order to improve collection of data on global burden of mortality and morbidity due to birth defects;
- (3) to support Member States in developing national plans for implementation of effective interventions to prevent and manage birth defects within their national maternal,

newborn and child health plan, strengthening health systems and primary care, including improved coverage of vaccination against diseases such as measles and rubella, **of addressing tobacco and alcohol use among pregnant women and women trying to conceive, [Myanmar on behalf of countries of the South-East Asia Region]** and food fortification strategies, for the prevention of birth defects, and promoting equitable access to such services;

(4) to provide support to Member States in developing ethical and legal guidelines in relation to birth defects;

(5) to support Member States in the provision of appropriate community genetic services within the primary health-care system;

(6) to promote technical cooperation among Member States, nongovernmental organizations and other relevant bodies on prevention of birth defects;

(7) to support and facilitate research efforts on prevention and management of birth defects in order to improve the quality of life of those affected by such disorders;

(8) to report on progress in implementing this resolution to the Sixty-seventh World Health Assembly, through the Executive Board, in 2014.

Dr FENG Yong (China) asked for clarification of the three options for subparagraph 1(5). The options appeared to be similar and it should not be too difficult to reach a consensus on an appropriate text.

At the suggestion of the CHAIRMAN, Dr WACHARA RIEWPAIBOON (Thailand), Mr SEARL (United Kingdom of Great Britain and Northern Ireland) and Ms RUIZ VARGAS (Mexico) agreed that their three delegations would meet informally to seek consensus.

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

Dr WACHARA RIEWPAIBOON (Thailand) announced that, after brief informal consultations, the three delegations proposed that subparagraph 1(5) should read “to develop and strengthen registration and surveillance systems for birth defects within the framework of national health information systems in order to have accurate information available for taking decisions on prevention and control of these birth defects and to continue care and support to individuals affected by birth defects”.

The draft resolution, as amended, was approved.¹

Viral hepatitis: Item 11.12 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R16 and A63/15) (continued from the tenth meeting)

The CHAIRMAN drew attention to a revised version of the resolution contained in resolution EB126.R16, which read:

The Sixty-third World Health Assembly,

PP1 Having considered the report on viral hepatitis;²

PP2 Taking into account the fact that some 2000 million people have been infected by hepatitis B virus and that about 350 million people live with a chronic form of the disease;

PP3 Considering that hepatitis C is still not preventable by vaccination and around 80% of hepatitis C virus infections become a chronic infection;

¹ Transmitted to the Health Assembly in its fifth report and adopted as resolution WHA63.17.

² Document EB126/15.

PP4 Considering the seriousness of viral hepatitis as a global public health problem and the need for advocacy to ~~both~~ governments, **all parties [Thailand]** and populations for action on health promotion, disease prevention, diagnosis and treatment;

PP5 Expressing concern at the lack of progress in the prevention and control of viral hepatitis in developing countries, in particular in sub-Saharan Africa, due to the lack of access to affordable ~~treatments~~, **appropriate treatment and care [Thailand]** as well as an integrated approach to the **prevention and control measures management [Thailand]** of the disease;

PP6 Considering the need for a global approach to all forms of viral hepatitis – with a special focus on viral hepatitis B and C, which have the higher rates of morbidity;

PP7 Recalling that one route of transmission of hepatitis B and C viruses is parenteral and that the Health Assembly in resolution WHA28.72 on utilization and supply of human blood and blood products recommended the development of national public services for blood donation and in resolution WHA58.13 agreed to the establishment of an annual World Blood Donor Day, and that in both resolutions the Health Assembly recognized the need for safe blood to be available to blood recipients;

PP8 Reaffirming resolution WHA45.17 on immunization and vaccine quality which urged Member States to include hepatitis B vaccines in national immunization programmes;

PP9 Considering the need to reduce liver cancer mortality rates and that viral hepatitis are responsible for 78% of cases of primary liver cancer;

PP10 Considering the collaborative linkages between prevention and control measures for viral hepatitis and those for infectious diseases like HIV and other related sexually transmitted and bloodborne infections;

PP11 Recognizing the need to reduce incidence to prevent and control viral hepatitis, to increase access to correct diagnosis and to provide appropriate treatment programmes in all regions;

PP12 Further recognizing the need for universal coverage for safe injection practices as promoted through the WHO Safe Injection Global Network (SIGN), [Kenya]

1. RESOLVES that 28 July **or such other day or days as individual Member States decide [Kenya]** shall be designated as World Hepatitis Day in order to provide an opportunity for education and greater understanding of viral hepatitis as a global public health problem, and to stimulate the strengthening of preventive and control measures of this disease in Member States;

2. URGES Member States:

(1) to implement and/or improve epidemiological surveillance systems **and to strengthen laboratory capacity, where necessary, [Thailand]** in order to generate reliable information for guiding prevention and control measures;

(2) to support or enable an integrated and cost-effective approach to the prevention, control and management of viral hepatitis considering the linkages with associated coinfection such as HIV through multisectoral collaboration among health and educational institutions, nongovernmental organizations and civil society, including measures that strengthen safety and quality and the regulation of blood ~~systems~~ **products; [Thailand]**

(3) to incorporate in their specific contexts the policies, strategies and tools recommended by WHO in order to define and implement preventive actions, diagnostic measures and the provision of assistance to the population affected by viral hepatitis **including migrant and vulnerable populations; [Thailand]**

(4) to strengthen national health systems in order to address prevention and control of viral hepatitis effectively through the provision of health promotion and national surveillance, including tools for prevention, diagnosis and treatment of viral hepatitis, vaccination, information, communication and injection safety;

- (5) to provide vaccination strategies, infection-control measures, and means for injection safety for health-care workers;
- (6) to use national and international resources, either human or financial, to provide technical support to strengthen health systems in order to provide local populations adequately with the most cost-effective and affordable interventions that suit the needs of local epidemiological situations;
- (7) to consider, as necessary, national legislative mechanisms for the use of the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights in order to promote access to specific pharmaceutical products;¹
- (8) to consider, whenever necessary, using existing administrative and legal means in order to promote access to preventive, diagnostic and treatment technologies against viral hepatitis;
- (9) to develop and implement monitoring and evaluation tools **in order to assess progress towards reducing the burden from viral hepatitis and to guide evidence-based strategy for policy decisions [Thailand]** related to preventive, diagnostic and treatment activities;
- (10) to promote the observance of 28 July each year, or on such other day or days as individual Member States may decide, as World Hepatitis Day;
- (11) to promote total injection safety at all levels of national healthcare system; [Kenya]**

3. REQUESTS the Director-General:

- (1) to establish in collaboration with Member States the necessary guidelines, **strategies**, time-bound goals; ~~strategies~~ and tools for the **surveillance, [Germany]** prevention and control of viral hepatitis;
- (2) to provide the necessary support to the development of scientific research related to the prevention, diagnosis and treatment of viral hepatitis;
- (3) to improve the assessment of **global and regional** ~~the~~ economic impact and estimate the burden of viral hepatitis ~~in the world~~; **[Thailand]**
- (4) to support, as appropriate, resource-constrained Member States in conducting events to mark World Hepatitis Day;
- ~~(5) to invite international organizations and financial institutions to give support to strengthen capacity in developing countries for increasing the use of reliable diagnostic and treatment methods suitable to local epidemiological situations and health systems;~~
- ~~(6) to encourage international organizations and financial institutions to assign resources for the prevention and control of viral hepatitis, providing technical support to countries in an equitable, most efficient and suitable manner; [Thailand]~~
- (5) to invite international organizations, financial institutions and other partners to give support and assign resources in strengthening of surveillance systems, prevention and control programme, diagnostic and laboratory capacity, and management of viral hepatitis to developing countries in an equitable, most efficient, and suitable manner; [Thailand]**
- ~~(7)~~**(8) [Kenya]** to collaborate with other organizations in the United Nations system, partners, international organizations and other relevant stakeholders in enhancing access to affordable treatments in developing countries;
- (7)bis to strengthen the WHO Safe Injection Global Network; [Kenya]**

¹ The WTO General Council in its Decision of 30 August 2003 (i.e. on Implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health) decided that “‘pharmaceutical product’ means any patented product, or product manufactured through a patented process, of the pharmaceutical sector needed to address the public health problems as recognized in paragraph 1 of the Declaration. It is understood that active ingredients necessary for its manufacture and diagnostic kits needed for its use would be included.”

(8)(9) [Kenya] to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the implementation of this resolution.

The draft resolution, as amended, was approved.¹

2. ORGANIZATION OF WORK

The CHAIRMAN announced that items 11.14 (Chagas disease: control and elimination), 11.19 (WHO's role and responsibilities in health research) and 11.21 (Human organ and tissue transplantation) had been transferred back to Committee A from Committee B and would be considered after a short suspension.

The meeting was suspended at 10:15 and resumed at 10:35.

3. TECHNICAL AND HEALTH MATTERS (resumed)

Chagas disease: control and elimination: Item 11.14 of the Agenda (Documents A63/17, A63/17 Add.1, and EB124/2009/REC/1, resolution EB124.R7) (continued from the fourth meeting of Committee B)

Ms BRANCHI (France), also speaking on behalf of Italy and Spain, recalled that, during the discussions of the item at the fourth meeting of Committee B, an informal drafting group had been established to consider the amendments to the draft resolution contained in resolution EB124.R7 that had been proposed at the second and fourth meetings of the Committee. She introduced the revised text of the draft resolution proposed by the informal drafting group, which read:

The Sixty-third World Health Assembly,

PP1 Having considered the report on Chagas disease: control and elimination;

PP2 Recognizing that all transmission routes (namely by vectors, transfusion, organ transplantation, and by vertical and oral routes) have to be tackled, and that, in particular, domestic vectorial transmission in Latin America has to be eliminated, with the **understanding that elimination means stable interruption of domestic transmission [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain];**

PP3 Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease by 2010, as recommended in resolution WHA51.14;

PP4 Underlining that 2009 ~~will remark~~ **marked [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]** the centenary of the description of this disease by Dr Carlos Chagas;

~~PP4 Acknowledging the progress made with vector control strategies;~~

PP5 Recognizing the success achieved through the intergovernmental initiatives in Latin America, and **acknowledging the progress made through vector-control strategies; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**

PP6 Recognizing the increasing number of cases of Chagas disease in countries where the disease was previously not endemic [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain];

¹ Transmitted to the Health Assembly in its fifth report and adopted as resolution WHA63.18.

PP7 Taking into account the need for harmonization of diagnostic and treatment procedures;

PP8 Recognizing the need for the provision of ~~adequate~~ **appropriate medical care for affected persons with all clinical presentations of Chagas disease late severe clinical manifestations**; [Argentina, Bolivia (Plurinational State of), Brazil, Paraguay]

PP9 Underlining the need for more effective, safe and adequate **medicines** [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay], including paediatric formulations, and for better coverage and distribution of those currently available;

PP10 **Recalling resolution CD49.R19 adopted by the 49th Directing Council of PAHO in 2009, which urges Members States to commit themselves to the elimination or the reduction of neglected diseases and other related poverty diseases, including Chagas disease, with the aim that disease no longer represents a public health problem in 2015**; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

~~PP10 Recognizing that the risk of transmission through blood transfusion and organ transplantation and of congenital transmission is increasing~~ [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]

PP11 Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:

(1) to reinforce efforts to strengthen and consolidate national control programmes especially in areas where Chagas disease has re-emerged, [USA] in disease-endemic and non-endemic countries and to establish them where there are none; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

(2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention and the integration of specific actions within health services based on primary care, **together with strengthening community participation**; [Thailand]

(3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;

(4) to integrate the care of patients with acute and chronic clinical forms of Chagas disease into primary health services; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]

(5) to reinforce the provision of existing treatments in disease-endemic countries with the aim of making access universal; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]

(4)(6) to promote and encourage operational research on control of Chagas diseases in order:

(a) ~~to control and/or eliminate domestic vector populations in order~~ [Thailand] to interrupt transmission by domestic insect vectors through their control and elimination; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

(b) ~~to develop more suitable, safer and more affordable medicines~~ to promote the development of medicines that are more suitable, safe and affordable; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

(c) to promote the development of a valid and accessible test of cure; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]

~~(d)~~ (d) to reduce the risk of late complications of the infection;

(e) to establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;

(f) **to optimize** blood transfusion safety and screening procedures in endemic countries and ~~to give appropriate consideration to implementing~~ consider implementation of appropriate screening procedures in [Thailand] countries where the disease is not endemic, with special focus on areas where the disease is endemic; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

(7) to strengthen and harmonize public health policies to reduce the burden of Chagas disease, particularly in countries where the disease is not endemic; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

~~(5)~~(8) to promote the development of public health measures in disease-endemic and non-endemic countries, with special focus on endemic areas, for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]

(9) to integrate, at the primary health-care level, diagnosis and treatment of Chagas disease in patients in both acute and chronic phases of the disease; [USA]

2. REQUESTS the Director-General:

(1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;

(2) to strengthen implementation of vector-control activities in order to achieve interruption of **domestic [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] transmission of *Trypanosoma cruzi* [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]** and to promote research to improve or develop new prevention strategies;

(3) **to promote in areas endemic for Chagas disease action to detect infected donors at blood banks in order to integrate strategies for safe blood; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**

(4) to provide support to the countries of the Americas in order to strengthen intergovernmental initiatives and **the technical secretariat of [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] the Pan American Sanitary Bureau as a successful form of technical cooperation among countries, and to consider an initiative for the prevention and control of Chagas disease in non-endemic regions; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]**

~~(5)~~ **to collaborate in order that countries with Member States and intergovernmental initiatives with the aim of setting objectives and goals for the interruption of transmission, particularly for domestic vectorial transmission in Latin American countries; [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain]**

(6) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;

~~(6)~~(7) **to integrate, at the primary health-care level, diagnosis and treatment of Chagas disease in patients in both acute and chronic phases of the disease; [USA]**

~~(6)~~(7) to promote research **related to prevention, control and care [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] on elimination [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] of Chagas disease;**

~~(7)~~(8) to promote intersectoral efforts and collaboration, and facilitate networking between organizations and partners [Argentina, Bolivia (Plurinational State of), Brazil, France, Italy, Japan, Paraguay, Spain] interested in supporting the development and the strengthening among multisectoral actors, networking among organizations and other interested parties to support the development and implementation [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] of Chagas disease-control programmes;

~~(8)~~(9) to report on progress in the elimination of Chagas disease to the Sixty-fifth World Health Assembly through the Executive Board.

Dr GAMARRA (Paraguay) pointed out that subparagraph 1(6), “Chagas diseases” should be changed to the singular. She proposed that in the eighth preambular paragraph the words “affected persons with all clinical presentations of Chagas disease” be amended to read “persons with Chagas disease”.

Dr NAGAI (Japan) proposed that in the second preambular paragraph the phrase “with the understanding that elimination means stable interruption of domestic transmission” should be deleted. In the sixth preambular paragraph the phrase “was previously not endemic” should be replaced with “is not endemic”, in order to clarify that there was no vector transmission in the countries concerned.

Dr GAMARRA (Paraguay) said that she could not support the deletion proposed by the delegate of Japan, as the definition of elimination helped to contextualize the material in the document.

Dr NAGAI (Japan) said that, on the understanding that it only referred to endemic countries, the definition of elimination included in the draft resolution could stand, especially since it was not an official WHO definition. She therefore withdrew her proposal for deletion.

Dr MHLANGA (South Africa) requested the Secretariat to check whether the word “vectoral” or “vectorial” was the correct term and to amend the draft resolution accordingly.

The draft resolution, as amended, was approved.¹

WHO’s role and responsibilities in health research: Item 11.19 of the Agenda (Documents A63/22, A63/22 Add.1 and EB124/2009/REC/1, resolution EB124.R12)

The CHAIRMAN introduced the item and drew attention to the draft resolution contained in resolution EB124.R12.

Ms BILLINGS (Canada), welcoming the draft WHO strategy on research for health,² said that the draft strategy would be effective in strengthening WHO’s role in research for health. There were several opportunities for alignment of the strategy with other WHO initiatives, such as the global strategy and plan of action on public health, innovation and intellectual property, particularly as they both focused on diseases that disproportionately affected poor people.

Mr AL-TAAE (Iraq) said that one of the Organization’s main roles was to encourage research and development in the field of health and, in particular, to facilitate information-sharing among Member States in order to stimulate their own research and development efforts. Research capacities of Member States should be strengthened to prepare them to address important issues, such as primary health care.

Miss CATTLEEYA KONGSUPAPSIRI (Thailand) said that the situation of national health systems and researchers and the resources available for health research at the country level, especially in developing countries, should be mentioned in the draft strategy in order to reflect the needs for capacity building. She also proposed that the words “including capacity building to build a sustainable

¹ Transmitted to the Health Assembly in its fifth report and adopted as resolution WHA63.20.

² Document A63/22.

critical mass of health system and health policy researchers in developing countries” should be added to the end of subparagraph 4(6) of the draft resolution.

Ms WROLDSEN (Norway), welcoming the draft strategy, noted that the draft strategy would be a useful tool for strengthening both the conduct and use of health research within and outside of WHO. She looked forward to learning more about how the Secretariat planned to implement the strategy, including funding and finance mechanisms, and about the role of WHO’s regional and country offices therein. Furthermore, WHO’s Advisory Committee on Health Research should continue to play a significant advisory role on issues related to health research.

Dr NORHIZAN ISMAIL (Malaysia), acknowledging the importance of high quality research to the improvement of global health and health equity, said that WHO must continue to strengthen its leadership role in fostering high quality research for use by policy-makers.

Malaysia had taken steps to strengthen its health research system, including the establishment in 1995 of a platform for the identification and management of health research priorities. His Government had increased research and development funding and was upgrading its research capacity and infrastructure. Malaysia was a founding member of EVIPNet Asia, which was part of WHO’s Evidence-Informed Policy Network (EVIPNet), the main objective of which was to provide decision- and policy-makers with access to high quality research.

Dr SIMON (New Zealand) supported the Organization’s role in spearheading the global research agenda for health improvement and urged Member States to seek and put into practice solutions that would lead to improved health and health equity.

Higher-income countries had a part to play in assisting low-income countries to build their capacity for producing, synthesizing and using knowledge to support national health priorities. WHO could greatly facilitate that process, for example by using its Fellowships Programme to help bright students from developing countries to attend appropriate universities and by giving WHO regional staff time to participate in local research work and then use that information to modify strategic work programmes.

Mr PRAZ (Switzerland) said that many of the principal organizations and programmes related to health research were located in his country, with different but complementary roles. Nevertheless, coordination of those activities was sometimes inadequate, as was overall political support for them. Health research had been recognized for several years as vital to improving health systems and building local capacities, and various ministerial summits had drawn attention to the need to harmonize research funding at the global level. The draft strategy was therefore welcome and, like the delegate of Norway, he looked forward to learning how the Secretariat planned to implement it.

Dr LIU Dengfeng (China) suggested that the role of WHO with regard to health research should include promotion of technology transfer to developing countries. That action should include encouragement of developed countries to provide financial support; exploration of the possibility of creating an information database for researchers; effective use and regulation of the intellectual property system to promote public health; strengthening of technical training capacity; establishment of research institutes; and bolstering of international cooperation and information exchanges.

Mr KHELFAAT (Algeria), speaking on behalf of the Member States of the African Region, said that research played a vital role in improving health and developing health systems, as it strengthened institutional capacity, facilitated dissemination of knowledge and helped to raise awareness of health issues, such as pandemics or emergency situations.

Despite the progress made in the area of health research, the African Region saw little benefit owing to the widening gap between North and South in terms of access to new technologies. Furthermore, the limited cost-effectiveness of national programmes in the African countries

considerably reduced their ability to address numerous health issues. Health ministers meeting at the Ministerial Conference on Research for Health in the African Region in June 2008 had pledged to work together to strengthen national research, information and knowledge management systems through the optimization of investment and better coordination of programmes aimed at improving health services.

In the Algiers Declaration (2008), the Member States of the African Region had urged the Secretariat to appeal to donor countries and development partners to increase funds dedicated to health research in Africa. The Global Ministerial Forum on Research for Health (Bamako, 17–19 November 2008), had reaffirmed the crucial role of health research in the generation of knowledge, development of new technologies, decision-making and programme evaluation. A decision to establish a health observatory in Africa had been taken by the Committee for Africa at its fifty-ninth session in September 2009.

The Member States of the African Region faced the following challenges in the field of health research: mobilizing resources; strengthening institutions and infrastructure; building regulatory frameworks; developing human resources; and promoting access to scientific information. It was vital that any funding provided was shared equally among the beneficiary countries.

He welcomed the collaboration between WHO, the New Partnership for Africa's Development and the Pan-African Parliament, with the support of donors, for the establishment of a consortium aimed at improving access to medicines in African countries through harmonization of regulatory frameworks.

Dr KOUYATE (Burkina Faso) emphasized the importance of using research evidence for policy-making. A good practice in that regard was the Evidence Informed Policy Network, a social network set up in 2005 by WHO in collaboration with the Member States in order to promote the use of health research evidence in policy-making and to strengthen health systems, and thus foster interaction between researchers, policy-makers and civil society. The list of indicators contained in Table 2 in the annex to the report did not provide a measure of progress in the use of health research evidence. It would be useful, therefore, to add to that list further indicators to reflect: the number of policy decisions based on scientific research; and the number of Member States with mechanisms to facilitate the use of health research evidence in policy-making. Not enough use was made of the substantial scientific evidence generated by developing countries.

Dr GAMARRA (Paraguay) said that scientific research was vital to economic development and global health security and was an essential tool for making appropriate decisions on complex, sensitive and critical issues. Research evidence made it possible to support public policy, especially in the light of limited resources. In collaboration with the Evidence-Informed Policy Network, three workshops on prevention of noncommunicable diseases had been held in her country and policy briefings had led to the elaboration and implementation of a national plan. She therefore agreed with the delegate of Burkina Faso that a measure of the number of policy decisions based on scientific research should be added to the list of indicators.

Mr MBEWU (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, said that evidence derived from research should inform all of WHO's activities including the establishment of norms and standards, the promotion of evidence-based policies, the provision of technical support and the monitoring of the health status of populations. The WHO strategy on research for health had been developed through a careful and inclusive consultation process to which the Global Forum had contributed. He welcomed the draft strategy's call for the Secretariat to work with Member States and partners to harness science and technology, and broaden knowledge in order to produce research-based evidence and tools for improving health outcomes. The Secretariat should pay careful attention to the first goal of the draft strategy, namely, strengthening of the research culture across the Organization without which successful implementation would be difficult. He looked forward to a time when WHO professional staff at headquarters and regional and

country offices would be hired, promoted and rewarded based in part on their ability to use and generate research knowledge effectively .

Dr EVANS (Assistant Director-General), noting the comments by Member States, expressed appreciation for their support for the strategy. He underlined the fact that the list of indicators provided in the report was illustrative, and more comprehensive frameworks including indicators on the use of research and the extent to which it was informing policy had been developed in relation to the WHO strategy on research for health and the global strategy and plan of action on public health innovation and intellectual property. He thanked the many experts worldwide for their significant contribution to the development of the strategy and looked forward to working with Member States on implementing it.

Ms VESTAL (Assistant Secretary) said that the delegate of Thailand had proposed amending the draft resolution by adding at the end of subparagraph 4(6) “including capacity building to build a sustainable critical mass of health systems and health policy researchers in developing countries”.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

Human organ and tissue transplantation: Item 11.21 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R13, A63/24 and A63/24 Add.1)

The CHAIRMAN, introducing the item, drew attention to the draft resolution contained in resolution EB124.R13.

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the Member States of the European Union, Turkey, Croatia and The former Yugoslav Republic of Macedonia, candidate countries Albania, Bosnia and Herzegovina, Montenegro and Serbia, the countries of the Stabilisation and Association Process and potential candidates Ukraine, the Republic of Moldova and Armenia, supported the revision of the WHO Guiding Principles on Human Organ Transplantation, which provided a solid framework to support progress in human organ and tissue transplantation. The principles were a model for national policies and legislation to promote transplantation and prevent commercial trade and trafficking in human organs. He therefore encouraged the Health Assembly to endorse the Guiding Principles and the draft resolution contained in resolution EB124.R13. The text should be harmonized with that of the report so as to emphasize that there could not be one single and universal coding system.

Advances in transplantation medicine and science had led to increased demand, which still exceeded supply despite the rising number of donations from deceased and living donors in recent years. According to the World Transplant Registry, the 100 000 organs transplanted in 2008 had covered only 10% of the estimated global need. The shortage of organs prevented many patients from obtaining a place on waiting lists. Together with unequal distribution of wealth, the shortage of organs gave rise to organ and human trafficking and constituted a serious violation of the rights to human dignity and physical integrity. High-income countries were equally affected, and many potential recipients travelled to countries with less stringent regulations to obtain organs, which were usually harvested from underprivileged and vulnerable people. The best way to fight organ trafficking was to increase the number of organs available and guarantee quality and safety.

The European Union had just approved a new legislative framework and a Directive and Action Plan on organ donation and transplantation designed to establish common quality and safety standards

¹ Transmitted to the Health Assembly in its fifth report and adopted as resolution WHA63.21.

for human organs intended for transplantation. The Directive encompassed binding provisions for the establishment of competent national bodies to authorize and supervise donation and transplantation activities in order to guarantee organ quality and safety. It also contained comprehensive provisions on the protection of live donors and recipients.

The draft resolution would encourage Member States to take account of the Guiding Principles when preparing legislation on transplantation and setting up national and international mechanisms to ensure coordination of donation and transplantation activities.

Dr KHOUILLA (Gabon), speaking on behalf of the Member States of the African Region, said that organ transplantation was of increasing concern. Apart from the competence of staff and technical issues, ethical problems had arisen in the wake of globalization. The demand for human organ and tissue transplantation had increased but available treatment only met 10% of the demand. That had led to alternative actions that violated the principles of equity, justice and human dignity.

The African Region was particularly vulnerable to commercial transplantation, transplant tourism and organ trafficking, which could evolve into human trafficking of the poor and vulnerable, especially children. Unfortunately, the WHO Guiding Principles on Human Organ Transplantation had generally not been integrated into the legislation of countries in the Region as quickly as in some other regions. At their meeting in Abuja, Nigeria in July 2009, experts from the African Region had called for the establishment of a legal framework and monitoring authority in each country in order to enhance safety, security and respect for ethical principles.

The populations of the Member States in the Region had a right to have access to human organ and tissue transplantation, within an ethical framework of respect for human dignity. Countries in the African Region should step up their exchange of practices and experiences in the field of transplantation. The African Region requested the assistance of WHO in drafting and implementing national legislation designed to end commercial trade in human organs and improve access to grafts. He supported the draft resolution.

Ms HSU (United States of America) said that the WHO Guiding Principles, the revised version of which she endorsed, raised international awareness of important ethical, human rights, and safety issues. While living organ donation had given rise to serious global human rights abuses, it offered substantial health benefits to the recipient. Living donation was acceptable, therefore, when diligent efforts had been made to ascertain that the offer to donate was truly altruistic.

Safe and effective transplantation of human organs and tissues should be made available to alleviate disease worldwide. Demand currently exceeded supply, underlining the need for procurement and allocation of human materials for transplantation. It was possible to set up a system in which human tissues could be recovered, processed, distributed and tracked, with appropriate regulatory oversight, to minimize the transmission of infectious diseases. Her country was ready to share with other Member States the experiences of the the United States Department of Health and Human Services in developing regulatory oversight. She supported the draft resolution.

Professor BISHOP (Australia) supported the draft resolution. In particular, he agreed with the recommendations in paragraph 2 of the resolution and supported the promulgation of the updated Guiding Principles as outlined in paragraph 3. Through the adoption of the resolution and the implementation of the Guiding Principles, Member States were taking a significant step towards recognizing the importance of respect for human dignity and protection of the poor and vulnerable. His Government was funding a national reform package to boost the number of life-saving organ transplants, while ensuring that practices continued to operate in a safe, effective and ethical manner with increasing transparency. It had criminalized the trafficking of people into, out of and within Australia, including for the purpose of illegal removal of organs. He urged the Health Assembly to “endorse” the Guiding Principles in paragraph 1 of the draft resolution.

Mr AL-TAAE (Iraq) said that the issue of human organ and tissue transplantation required a comprehensive review in order to ensure that all activities complied with legal, religious, ethical and social standards. Such a review should lead to the adoption of new indicators and standards. Full quality assurance must be applied throughout the entire transplantation process, from removal of the organs to follow-up, monitoring and evaluation. In assisting Member States, the Secretariat should focus on the exchange of expertise between countries and regions; the promotion of research; capacity building for enhancement and development of transplantation activities; and incorporation of transplantation issues into public health and primary health care.

Dr MISHRA (Nepal) endorsed the statements by previous speakers regarding legislation and ethical issues relating to human organ and tissue transplantation. However, the prevention of noncommunicable diseases and the promotion of health, in developing countries in particular, should be linked with transplantation through approaches comprising information, education and communication and behaviour change communication. Developing countries needed WHO's assistance with capacity building, infrastructure improvement, resolving legal issues and drafting more flexible legislation with regard to transplantation issues.

Dr PENNAPA KAWEEWONGPRASERT (Thailand) fully endorsed the revised Guiding Principles. Her country advocated voluntary organ and tissue donation through fully-informed consent for deceased and living donors. All living donors should thoroughly understand post-operative risks and must be able to withdraw their consent at any time. Living donor registration was important for the surveillance of post-operative adverse reactions, and ensuring the welfare and safety of donors should encourage more people to donate organs. Guiding Principle 2 on the prevention of conflicts of interest was the cornerstone of a trustworthy system of organ donation.

She proposed several amendments to the draft resolution. The beginning of the eighth preambular paragraph should be amended to read: "Sensitive to the need of post-transplantation surveillance for adverse events and reactions associated with the donations, including long-term follow up of living donors, processing and transplantation". At the beginning of subparagraph 2(2), the words "to foster" should be deleted and new text inserted to read "to promote the development of altruistic, voluntary, non-remunerated donation systems of cells, tissues and organs, and increase". In subparagraph 2(4), the phrase "a system of transparent, equitable allocation of organs, cells and tissues guided by clinical criteria and ethical norms, as well as" should be inserted after "to promote" and before "equitable access". In subparagraph 2(6), "with appropriate health care services and long-term follow-up" should be inserted at the end. In subparagraph 3(5), "and traceable coding" should be inserted after "and suitable".

Dr LIU Xia (China), endorsing the draft resolution, said that China attached great importance to human organ transplantation. In recent years China had enacted legislation on human organ transplantation that prohibited trafficking in human organs. It had also imposed strict licensing on hospitals practising human organ transplantation, reducing the number of such hospitals from 600 to 163. His Government also prohibited transplant tourism and foreigners in search of organ transplantations in China needed to obtain approval from the Ministry of Health. It had also established an organ transplantation registry. A serious lack of organs was a common problem facing countries around the world and China welcomed WHO's efforts to promote and regulate transplantation of human organs. It looked forward to WHO's continued efforts in the area of transplantation, which included issues arising from the Guiding Principles, such as provision of guidelines on assessing the potential health risks faced by living organ donors, and making rules for organ recipients living in countries which did not have capability for organ transplantation.

Dr ACOSTA SAAL (Peru) supported the draft resolution, which was in line with a set of reforms carried out by Peru. He agreed with the delegate of Spain that the resolution would fill a considerable legislative gap that existed in Latin American countries, where there was an

IberoAmerican Council for Donations and Transplantations which, with the support and technical assistance of Spain, was achieving excellent results. Peru had also established mechanisms to regulate the accreditation of transplantation activities, legalize procedures for the donor waiting list, and reduce transplant tourism.

Dr MHLANGA (South Africa) said that his country was currently dealing with cases of organ trafficking and transplant tourism, which was being addressed jointly by the Ministry of Health and the police authorities. There had also been cases of the theft of placentas, which were transported over the border and sold. South Africa's Health Act contained a section that dealt with human tissue but not specifically with organ and tissue transplantation and that loophole was currently under review. He stressed that Member States should engage with civil society in combating organ trafficking, as poor communities often lacked the means to be vigilant against such practices. South Africa supported Member States that had called for the inclusion of organ transplantation issues in primary health care. He proposed that the word "any" should be removed from Guiding Principle subparagraph 1(a), so that the subparagraph would read: "(a) consent required by law is obtained, and".

Dr HYDER (Pakistan), expressing full support for the draft resolution, said that about 50 000 people died each year from end-stage organ failure resulting from the absence of available organs. The landmark Transplantation of Human Organs and Tissues Act had been adopted by his country's National Assembly on 12 November 2009 and its main purpose was to regulate human organ and tissue transplantation, bring to an end rampant unethical practices, and restore the dignity of human life.

Dr JADUE (Chile) said that the Guiding Principles had been broadly provided for in recently updated Chilean transplant legislation. It was clear that Chile needed to improve mechanisms to find organ donors and upgrade its donation and transplant registers; the challenge in the future was to enhance information sharing at the regional and international level in order to bring more transparency and quality to transplantation processes. Chile had signed a bilateral agreement with Uruguay in February 2010 which set forth the possibility of organ exchange between the two countries in cases where no recipients for organs could be found in the country where the organs had been donated. Such an agreement would be useful when there was a dearth of certain organs in a country and Chile was fully aware of the need to implement a more extensive system of regional organ exchange, similar to the European "Eurotransplant".

Professor Shan-Chwen CHANG (Chinese Taipei) fully supported the draft resolution and said that Chinese Taipei had enacted its own Human Organ Transplantation Act in 1987, which was in conformity with the Guiding Principles. In Chinese Taipei, organ donation was free, with all costs being borne by its universal health system, and the sale or advertising of organs was prohibited. The system of organ sharing was fair and transparent and donor and recipient personal information was properly protected. The import and export of human organs, tissues and cells had to be approved by the health authority. Transplantation medicine had begun in Chinese Taipei in 1968 and survival rates were comparable to those in advanced countries. Organ donation rates were on the increase and were the second highest in Asia.

Dr ETIENNE (Assistant Director-General) thanked Member States for their comments, participation and cooperation during the extensive consultative process at national, regional and subregional levels. She noted that there was growing demand for Member States, supported by the Secretariat, to address increasing access to transplantation and pursuing self-sufficiency at national and regional levels, and to adopt comprehensive approaches to vigilance and surveillance. There was also a growing call for the Secretariat to support Member States in addressing commercial transplantation and trafficking. She assured the delegations from the African Region that WHO had already issued guidelines on legislation and that it recognized the need for capacity building, including exchange visits and support for regulatory mechanisms. She also noted the importance of efforts to

reduce the need for transplantation through the adoption of prevention and health promotion actions, for example for noncommunicable diseases.

Mr ROBERTS (Secretary) said that two delegations had proposed amendments to the draft resolution contained in resolution EB124.R13. The delegate of Australia had proposed that in paragraph 1 the word “welcomes” be replaced with the word “endorses”.

The delegate of Thailand had proposed five amendments. The eighth preambular paragraph would read: “Sensitive to the need of post-transplantation surveillance of adverse events and reactions associated with the donation, including long-term follow-up of living donor, processing and transplantation of human cells, tissues and organs as such and for international exchange of such data to optimize the safety and efficacy of transplantation.” Subparagraph 2(2) would read: “To promote the development of altruistic, voluntary, non-remunerated donation systems of cells, tissues and organs and increase public awareness of the benefit of such systems in contrast to the physical, psychological and social risks to individuals and communities caused by trafficking in material of human origin and transplant tourism.” Subparagraph 2(4) would read: “To promote a system of transparent, equitable allocation of organs, cells and tissues, guided by clinical criteria and ethical norms, as well as equitable access to transplantation services in accordance with national capacities, which provides the foundation for public support of voluntary donation.” The words “and welfare of living donors with appropriate health-care services and long-term follow-up.” would be added at the end of subparagraph 2(6). The second line of subparagraph 3(5) would read: “developing national legislation and regulation on suitable and traceable coding systems for donation and transplantation”.

Mrs TZIMAS (Germany) said that in principle she had no objection to the amendments but proposed that in subparagraphs 2(2) and 2(4), as amended by the delegate of Thailand, the words “as such” should be added after the word “organs”.

Dr PENNAPA KAWEEWONGPRASERT (Thailand) accepted those amendments.

In response to a request from the CHAIRMAN, Mr ROBERTS (Secretary) read out the amended subparagraph 2(2): “to promote the development of altruistic, voluntary, non-remunerated donation systems of cells, tissues and organs as such and increase public awareness”; the end of the paragraph remained the same. Similarly, subparagraph 2(4) would read: “to promote a system of transparent, equitable allocation of organs as such” and the end of the paragraph remained the same.

The draft resolution, as amended, was approved.¹

4. ORGANIZATION OF WORK (resumed)

The CHAIRMAN asked whether the Committee agreed to re-transfer items 11.18 (Strategic Approach to International Chemicals Management) and 11.22 (Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services) back from Committee B to Committee A.

It was so agreed.

The meeting rose at 12:30.

¹ Transmitted to the Health Assembly in its fifth report and adopted as resolution WHA63.22.

TWELFTH MEETING

Friday, 21 May 2010, at 14:35

Chairman: Dr M. MUGITANI (Japan)

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

Infant and young child nutrition: Item 11.6 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R5 and A63/9) (continued from the eleventh meeting, section 1)

Mr CHOCANO BURGA (Peru), speaking as chairman of the open-ended informal drafting group, said that consensus had been reached on all the proposed amendments on the draft resolution recommended for adoption in resolution EB126.R5.

The CHAIRMAN asked the Secretariat to read out the proposed amendments.

Ms KORTUM (Secretariat) said that preambular paragraph 2 should read: "Recalling resolutions WHA33.32, WHA34.22, WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32, WHA59.21 and WHA61.20 on infant and young child nutrition and on nutrition and HIV/AIDS and Codex Alimentarius document CAC/GL/23". Preambular paragraph 4 should read: "Aware that worldwide malnutrition accounts for 11% of the global burden of disease, leading to long-term poor health and disability and poor educational and developmental outcomes; that worldwide 186 million children are stunted and 20 million suffer from the most deadly form of severe acute malnutrition every year; and that nutritional risk factors, including underweight, suboptimal breastfeeding and vitamin and mineral deficiencies, particularly of vitamin A, iron, iodine and zinc, are responsible for 3.9 million deaths (35% of total deaths) and 144 million disability-adjusted life years (33% of total disability-adjusted life years) in children less than five years old". Preambular paragraph 6 bis should read: "Recognizing that the promotion of breast-milk substitutes and some commercial foods for infants and young children undermines progress in optimal infant and young child feeding". Preambular paragraph 7 bis should read: "Concerned that in emergencies, many of which occur in countries not on track to attain Millennium Development Goal 4 and include situations created by the effects of climate change, infants and young children are particularly vulnerable to malnutrition, illness and death". Preambular paragraph 7 ter should read: "Recognizing that national emergency preparedness plans and international emergency responses do not always cover protection, promotion and support of optimal infant and young child feeding". Preambular paragraph 7 quater should read: "Expressing deep concern over persistent reports of violations of the International Code of Marketing of Breast-milk Substitutes by some infant food manufacturers and distributors with regard to promotion targeting mothers and health-care workers". Preambular paragraph 7 quinquies should read: "Expressing further concern over reports of the ineffectiveness of measures, particularly voluntary measures, to ensure compliance with the International Code of Marketing of Breast-milk Substitutes in some countries". Preambular paragraph 10 should read: "Mindful of the fact that implementation of the global strategy for infant and young child feeding and its operational targets requires strong political commitment and a comprehensive approach, including strengthening of health systems and communities with particular emphasis on the Baby-friendly Hospitals Initiative, and careful monitoring of the effectiveness of the interventions used". In the operative part of the resolution, subparagraph 1(1) should read: "to increase political commitment in order to prevent and reduce malnutrition in all its forms". Subparagraph 1(2)

should read: “to strengthen and expedite the sustainable implementation of the global strategy for infant and young child feeding, including emphasis on giving effect to the aim and principles of the International Code of Marketing of Breast-milk Substitutes and the implementation of the Baby-friendly Hospital Initiative”. Subparagraph 1(2) bis should read: “to develop and/or strengthen legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes to give effect to the International Code of Marketing of Breast-milk Substitutes and relevant WHA resolutions”. Subparagraph 1(2) ter should read: “to end inappropriate promotion of food for infants and young children and to ensure that nutrition and health claims shall not be permitted for food for infants and young children, except where specifically provided for in relevant Codex standards or national legislation”. Subparagraph 1(3) should read: “to develop or review current policy frameworks addressing the double burden of malnutrition including childhood obesity and food security and allocate adequate human and financial resources to ensure their implementation”. Subparagraph 1(4) should read: “to scale up interventions to improve infant and young child nutrition in an integrated manner with the protection, promotion and support of breastfeeding and timely, safe and appropriate complementary feeding as core interventions; the implementation of interventions for the prevention and management of severe malnutrition; and the targeted control of vitamin and mineral deficiencies”. Subparagraph 1(4) bis should read: “to consider and implement as appropriate the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009, in order to address the infant feeding dilemma for HIV-infected mothers and their families while ensuring protection, promotion and support of exclusive and sustained breastfeeding for the general population”. Subparagraph 1(4) ter should read: “to ensure that national and international preparedness plans and emergency responses follow the evidence-based Operational Guidance for Emergency Relief Staff and Programme Managers on infant and young child feeding in emergencies, which includes the protection, promotion and support for optimal breastfeeding, and the need to minimize the risks of artificial feeding, by ensuring that any required breast-milk substitutes are purchased, distributed and used according to strict criteria”. Subparagraph 1(8) should read: “to implement the measures for prevention of malnutrition as specified in the WHO strategy for community-based management of severe acute malnutrition, most importantly improving water and sanitation systems and hygiene practices to protect children against communicable diseases and infections”. Paragraph 2 should read: “CALLS UPON infant food manufacturers and distributors to fully comply with their responsibilities under the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions”. Subparagraph 3(2) should read: “to mainstream nutrition in all WHO’s health policies and strategies and confirm the presence of essential nutrition actions, including integration of the revised principles and recommendations on infant feeding in the context of HIV, issued by WHO in 2009, in the context of the reform of primary health care”. Subparagraph 3(3) should read: “to continue and strengthen the existing mechanisms for collaboration with the other United Nations agencies and international organizations involved in the process of ensuring improved nutrition including clear identification of leadership, division of labour and outcomes”. Subparagraph 3(4) should read: “to support Member States, on request, in expanding their nutritional interventions related to the double burden of malnutrition, monitoring and evaluating impact, strengthening or establishing effective nutrition surveillance systems, and implementing the WHO Child Growth Standards, and the Baby-friendly Hospital Initiative”. Subparagraph 3(5) should read: “to support Member States, on request, in their efforts to develop and/or strengthen legislative, regulatory or other effective measures to control marketing of breast-milk substitutes”. Subparagraph 3(6) should read: “to develop a comprehensive implementation plan on infant and young child nutrition as a critical component of a global multisectoral nutrition framework for preliminary discussion at the Sixty-fourth World Health Assembly and for final delivery at the Sixty-fifth World Health Assembly, through the Executive Board and after broad consultation with Member States”.

The CHAIRMAN, responding to a request from Miss APIRADEE TREERUTKUARKUL (Thailand), asked the Secretariat to read out the amended wording of preambular paragraph 11.

Ms KORTUM (Secretariat) said that preambular paragraph 11 should read: “Recognizing that the improvement of exclusive breastfeeding practices, adequate and timely complementary feeding along with continued breastfeeding for up to two years or beyond could save annually the lives of 1.5 million children under five years of age”.

Dr HAMA (Niger) requested clarification of the phrase “commercial foods for infants and young children” in preambular paragraph 6 bis, since there were references elsewhere in the resolution to “breast-milk substitutes”.

Mr CHOCANO BURGA (Peru), speaking as the chairman of the informal drafting group, said that the aim of preambular paragraph 6 bis was to make a distinction between breast-milk substitutes and some commercial foods, both of which undermined progress in optimal infant and young child nutrition.

Dr CAMPBELL-FORRESTER (Jamaica) proposed that in subparagraph 1(3) the word “double” should be deleted since “childhood obesity and food security” had been added after “double burden of malnutrition”. Alternatively, the wording could be amended to read: “double burden of malnutrition and to include in the frameworks childhood obesity and food security”.

Mr CHOCANO BURGA (Peru), in response to the proposal by the delegate of Jamaica, urged Member States to show flexibility and encouraged them to adopt the amended draft resolution as it stood; it was the result of extensive consultation. He reminded Member States that the main objective of the draft resolution was the promotion of infant and young child nutrition within the framework of the Millennium Development Goal targets.

Dr CAMPBELL-FORRESTER (Jamaica) said that her proposal had been misunderstood. The phrase “including childhood obesity and food security” added two extra elements to the original wording, which could not be included under the “double burden of malnutrition”. She therefore maintained her proposal.

Mr CHOCANO BURGA (Peru) said that the amendment proposed by the delegate of Jamaica was acceptable.

Ms DLADLA (South Africa) supported the draft resolution, noting its importance with regard to Millennium Development Goal 4 (Reduce child mortality) and to the improvement of the nutritional status of infants and young children. In the spirit of moving forward on the issue, her delegation had compromised on the wording of subparagraph 1(2) ter. She would have preferred the use of the words “to end all forms of promotion of foods for infants and young children” rather than the proposed wording, which was “to end inappropriate promotion of food for infants and young children”, because the words “inappropriate promotion” were ambiguous. She asked that her delegation’s concerns be recorded and said that a future resolution on the subject should deal specifically with the control and regulation of all forms of commercial promotion of foods for infants and young children.

The CHAIRMAN noted the request made by the delegate of South Africa.

Dr LUKITO (Indonesia), commending the work of the drafting group, supported the amended draft resolution. Noting, however, that access to affordable, safe and good-quality complementary feeding should be given priority by Member States and facilitated by WHO, he expressed the hope that that matter would be discussed at a future Health Assembly.

The CHAIRMAN noted the request made by the delegate of Indonesia.

Dr HAMA (Niger), referring to preambular paragraph 6 bis, said that he agreed with the suggestion made by a previous speaker regarding the control of commercial foods for infants and young children. Policies focusing on infant and young child nutrition, especially in developing countries, could be undermined if the wording of that paragraph was retained, since access to certain essential products might be denied.

The CHAIRMAN noted the comments made by the delegate of Niger.

Mr MAPHOSA (Swaziland) supported the revised resolution and the statement made by the delegate of South Africa. His country faced various challenges in the attainment of the Millennium Development Goals. He expressed concern that, although the International Code of Marketing of Breast-milk Substitutes had been established, the producers of infant foods, by sponsoring doctors and other professionals and even hosting technical meetings, were involved in the explicit promotion of their products. Therefore, issues concerning conflicts of interest should be addressed in the context of partnerships. In addition, mothers, especially vulnerable in developing countries, should be protected. It was critical to define “promotion” and to put an end to the promotion and marketing of certain foods in order to overcome the challenges faced by many Member States.

The CHAIRMAN noted the comments made by the delegate of Swaziland. He invited the Committee to approve the amended draft resolution.

The draft resolution, as amended, was approved.¹

Treatment and prevention of pneumonia: Item 11.23 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R15 and A63/26)

Dr ZARAMBA (representative of the Executive Board), said that, at its 126th session in January 2010, the Executive Board had considered the report on treatment and prevention of pneumonia and adopted resolution EB126.R15 in which it recommended a text to the Health Assembly for adoption.

Mr AL-TAAE (Iraq) said that pneumonia was of increasing significance to public health. His country had incorporated prevention, early detection and treatment of the disease into primary health care; and developed activities relating to acute respiratory infection in children under five years of age within the Integrated Management of Childhood Illness strategy. For other age groups, activities to combat pneumonia were integrated within the prevention of respiratory diseases. Progress had been made in advocacy and health education measures and in the introduction of the pneumococcal conjugate vaccine as a pilot project within the Expanded Programme on Immunization, with continuation of the vaccination of high-risk groups.

WHO should scale up its actions on pneumonia control; facilitate the exchange of experiences of use of the pneumococcal vaccine within the Expanded Programme on Immunization; encourage research and studies within integrated research for primary health care services; and consider the problem of pneumonia prevention within health promotion activities.

Dr WANGCHUK (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, welcomed the draft resolution. His Region bore the highest burden in respect of pneumonias, with almost 40% of global cases and around 32% of mortality. All age groups were affected. High morbidity and mortality from pneumonia in the Region were linked to poverty, malnutrition and access to care. Undernutrition, including zinc deficiency, contributed to more than one third of all

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA63.23.

child mortality that resulted from pneumonia. Unhealthy living conditions, including indoor air pollution, posed additional risks. Non-pharmaceutical interventions such as handwashing and respiratory hygiene were important barriers to the spread of respiratory infection, but were not practised widely. Frequent handwashing had been shown to reduce pneumonia incidence by almost half.

The Region lacked reliable data on what proportion of pneumonia cases in children under five years of age was attributable to a specific organism; however, bacterial causes could contribute to primary or secondary ailments. Some of the new vaccines could be useful protective tools for minimizing morbidity; however, the effectiveness of those for use in the Region was unclear and the high cost was an important issue. The effectiveness of case management of pneumonia, including treatment with antibiotics by trained health workers, had been demonstrated in community-based studies and was being strengthened as a priority. Synergistic actions under existing programmes were essential, such as nutrition, immunization, environment, and interventions to encourage behavioural change. Strengthening the strategy for Integrated Management of Childhood Illness would improve the treatment and care of pneumonia in children under five years of age. Mobilizing the support of all partners would be equally important. The high burden of pneumonia – despite the availability of simple, safe, effective and yet relatively inexpensive interventions – was an unacceptable situation for the Region. Strengthening of surveillance was needed through periodic surveys and improved laboratory capacity to monitor trends and the emergence of antimicrobial resistance. His Region sought solidarity and support from the rest of the international community in building its capacity to reduce the burden of pneumonia.

Efforts for the prevention and control of pneumonia should be integrated with those for acute diarrhoea, in view of the limited resources and similar target populations, associated underlying risk factors and control strategies. As the disease in one age group tended to spread to other age groups in the same community, the effort should extend across the age spectrum. Such integration would be cost-effective and accord with the revitalized approach to primary health care. Prevention and control of pneumonia should be accorded high priority and called for surveillance, effective case management and prevention.

Mr ZIMPITA (Malawi), speaking on behalf of the Member States of the African Region, said that pneumonia was a significant problem in the Region, with high rates of mortality for children under five years of age, and placed a huge burden on families and health systems. Pneumonia control was therefore essential for achievement of the Millennium Development Goals, especially Goal 4 (Reduce child mortality).

He expressed support for the effective prevention and control strategies highlighted in the Secretariat's report. After outlining the scale of the problem posed by pneumonia in Malawi, he requested national and international agencies to intensify their financial support for pneumonia control, especially in developing countries. He asked WHO and partners to continue research in pneumonia control and to continue developing tools for use in that area. He supported the draft resolution.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) expressed satisfaction at the strong support that the draft resolution proposed by her delegation had received from the Executive Board. She announced that, in addition to the 29 Member States from all regions that had sponsored the resolution in the Executive Board, China, Mauritius and Norway wished to be added to the list of sponsors. Pneumonia control was essential for achievement of Millennium Development Goal 4 (Reduce child mortality). The Global Action Plan for the Prevention and Control of Pneumonia launched in November 2009 endorsed a coordinated, multisectoral, multifaceted approach to the issue. Global consensus on the need to tackle pneumonia was a vital first step; what was needed next was to act swiftly to implement the plan and encourage partners to recognize that the tools to prevent and treat pneumonia did exist and were within their grasp. Action taken on pneumonia would save the lives of millions of children.

Dr CHAWETSAN NAMWAT (Thailand) proposed several amendments to the draft resolution. To highlight the importance of case management, the order of points (a) and (b) in subparagraph 1(5) should be inverted. In subparagraph 2(2), the words “and affordability” should be inserted after “availability”, to ensure consistency with the content and spirit of the fourth preambular paragraph. The implementation of interventions to prevent and control pneumonia should be carried out in an integrated manner, thereby ensuring effective coverage of those services at primary care level, together with improved access.

Mr HAGE CARMO (Brazil) welcomed the information contained in the Secretariat’s report related to advances in the prevention of respiratory infections; the expansion of immunization programmes was one effective strategy to reduce the burden of morbidity and mortality that resulted from such infections. In his country, new vaccines introduced aimed to reduce the burden of disease in children under five years of age, and included pneumococcal and meningococcal vaccines which in 2010 would be available to all children under the age of two. That had only been possible thanks to the transfer of technology to national laboratories, given the prohibitive cost of the vaccines in developing countries. The question of affordability should be included in the draft resolution, recalling resolution WHA58.15 on the global immunization strategy. He therefore supported the amendment proposed by Thailand.

Mr MCIFF (United States of America) thanked WHO and UNICEF for their leadership in developing the global strategy. His country had been a leader in the international fight to reduce under-five mortality from pneumonia in the developing world and was committed to meeting the relevant Millennium Development Goal by 2015. His Government supported the implementation strategies and research on prevention and treatment of pneumonia in children through such measures as the development, licensing, commercial production and implementation of appropriate vaccination programmes and improved access to health-care facilities. It also supported research on the impact of a healthy home environment with clean indoor air on the reduction of pneumonia in children in lower-income countries, as well as promising research on management of severe pneumonia and newborn sepsis. His country encouraged those Member States with a high burden of acute respiratory infection in children to improve access and coverage of evidence-based preventive and treatment strategies and to strengthen efforts at all levels of the health system. Health workers needed to be involved, and the use of health system platforms, such as the community treatment of malaria, should be considered. He supported the draft resolution.

Dr WAMAE (Kenya) said that it was unacceptable that, despite being preventable and treatable, pneumonia continued to cause deaths in children under five years of age. In Kenya, pneumonia, diarrhoea and neonatal conditions were becoming the main causes of the slow progress towards achievement of Millennium Development Goal 4 (Reduce child mortality). Pneumonia prevention and treatment measures included: training of health workers in the Integrated Management of Childhood Illness; and adapting the guidelines for integrated case management for childhood illness and exclusive breastfeeding. The WHO guidelines on infant and young child feeding in the context of HIV had been adopted. The *Haemophilus influenzae* type b vaccine had been included in the routine immunization schedule.

She thanked WHO, the GAVI Alliance and other stakeholders for facilitating the prequalification of the two-dose PCV10 pneumococcal vaccine in her country. She expressed the hope that the Integrated Management of Childhood Illness strategy would be used as the vehicle for case management of pneumonia at all levels. She appealed to WHO to support the mobilization of resources for the Integrated Management of Childhood Illness strategy. She proposed that the word “integrated” be inserted before “case management” in subparagraph 1(5)(b) of the draft resolution.

Dr SEAKGOSING (Botswana) welcomed WHO’s support for the Integrated Management of Childhood Illness strategy, including initiatives for prevention and treatment of pneumonia, which

Botswana had adopted in 1998. In his country, more than 40% of health workers had been trained in case management skills by 2009, and that work was continuing. Efforts continued to promote key practices within families and households through Integrated Management of Childhood Illness committees, which emphasized the importance of early care-seeking with respect to pneumonia. Botswana had recently introduced the Accelerated Child Survival and Development strategy with a view to reducing mortality among children under five years of age and achieving the health-related Millennium Development Goals by 2015.

Mrs TYSON (United Kingdom of Great Britain and Northern Ireland) thanked the delegates of Kenya and Thailand for their proposed amendments, which were acceptable to her delegation.

Ms KIANIAN-FIROUZGAR (UNICEF) said that not enough attention and resources were devoted to pneumonia, despite it being the leading cause of child mortality globally. Similarly, diarrhoea, the second most widespread cause of child mortality, remained inadequately addressed in most health programmes. Pneumonia and diarrhoea were responsible for at least one third of the estimated annual mortality rate of nine million children under five years of age and most often affected those living with limited access to sanitation, clean water, good nutrition and health services.

WHO and UNICEF were supporting efforts to implement key strategies to reduce the incidence and impact of pneumonia and diarrhoea. Healthy behaviour such as early and exclusive breastfeeding, hand-washing with soap, immunization, home care and improved care-seeking in response to danger signs would contribute to controlling both pneumonia and diarrhoea. Governments and partners should support those behaviours through communication, high-impact interventions and by encouraging community engagement. She expressed appreciation for the draft resolution that would help to mobilize the resources and support needed.

Ms MAFUBELU (Assistant Director-General) thanked the delegations for their comments and commended Member States on measures taken to prevent and treat pneumonia, which would contribute significantly to achieving Millennium Development Goal 4 (Reduce child mortality). She took note of the challenges that countries were facing in the treatment and prevention of pneumonia, and of the comment by the delegate of Bhutan, on behalf of the Member States of the South-East Asia Region, regarding the lack of information on etiology. WHO was providing technical support for the preparation of two large multi-country studies to assess the etiology of pneumonia in four countries in the South-East Asia Region and five countries in the African Region; it was also facilitating the establishment of sentinel site surveillance and strengthening laboratory capacity and regional reference laboratories. As Member States had noted, management of pneumonia required a multifaceted, integrated approach, not just pharmaceutical interventions. WHO would continue to provide technical support to Member States for the management of that disease, which was a leading cause of mortality in children under five years of age.

Ms VESTAL (Assistant Secretary), in response to a request by the CHAIRMAN, read out the amendments. The delegation of Kenya had proposed that the word “integrated” be inserted before the words “case management” in subparagraph 1(5)(b). The delegation of Thailand had proposed to invert the order of subparagraphs 1(5)(a) and 1(5)(b). The delegation of Thailand supported by the delegation of Brazil, had proposed that the words “and affordability” be inserted after the words “to promote the availability” in subparagraph 2(2).

The resolution, as amended, was approved.¹

¹Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA63.24.

Counterfeit medical products: Item 11.20 of the Agenda (Documents A63/23 and A63/INF.DOC./3) (continued from the eleventh meeting, section 1)

The CHAIRMAN asked the chairman of the informal working group on the item to brief the Committee on the outcome of the group's deliberations.

Mr AHMADI (Islamic Republic of Iran), speaking as chairman of the working group, said that the working group had succeeded in reaching consensus on a draft decision on substandard, spurious, falsely-labelled, falsified, counterfeit medical products, which incorporated elements of the several draft resolutions proposed previously. He expressed appreciation for the support provided by all contributors.

The CHAIRMAN asked the Secretary to read out the text of the draft decision for the purposes of interpretation from English, since it had not yet been distributed in all languages.

Ms VESTAL (Assistant Secretary) read out the following text of the draft decision:

The Sixty-third World Health Assembly,
Reaffirming the fundamental role of WHO in ensuring safety, quality and efficacy of medical products;

Noting the work of WHO in ensuring safety, quality and efficacy of medical products,

1. DECIDES to establish a time-limited and results-oriented working group on substandard/spurious/falsely-labelled/falsified/counterfeit medical products, comprised of and open to all Member States;
2. REQUESTS the Director-General to convene and facilitate the work of the working group;
3. DECIDES that the working group will examine from a public health perspective, excluding trade and intellectual property considerations, the following:
 - (a) WHO's role in measures to ensure availability of quality, safe, efficacious and affordable medical products;
 - (b) WHO's relationship with the International Medical Products Anti-Counterfeiting Taskforce;
 - (c) WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy such as substandard/spurious/falsely-labelled/falsified/counterfeit medical products from a public health perspective, excluding trade and intellectual property considerations;
 - (d) any issue or issues raised in the proposals in documents, A63/A/Conf.Paper No.4 Rev.1, A63/A/Conf.Paper No.5 and A63/A/Conf.Paper No.7, starting with those issues referred to in items (a), (b) and (c) above;
4. DECIDES that the working group shall make specific recommendations in relation to the issues set out in paragraph 3 above and report to the Sixty-fourth World Health Assembly, and shall report on this decision to the Executive Board, at its 128th session.

Mr CAVALERI (Argentina) noted that the members of the working group had agreed to use the formula "substandard/spurious/falsely-labelled/falsified/counterfeit medical products" throughout the document, with the adjectives separated by slashes rather than commas.

Dr YANO (Kenya) said that he would prefer to delay approval of the draft decision until it had been duly distributed.

The CHAIRMAN, noting that it had been impossible to distribute the document in all six official languages since it had been prepared only that morning, asked delegates to show flexibility.

Mr PARRONDO (Spain), speaking on behalf of the European Union, said that the outcome of the thorough discussions held was not fully satisfactory to the European Union, but, in a spirit of compromise, it was prepared to accept the draft decision. All Members of the European Union were united behind the common objective of waging war on counterfeit medical products, and were interested not in trade matters but in health concerns. The European Union was ready to discuss concerns about the role of the Organization regarding the issue in an open-minded and impartial manner.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to approve the draft decision.

The draft decision was approved.¹

Ms FARANI AZEVÊDO (Brazil) said that the spirit of compromise had led Brazil, like the European Union, to accept the draft decision even though it did not constitute an entirely satisfactory result. She expressed the hope that the same spirit would inform the work of the working group established by virtue of the draft decision, since the final objective remained the same: that Member States should determine the policies of the Organization.

Mr GOPINATHAN (India) said that like the European Union and Brazil, India had not been fully satisfied with the outcome, and he expressed appreciation for the spirit of compromise exhibited by all delegations and particularly thanked the chairman of the working group for his guidance of the deliberations.

Dr MOREIRA (Ecuador) said that his delegation was very satisfied with the outcome of the discussions, and appreciated the flexibility shown by other Member States.

2. FOURTH REPORT OF COMMITTEE A (Document A63/64)

The CHAIRMAN read out the draft fourth report of Committee A.

The report was adopted.²

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA63(10).

² See page 322.

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

Strategic Approach to International Chemicals Management: Item 11.18 of the Agenda (Documents EB126/2010/REC/1, resolutions EB126.R12 and EB126.R13, and A63/21)

The CHAIRMAN introduced the item and drew attention to the draft resolutions EB126.R12 and EB126.R13, contained in document A63/21.

Dr KUNDIIEV (Ukraine) said that the importance of the sound management of chemicals for the protection of human health was not yet fully appreciated. The problem of chemical safety could be resolved if modern technology was introduced to minimize or eliminate the possibility of exposure to chemicals. Strict regulation of the use of all toxic or chemical substances, without exception, was also needed. The Secretariat's report on the Strategic Approach to International Chemicals Management¹ did not devote sufficient attention to the role that nanotechnology and nanomaterials could play in resolving the problem. Industry and medical circles held high expectations for those areas, which were attracting substantial investments. The effect of nanoparticles on organisms, however, entailed proven risks that were often forgotten or overlooked. Nanosecurity should therefore be recognized as a new area of research, as the failure to establish safe thresholds for the use of chemicals was a serious issue.

Turning to the subject of asbestos, he said that there was no scientific basis for grouping all types of asbestos together insofar as their physical and chemical properties differed, as did the risks associated with them. Chrysotile asbestos, for example, should not be included in the ban on amphibole asbestos, as laboratory findings from Kazakhstan, the Russian Federation and Ukraine showed that chrysotile asbestos presented no risk. He supported the draft resolutions.

Mr PARRONDO (Spain), speaking on behalf of the Member States of the European Union, said that the candidate countries Turkey, Croatia and The former Yugoslav Republic of Macedonia, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, and Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with his statement. It was four years since the Health Assembly had first discussed international chemicals management and the renewed consideration was an opportunity to evaluate the work done and set new goals. Participants in the second session of the International Conference on Chemicals Management, held in May 2009, had placed emphasis on the close link between health and sound chemicals management and the need for more active involvement by the health sector. The Executive Board's fruitful discussions on the subject in January 2010 had produced fresh ideas in the context of strengthening global health.

Referring to the need for WHO to demonstrate greater commitment to the Strategic Approach process, he urged WHO to redouble its efforts to implement the actions listed in paragraphs 12 and 15 of the Secretariat's report, and to work with other actors to protect and strengthen global health in the context of chemicals management. That would include emerging policy issues such as nanotechnology and manufactured nanomaterials, hazardous substances within the life cycle of electronic products, and lead in paints. In that connection, special attention should be paid to long-term funding and to the achievement of synergies between the multilateral environment agreements listed in paragraph 5 of the report. WHO should also work hand in hand with other relevant international organizations, specifically the United Nations Environment Programme, and provide support to the Strategic Approach secretariat.

He welcomed the draft resolution on improvement of health through sound management of obsolete pesticides and other obsolete chemicals; he encouraged WHO to do more in that area at the national level. Adoption of the resolution would encourage action particularly in affected countries, and also raise WHO's profile. The European Union looked forward to further progress in the sound

¹ Document A63/21.

management of such chemicals and to future discussions on the subject at the Sixty-fourth World Health Assembly in 2011. Lastly, he reiterated his support for the draft resolution on improvement of health through safe and environmentally sound waste management.

Mr ALVAREZ (Chile), speaking on behalf of the Latin American and Caribbean Group, said that much of interest had emerged from the consultation meeting held in Slovenia in February 2010 on the strategy being developed by the secretariat of the Strategic Approach, in consultation with WHO, for strengthening the engagement of the health sector in the implementation of the Strategic Approach. He therefore looked forward to the first draft of the strategy to be produced in August 2010, which would serve as a basis for further consultations. WHO's contribution to the Strategic Approach would be enhanced for the benefit of developing countries in particular.

He proposed that in the tenth preambular paragraph of the draft resolution contained in resolution EB126.R13 the phrase "or inherited from past periods of pesticide overconsumption" be inserted after the words "phase-out period". He also proposed that in the thirteenth preambular paragraph the word "economic" should be replaced with "health".

Ms KARAGULOVA (Kazakhstan) expressed concern at the failure to take due account of the objection raised by her delegation, at the 126th session of the Executive Board and regarding the penultimate sentence of paragraph 3 of the Secretariat report, which read: "Cancer of the lung and mesothelioma are caused by exposure to asbestos, which remains in use in some countries." Kazakhstan had been supported in that objection by the delegation of the Russian Federation, which had submitted a written appeal to the Secretariat. The Secretariat had commented that it had taken into consideration the principled position of both countries; it was thus regrettable that the text of the paragraph in question remained. The sensitive matter of asbestos, particularly chrysotile asbestos, was of socioeconomic importance to Kazakhstan. Whereas the crocidolite and amphibole varieties of asbestos were known to be dangerous to human health, the risk factors associated with the chrysotile variety were disputed by research findings. She requested WHO to consider a differential approach to the regulation of diverse asbestos and asbestos-related substances.

Accordingly, she noted that the word "amphibole" should have been inserted before the word "asbestos" in the penultimate sentence of paragraph 3 of the report or the entire sentence should have been omitted.

Mr MCIFF (United States of America) said that his country looked forward to continued participation in the implementation process of the Strategic Approach, working with partners and providing technical support to Member States where needed. The Strategic Approach provided developing countries in particular with a road map for achieving the aim set at the World Summit on Sustainable Development, that by 2020 chemicals be used and produced in ways that led to the minimization of significant adverse effects on human health and the environment. He supported the intersectoral approach advocated in the report together with the emphasis on the roles and responsibilities of the health sector in chemicals management and applauded WHO's efforts in that sphere. He recommended acceptance of the two draft resolutions and encouraged support for the activities listed therein.

He proposed amendments to those resolutions. In subparagraph 2(5) of the draft resolution contained in EB126.R12, the words "and civil society" should be inserted after the words "business sectors" and the word "instruments" should be replaced by "strategies and approaches". In regard to the draft resolution contained in resolution EB126.R13, he proposed that in the thirteenth preambular paragraph the words "recovery, reuse and recycling" should be replaced by "handling". In the environmental arena in particular, those three words were often rightly used, whereas their use was not always appropriate in the context of chemicals. By contrast, the word "handling" could convey the intended meaning of those three words while avoiding any inappropriateness of meaning.

Mr Koba (Indonesia) said that Indonesia, as President of the Ninth Conference of the Parties to the Basel Convention on the Control of Transboundary Movement of Hazardous Wastes and their Disposal, said that it was essential to address the environmentally sound management of waste and its linkage to human health, and he therefore urged Member States to support the draft resolution contained in resolution EB126.R12.

Dr HUSAINI (Brunei Darussalam) said that the potentially harmful impact on health of chemical exposure could not be underestimated. A major challenge would be to convince stakeholders in chemical production to implement measures to avoid compromising human health. However, the health sector must first have the capacity and expertise to identify and manage chemical hazards and to intervene and provide appropriate treatment. He therefore supported the two draft resolutions.

Dr ZHANG Xudong (China) said that his Government attached great importance to the management of hazardous waste and chemicals as reflected in the environmental protection laws. China supported the two draft resolutions. Health ministries were not the competent authorities to deal with hazardous waste and chemicals; therefore, the relevant international organizations should strengthen communication with governmental authorities to establish the intersectoral coordinating mechanisms necessary to address the problem of hazardous waste and chemicals, thereby ensuring the participation of ministries of health and the effective implementation of WHO's resolutions.

Mrs ORAPAN SRISOOKWATANA (Thailand) said that it was unacceptable that asbestos remained in use in many developing countries, despite a ban in over 40 countries around the world, including asbestos-exporting countries.

She proposed amendments to the draft resolution contained in resolution EB126.R12. Paragraph 1 should begin with the words "URGES Member States", and the remaining text should become subparagraph 1(1). In the first line of new subparagraph 1(1), the words "to apply the Health Impact Assessment (HIA) as one of the key tools" should be inserted before the words "to assess"; and the words "the Stockholm Convention on the control of carcinogens exposure, the Rotterdam Convention on the control of toxic chemicals information" should be inserted between "Chemicals Management" and "the Basel Convention". She proposed that a further three subparagraphs should be added, to read:

- (2) to put in place the appropriate legal structure, in compliance with international standards, to prohibit the importation, production and distribution of asbestos and asbestos-containing products, when other substitutes are available;
- (3) to enhance and facilitate local authorities to participate in toxic waste management in the communities, as well as to ensure the active role of the private sector in safe and environmentally sound waste management based on the principles of producers' responsibility, the polluter pays principle, and sustainable consumption and production;
- (4) to ensure the access to justice through developing the national, regional and international judicial process and establishing specialized tribunals and courts related to waste and human health conflicts.

She supported the draft resolution contained in resolution EB126.R13.

Mr KOVALEVSKIJ (Russian Federation) said that his country recognized the importance to human health of appropriate regulations governing international chemicals and waste management. It therefore supported the draft resolutions contained in resolutions EB126.R12 and EB126.R13 and the amendments proposed by the United States. There were many new chemical substances, such as those used in nanotechnology, synthetic materials and electronics, which, if not used appropriately, could threaten human health and the environment. However, the Secretariat's report had singled out certain chemicals without taking due account of factors existing in different regions and countries, and its value was thereby diminished. By focusing on outdated issues, the international community was failing to recognize the serious threat of new substances and was therefore not targeting its resources adequately. He expressed disappointment that, although his delegation had already made that point at

the 126th session of the Executive Board, the report under consideration had failed to reflect his delegation's position, notably in regard to the contents of paragraphs 3 and 4. Accordingly, he requested that the following points be noted. In paragraph 3 of the report two sentences beginning "About 800 000 children" and ending with the words "many developed countries", as well as the sentence beginning "Cancer of the lung" and ending "in some countries" should have been omitted. In paragraph 4, the words "chemicals such as mercury, lead and asbestos" should have been replaced by "persistent organic pollutants, heavy metals, toxic chemicals, including those in children's products, and by many other factors". In the second subparagraph of paragraph 12, the words "such as lead, mercury, persistent organic pollutants and asbestos" should have been omitted.

Dr MULESHE (Kenya) said that his country, which imported most of the chemicals required for its industries, had recently experienced several serious accidents involving chemicals. The disease burden attributable to chemicals mismanagement had not been determined; however, the increase in cases of various forms of cancer and respiratory diseases pointed to the need for further investigation of chemical exposure. His country had received the support of The United Nations Institute for Training and Research in implementing the Strategic Approach. The Libreville Declaration on Health and Environment in Africa (2008), which his country had signed, would enable it to address the Strategic Approach and the implementation of other relevant international instruments. He requested support in capacity building, especially in electronic waste management, and in developing the national chemicals management database.

Mr AL-TAAE (Iraq) said that WHO had an essential role to play in waste management in health institutions, in the integration of waste management in environmental health domains and primary health care, and in upgrading waste management activities in the attainment of Millennium Development Goal 7 (To ensure environmental sustainability).

Dr SEAKGOSING (Botswana) said that in order to remedy the continuing problem of exposure to toxic chemicals, his Government was developing legislation on chemicals safety in line with internationally accepted standards and had already introduced regulations on exposure to chemicals in the agricultural sector. All imported chemicals would be registered on an established database which would link to international chemicals databases. His Government had also launched a public awareness programme on the effects and safe use of chemicals and pesticides. He supported the two draft resolutions.

Mr ALVAREZ (Chile), speaking on behalf of the Latin American and Caribbean Group, said that although the principles of recovery, reuse and recycling were environmentally important, he could agree to the proposal by the delegate of the United States to replace those words by the word "handling" in the thirteenth preambular paragraph of the draft resolution contained in resolution EB126.R13.

He could not, however, support the amendments proposed by Thailand to paragraph 1 of the draft resolution contained in draft resolution EB126.R12. The proposed new subparagraphs 1(2) and 1(3) related to the issue of waste management, already regulated through specific legal instruments. That issue was probably not therefore within the competence of WHO or the scope of the Strategic Approach: the ultimate aim of the two draft resolutions was to protect human health through the protection of the environment. He requested the view of the Legal Counsel on that point.

Moreover, in the proposed new subparagraph 1(1), the references to the Stockholm and Rotterdam Conventions did not reflect their legal names, which were the Stockholm Convention on Persistent Organic Pollutants and the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade.

The CHAIRMAN asked whether the delegation of Thailand would be willing to withdraw its proposed amendments.

Dr NALINEE SRIPAUNG (Thailand) said that her delegation would be prepared to withdraw the proposed new subparagraphs 1(2) and 1(3), but the proposed insertion of references to the Stockholm and Rotterdam Conventions in paragraph 1(1) should remain since those related to environmental pollution, and Thailand was concerned about protecting workers in the formal and informal sectors.

The CHAIRMAN asked the delegate of Chile whether he could accept the amendments to subparagraph 1(1) proposed by Thailand.

Mr ALVAREZ (Chile), speaking on behalf of the Latin American and Caribbean Group, said that he could agree to the amendments proposed by Thailand to subparagraph 1(1), provided that the conventions were cited correctly, but could not endorse the proposed additional subparagraphs 1(2), 1(3) and 1(4).

Mr KOVALEVSKIJ (Russian Federation) endorsed the amendment proposed by the delegate of the United States of America, which had no impact on the overall sense and improved the clarity of the resolution. He could not accept the amendments proposed by Thailand, which in any case needed clarification, particularly with regard to the use of the word “asbestos”, which appeared to single out one particular substance from a group of very dangerous substances, including industrial fibres.

Dr NALINEE SRIPAUNG (Thailand), replying to the delegate of the Russian Federation, said that her delegation’s first proposed amendment, which included a reference to the Health Impact Assessment, should not be contentious, as its purpose was to ensure the prevention and control of dangerous chemical substances. Moreover, more than 40 countries had already banned asbestos. She therefore did not wish to withdraw the amendment but was prepared to withdraw the proposal to add new subparagraphs 1(2), 1(3) and 1(4).

Ms KARAGULOVA (Kazakhstan) drew attention to the fact that “asbestos” was a trade name for a group of products and should not be used without qualification.

Dr NALINEE SRIPAUNG (Thailand) said that her delegation was willing to withdraw the proposed amendments. However, she wished to emphasize that prevention and control were more important than treatment and cure and would welcome suggestions for a substitute term for asbestos.

Mr ALVAREZ (Chile) said that Thailand’s contributions to the effective control of dangerous chemical substances were commendable, but those concerns were dealt with in two specific conventions, the Rotterdam Convention on the Prior Informed Consent Procedure for Certain Hazardous Chemicals and Pesticides in International Trade (1998), and the Stockholm Convention on Persistent Organic Pollutants (2001). He thanked the delegation of Thailand for its flexibility on the issue.

Mr KOVALEVSKIJ (Russian Federation) asked whether final versions of the amendments to the draft resolutions would be made available to delegates, and whether those versions would include amendments other than those that had already been agreed.

The CHAIRMAN said that he would take action on the point raised by the previous speaker. In addition, the changes to the report contained in document A63/21 as suggested by the delegates of Kazakhstan and the Russian Federation, had been duly noted and would be taken into consideration by the Secretariat.

Dr NEIRA (Protection of the Human Environment) thanked all Member States for recognizing the importance of the sound management of chemicals to protect public health; the strong linkages

between human health and the environment; and the growth in the number of chemical threats to the health of their populations. She appreciated the importance paid by Member States to the topic of intersectoral collaboration and close partnerships with relevant organizations. She noted the request from the delegations of Spain, Chile and the United States of America for more work on nanotechnology and said that WHO was already participating in work on nanotechnology in developing countries. She noted the reference made by the delegation of Kenya to the Libreville Declaration on Health and Environment in Africa (2008), pursuant to which progress was being made in addressing environmental threats to health.

Referring to the concern raised by Thailand regarding asbestos, she said that in 2009 the International Agency for Research on Cancer had re-evaluated all forms of asbestos, including chrysotile asbestos, and concluded that they were carcinogenic to humans and caused mesothelioma and cancer of the lung, larynx and ovary.

The CHAIRMAN drew attention to the proposed amendments to the draft resolution contained in resolution EB126.R12.

Mr Koba (Indonesia) drew attention to the title of the resolution: "Improvement of health through safe and environmentally sound waste management". Any reference to the Stockholm and Rotterdam Conventions, as proposed by the delegation of Thailand, would be inappropriate as those conventions did not deal with waste management.

The CHAIRMAN asked whether the delegation of Thailand was willing to withdraw its proposal for the inclusion, in its proposed amendment to paragraph 1, of a reference to the Stockholm and Rotterdam Conventions.

Dr NALINEE SRIPAUNG (Thailand) agreed to withdraw the proposal in question.

The CHAIRMAN asked the Secretary to read out the proposed amendments to the draft resolution contained in resolution EB126.R12.

Dr DOLEA (Assistant Secretary) said that the delegation of Thailand had proposed that in paragraph 1 the words "to apply the Health Impact Assessment as one of the key tools" should be inserted before the words "to assess the health aspects". In subparagraph 2(5), the delegation of the United States of America had proposed that the words "and civil society" should be inserted after "regional economic integration organizations". The same delegation had proposed that the word "instruments" should be replaced with "strategies and approaches".

The resolution, as amended, was approved.¹

The CHAIRMAN asked the Secretary to read out the proposed amendments to the draft resolution contained in resolution EB126.R13.

Dr DOLEA (Assistant Secretary) said that the delegation of Chile had proposed that in the tenth preambular paragraph the phrase "or inherited from past periods of pesticide overconsumption" should be inserted after "phase-out period". In the thirteenth preambular paragraph, the same delegation had proposed that the word "economic" should be replaced with "health"; and the delegation of the United States of America had proposed that the words "recovery, reuse, recycling" should be replaced with "handling".

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA63.25.

The resolution, as amended, was approved.¹

Mr LOGAR (Slovenia), welcoming the Committee's endorsement of resolution EB126.R13, said that in 2009 his country had originally proposed that the important international issue of management of obsolete chemicals should be included in the Executive Board's agenda and he thanked all contributors to the improvements of the resolution.

Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services: Item 11.22 of the Agenda (Documents A63/25, A63/25 Corr.1 and A63/25 Add.1)

The CHAIRMAN, introduced the item and drew attention to the draft resolution contained in document A63/25.

Dr SEAKGOSING (Botswana), speaking on behalf of the Member States of the African Region, said that the wide and diverse range of economies in Africa was reflected in the continent's health requirements and health systems. Several countries in the Region used private providers to increase access in areas such as reproductive health and the fight against tuberculosis, malaria and HIV/AIDS.

The African Union, in its Africa Health Strategy 2007–2015, in line with the Ouagadougou Declaration (2008), called for governments, donors and providers to provide a coordinated and coherent approach to reduce the disease burden in Africa. Regulation of all health-care providers in the Region was still needed to ensure that the quality, safety and affordability of health care services were not compromised. The Region had been negatively affected by the emigration of skilled manpower to regions with strong economies, which had affected the ability to negotiate and regulate the provision of primary health care by private partners.

The African Union, in its strategy document, had called for the establishment of a multidisciplinary body responsible for the coordination of traditional medicine. However, the approaches of African nations in that area varied considerably and should be reviewed.

He welcomed the draft resolution but emphasized that certain factors would need further consideration including: the estimated cost implications for low- and middle-income countries; the inclusion of language that emphasized regulation, including the management of conflicts of interest in relation to pharmaceutical companies and nutrition-related issues; and support in the elaboration of legislation.

Dr WINAI SAWASDIVORN (Thailand), speaking on behalf of the Member States of the South-East Asia Region, said that the WHO Regional Committee for South-East Asia, at its sixty-second session, had agreed that public investment in health should continue to be a priority and that universal coverage must be at the heart of all public–private partnerships, in order to ensure that health services overall made significant progress towards equity. The Regional Committee had also urged that social services should be broadened to include private as well as public health-care providers through strategic purchasing and contractual agreements, and had agreed that strategic engagement with the private sector required government stewardship, especially in the area of regulation.

He strongly supported the draft resolution and emphasized that, transparent dialogue and trust were vital for constructive engagement, oversight and regulation of the private sector. The oversight capacity of governments in all areas needed to be strengthened, and technical support from WHO was essential.

¹ Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA63.26.

Mr MCIFF (United States of America) welcomed WHO's renewed commitment to primary health care and the efforts to bring together both public and private institutions to improve the quality of patient care. His Government supported WHO's work in building the regulatory capacity and stewardship role of health ministries in developing countries and in building constructive relationships between the public sector and private providers.

He proposed that, in subparagraphs 2(2) and 2(3) of the draft resolution, the words "set the research agenda" should be replaced by "support the research agenda set by Member States".

Dr TSESHKOVSKIY (Russian Federation) said that the report highlighted the main differences in private health-care provision between high-, low- and middle-income countries. In high-income countries the commercialization of medicine had widened both patient access and choice, whereas in low- and middle-income countries, the higher cost of private health-care services tended to marginalize certain segments of the population. Hence, strengthened State regulation of private health-care provision was needed, and with the involvement of civil society. In developing the private sector, policies should be targeted at the needs of individuals so that vulnerable groups were not excluded from access to health services. In building its own health services, his Government was endeavouring to achieve a balance between equity and stimulating entrepreneurship, and, to that end, it had legislated to enable medical centres to offer both public and private services. He expressed support for the draft resolution and said that his delegation would welcome a further exchange of experiences on the subject.

Mr AL-TAAE (Iraq) said that private health services were a major component of his country's health system; partnerships between the private and public sectors were essential in the delivery of primary health-care services. He called on the Secretariat to support Member States to exchange expertise; to develop appropriate guidelines in that regard; to involve both the public and private sectors in public-health and primary health-care activities, including capacity building, implementation of DOTS strategies and attainment of the Millennium Development Goals; and to ensure that investment in the private sector also benefitted the public sector.

Dr NORHIZAN ISMAIL (Malaysia) strongly supported the draft resolution. In 1998, his Government had legislated to strengthen partnerships between public and private health-care providers and it was now engaged in the creation of an integrated health system that would provide a choice of quality care. Although primary health care continued to underpin national health services, the private sector would assume greater responsibility for non-essential, as well as secondary and tertiary, health services.

He welcomed the Secretariat's support for exchanges between Member States in regard to engagement, oversight and regulation of all health-care providers.

Ms PATTERSON (Australia) supported the draft resolution. She had noted with satisfaction that provision had been made to facilitate implementation of the resolution in WHO's Proposed programme budget 2010–2011.

Mrs Su-wen TENG (Chinese Taipei) expressed appreciation for the draft resolution. In 1995, Chinese Taipei had launched a health insurance system that by 2009 had attained 99% coverage of the population. Simultaneously, health-care services had been progressively linked to health insurance in order to provide an integrated delivery system that would strengthen medical care and balance available resources between urban and rural areas. In future, more funding would be allocated to applying information and communications technologies to health services, including telemedicine and telecare. Chinese Taipei looked forward to sharing its experiences with the international community.

Dr ETIENNE (Assistant Director-General) welcomed the numerous comments and recommendations and acknowledged the role of the private sector in delivering health services in both

developed and developing countries. She had been encouraged to note that the focus had shifted to the unregulated commercialization of care in both the private and public sectors, which so often resulted in the fragmentation, segmentation, and high user fees that limited access and caused financial catastrophe. In developing countries the regulatory frameworks, as well as the institutional and operational capacity to enforce regulations, were weak.

It had become apparent, that Member States, particularly in developing countries, needed normative and technical support to enable them to carry out research and collect information and to share such intelligence and best practices. To that end, the Secretariat would support Member States to take full responsibility for insuring financial risk through pooling and pre-payment mechanisms with the aim of achieving universal coverage; and to build their capacity to enact and enforce regulations, raise awareness among consumers and build trust and consensus in the private sector through active engagement and inclusive policy dialogue.

The draft resolution, as amended, was approved.¹

Public health, innovation and intellectual property: global strategy and plan of action: Item 11.3 of the Agenda (Documents A63/6, A63/6 Add.1 and A63/6 Add.2) (continued from the second meeting, section 2)

Mr SILBERSCHMIDT (Switzerland), speaking as chairman of the informal working group, said that consensus had been reached on a draft resolution on the Establishment of a consultative expert working group on research and development: financing and coordination. He read out the text.

The Sixty-third World Health Assembly,

Having considered the report on public health, innovation and intellectual property: global strategy and plan of action, and the report of the Expert Working Group on Research and Development: Coordination and Financing;²

Considering resolution WHA61.21 which requests the Director-General “to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consideration of proposals from Member States, and to submit a progress report to the Sixty-second World Health Assembly and the final report to the Sixty-third World Health Assembly through the Executive Board”;

Noting that although the Expert Working Group made some progress in examining proposals for financing of, and coordination among, research and development activities, as called for in resolution WHA61.21, there was divergence between the expectations of Member States³ and the output of the Group, underlining the importance of a clear mandate;

Considering that, in its recommendations, the Expert Working Group states the need to conduct an in-depth review of the recommended proposals;

Recognizing the need to further “explore and, where appropriate, promote a range of incentive schemes for research and development including addressing, where appropriate, the de-linkage of the costs of research and development and the price of health products, for example through the award of prizes, with the objective of addressing diseases which disproportionately affect developing countries”;⁴

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA63.27.

² Documents A63/6 and A63/6 Add.1, respectively.

³ And, where applicable, regional economic integration organizations.

⁴ Resolution WHA61.21, Annex, Element 5, paragraph 5.3a.

Noting previous and ongoing work on innovative financing for health, research and development and the need to build on this work as relevant;

Emphasizing the importance of public funding of health research and development and the role of the Member States¹ in coordinating, facilitating and promoting health research and development;

Reaffirming the importance of other relevant actors in health research and development,

1. URGES Member States:¹
 - (1) to support the work of the Consultative Expert Working Group by:
 - (a) providing, where appropriate, information, submissions or additional proposals;
 - (b) organizing and/or supporting, where appropriate, regional and subregional consultations;
 - (c) proposing names of experts for the roster;

2. REQUESTS the Director-General:
 - (1) to make available electronically by the end of June 2010:
 - (a) all the proposals considered by the Expert Working Group including their source;
 - (b) the criteria used to assess the proposals;
 - (c) the methodology used by the Expert Working Group;
 - (d) the list of the stakeholders that were interviewed and those who contributed information;
 - (e) sources of statistics used;
 - (2) to establish a Consultative Expert Working Group that shall:
 - (a) take forward the work of the Expert Working Group;
 - (b) deepen the analysis of the proposals in the Expert Working Group's report, and in particular:
 - (i) examine the practical details of the four innovative sources of financing proposed by the Expert Working Group in its report;²
 - (ii) review the five promising proposals³ identified by the Expert Working Group in its report; and
 - (iii) further explore the six proposals that did not meet the criteria applied by the Expert Working Group;⁴
 - (c) consider additional submissions and proposals from Member States,¹ any regional and subregional consultations, and from other stakeholders;
 - (d) in carrying out the actions in subparagraphs 2(b) and 2(c), examine the appropriateness of different research and development financing approaches and the feasibility of implementation of these approaches in each of the six WHO regions, with subregional analysis, as appropriate;
 - (e) observe scientific integrity and be free from conflict of interest in its work;
 - (3) to provide, upon request, within available resources dedicated to the financing of the Consultative Expert Working Group, technical and financial support for regional

¹ And, where applicable, regional economic integration organizations.

² *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Chapter 5.3.

³ *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Chapter 5.6.

⁴ *Report of the Expert Working Group on Research and Development Financing*. Geneva, World Health Organization, 2010, Annex 2.

consultations, including meetings, in order to seek regional views to help inform the work of the Consultative Expert Working Group;

- (4) to invite Member States:
 - (a) to nominate experts whose details, following consultations with regional committees to achieve gender balance and diversity of technical competence and expertise, shall be submitted to the Director-General through the respective regional directors;
 - (b) to establish a roster of experts comprising all the nominations submitted by the regional directors;
 - (c) to propose a composition of the Group to the Executive Board for its approval, drawing on the roster of experts and taking into account regional representation according to the composition of the Executive Board, gender balance and diversity of expertise;
 - (d) upon approval by the Executive Board, to establish the Group and facilitate its work including its consultation with the Member States¹ and other relevant stakeholders, where appropriate;
- (5) to put particular emphasis on the transparent management of potential conflicts of interest by ensuring full compliance with the mechanisms established by the Director-General for that purpose;
- (6) to ensure full transparency for Member States¹ by providing the Consultative Expert Working Group's regular updates on the implementation of its workplan, and by making available all the documentation used by the Consultative Expert Working Group at the conclusion of the process;
- (7) to submit the workplan and inception report of the Consultative Expert Working Group to the Executive Board at its 129th session and a progress report to the Executive Board at its 130th session with a view to submitting the final report to the Sixty-fifth World Health Assembly.

Mr HOHMAN (United States of America) requested that the content of footnote 3 in the draft resolution should be deleted and replaced by the standard wording used in Health Assembly resolutions, namely: "Where applicable, also regional economic integration organizations". Replying to Mr SILBERSCHMIDT, he said that that footnote should be inserted after every reference to "Member States". He also proposed that at the end of the first line of subparagraph 2(4)(a), the word "within" should be replaced by "with".

Dr VIROJ TANGCHAROENSATHIEN (Thailand) proposed that a new subparagraph 2(2)(e) should be inserted, to read: "observe the scientific integrity and be free from conflict of interest in its work". Subparagraph 2(2) set out the functions of the consultative expert working group, whereas the rest of paragraph 2 outlined the mandate of the Director-General.

Dr CHIRIBOGA (Ecuador) supported the amendment proposed by the delegate of Thailand.

Dr MULESHE (Kenya), speaking on behalf of the Member States of the African Region, supported the amendment as stated.

Mr SILBERSCHMIDT (Switzerland), speaking as chairman of the informal working group, said that the amendments proposed by the delegates of Thailand and the United States of America were perfectly in keeping with the spirit of the draft resolution.

¹ And, where applicable, regional economic integration organizations.

Mrs FERNÁNDEZ DE LA HOZ ZEITLER (Spain), speaking on behalf of the European Union, endorsed the proposal by the United States of America to amend footnote 3 and to insert it after every mention of “Member States”.

The CHAIRMAN, in the absence of any objection, took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

Dr CHIRIBOGA (Ecuador), speaking on behalf of the Member States of the Union of South American Nations, expressed satisfaction at the approval of the resolution on the Establishment of a consultative expert working group on research and development: financing and coordination, the aim of which was the production of medicines for neglected diseases. Dissatisfaction had been expressed at the manner in which the Expert Working Group had fulfilled the mandate conferred on it by WHO. The resolution paved the way for a detailed assessment of the issues that would take account of the needs of every region; and for the implementation of sound strategies aimed at providing people with access to high-quality and affordable medicines.

4. FIFTH REPORT OF COMMITTEE A (Document A63/66)

The CHAIRMAN read out the draft fifth report of Committee A.

The report was adopted.²

5. CLOSURE

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

The meeting rose at 18:50.

¹ Transmitted to the Health Assembly in the Committee’s fifth report and adopted as resolution WHA63.28.

² See page 322.

COMMITTEE B

FIRST MEETING

Wednesday, 19 May 2010, at 09:45

Chairman: Dr W. JAYANTHA (Sri Lanka)

1. OPENING OF THE COMMITTEE: Item 12 of the Agenda

The CHAIRMAN welcomed participants and Dr Dahl-Regis, who, as Chair of the Programme, Budget and Administration Committee of the Executive Board, would report on several issues on the agenda dealt with on behalf of the Executive Board by that Committee at its twelfth meeting (Geneva, 14 May 2010).

He informed the Committee that Dr G.J. Komba-Kono (Sierra Leone) and Dr N. El Sayed (Egypt) had been nominated for the offices of Vice-Chairmen of Committee B, and Mr A.-P. Sanne (Norway) for the office of Rapporteur.

Decision: Committee B elected Dr G.J. Komba-Kono (Sierra Leone) and Dr N. El Sayed (Egypt) as Vice-Chairmen, and Mr A.-P. Sanne (Norway) as Rapporteur.¹

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit their statements to a maximum of three minutes. He drew attention to documents EB124/2009/REC/1 and EB126/2010/REC/2, which contained the resolutions and decisions adopted by the Executive Board at its 124th and 126th sessions respectively. He took it that the suggested working arrangements were acceptable to the Committee.

It was so agreed.

3. PROGRAMME AND BUDGET MATTERS: Item 14 of the Agenda

Programme budget 2008–2009: performance assessment: Item 14.1 of the Agenda (Documents A63/29 and A63/49)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee of the Executive Board, said that, at its twelfth meeting, the Committee had expressed its appreciation of the publication of the summary report of the performance assessment of the Programme budget 2008–2009 and had noted that for the first time the performance assessment and financial report had been published simultaneously. The report was concise and contained much essential information. Committee members had expressed concern at the definition of “partially

¹ Decision WHA63(3).

achieved” and had asked the Secretariat to consider the introduction of subcategories within that category. In response to the Committee’s request, it had been proposed that the document be further considered by the Committee at its thirteenth meeting, by the Executive Board at its 128th session, and by the regional committees at their forthcoming sessions. The Committee had requested that the links between the Programme budget performance assessment and the health-related Millennium Development Goals should be further elaborated, and that future performance assessments should include more analysis on cost-effectiveness.

Dr LIU Peilong (China) said that the report on the Programme budget 2008–2009 performance assessment offered important inputs for the Proposed programme budget 2012–2013. However, since its late publication had not allowed sufficient time for study, he endorsed the proposal to resume its consideration at the thirteenth session of the Programme, Budget and Administration Committee, at the 128th session of the Executive Board and at sessions of the regional committees. The category “partially achieved” was, he agreed, too broad and should be broken down; for example, details of implementation by region should be given.

He was concerned that base programmes were estimated to be underfunded in relation to the approved budget, affecting implementation in all regions; that the level of funds available for the partnerships and collaborative arrangements segment was higher than originally estimated; and that the funding received for strategic objectives 1 and 5 was mainly for activities outside the base programmes segment. The Secretariat should have strategic and operational control over its base programmes and its normative work. Without adequate funding there was a danger that the performance of the programme budget could be distorted. He urged the Secretariat to redouble its efforts to secure – and encouraged donors to provide – more flexible funding, in order to guarantee implementation of the programme budget.

Dr MADZORERA (Zimbabwe), speaking on behalf of the Member States of the African Region, described the performance assessment report as an important tool for evaluating the Secretariat’s performance in achieving the organizational results and Member States’ progress towards meeting the strategic objectives. The report showed that 42 of the 81 Organization-wide expected results had been fully achieved, and 39 had been partially achieved. Achievements had been made in most areas of the Organization’s strategic objectives. However, partial achievements remained a cause of grave concern, notably in the following areas: HIV/AIDS, tuberculosis and malaria; child, adolescent and maternal health, and sexual and reproductive health; ageing; healthier environment; and enabling and support functions.

It was gratifying that the Organization had been able to raise more funds than the approved Programme budget 2008–2009, even though most of the extra funding was for activities outside the base segment programmes. He was deeply concerned at the low level of funding for chronic noncommunicable diseases; for child, adolescent, maternal, sexual and reproductive health, and ageing; for social and economic determinants of health; and for nutrition and food safety. Malnutrition continued to plague the African continent and impair the general health of its population.

An analysis of the budget by segment gave rise to concern, for although overall availability of funds had exceeded 100%, base programmes had received only 82% of the approved budget amount, jeopardizing WHO’s exclusive strategic and operational control over its planned activities and its normative work. Expenditure in the latter segment was worryingly low. Not only were partnerships and collaborative arrangements, and outbreak and crisis response well funded, but expenditure was also commendable and had provided crucial funding for poliomyelitis eradication, response to outbreaks of other diseases and crisis response.

The African Region was grateful for the US\$ 1112 million – or 93% of the approved budget – that it had received during the biennium. However, expenditure had reached only 84%. In view of the huge gaps in the funding of health-related programmes across the continent, more could be done to spend the funds available. The high degree of specification of funds might be a contributing factor and should be examined.

The fact that only 19% of the total of US\$ 5000 million available for programme budget implementation had been provided through assessed contributions from Member States and that 65% of total funds provided during the biennium had been “specified to various degrees, often tightly” was also a cause for concern. He fully supported the Director-General’s efforts to encourage donors to increase not only funding for WHO generally, but also the proportion of flexible funds.

Mr LARSEN (Norway), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, said that the performance assessment of WHO was one of the most important topics on the agenda of the Committee. It had a strong bearing on the governance of the Organization, which was more relevant than ever in the current resource-restrained environment and with multiple stakeholders pursuing overlapping and competing agendas within health. The Nordic countries, among others, had pushed for the two-yearly performance assessment report to be issued in time to be discussed fully and adopted at the following Health Assembly, permitting real-time assessment and application of lessons learnt in the development of new budgets. While acknowledging the Secretariat’s efforts to meet that request, he said that the report’s publication was unacceptably late. It was absolutely necessary to receive the report at least two weeks before the Health Assembly. Therefore, although he would have preferred to have discussed the important issues of financing and governance raised in the report during the current Health Assembly, he endorsed the suggestion to postpone the discussion to the thirteenth meeting of the Programme, Budget and Administration Committee and the 128th session of the Executive Board. Results evaluation, the carrying forward of funds, imbalances in the funding of strategic objectives, flexible versus non-flexible funding and the consequences for WHO of the many partnerships were just some examples of the topics to which he would wish to revert after having studied the report.

He welcomed the Director-General’s initiative on a strategic debate on the future financing of WHO. The timelines of the initiative and the performance report should be coordinated, given the substantive interconnection and overlapping of the two.

Ms KITSELL (United Kingdom of Great Britain and Northern Ireland), welcoming the publication of the 2008–2009 performance assessment report at the earlier point in the biennium, regretted that time had been too short to allow Member States to discuss the document fully and enable the results of the discussion to be reflected properly in the next biennial planning cycle.

An improvement in the donor base should be driven through both improved results-based management and organizational efficiency. WHO was working hard to improve its results chain and address the issues of budgeting and alignment; however, it needed to show clearly how inputs related to outputs and outcomes. Noting that a working group had been established to propose ways of harmonizing strategic objectives 12 and 13, she asked when Member States would see the working group’s proposals. She urged WHO to develop new indicators to measure the value for money of its interventions, namely the efficiency and the effectiveness of its field operations. Noting that almost half the indicators in the report came into the “partially achieved” category, she said that it would be helpful to introduce a distinction between “almost fully achieved” and “not well achieved at all”.

Dr JAMA (Assistant Director-General) gave an assurance that the next biennial performance assessment report would be issued on time. He welcomed the suggestion to continue discussion of the current report at future meetings of the Programme, Budget and Administration Committee and sessions of the Executive Board and regional committees. The document would be presented simultaneously with the Proposed programme budget 2012–2013, allowing the lessons learnt from implementation of the Programme budget 2008–2009 to be incorporated. He had noted the comments on budget and structure and the fact that the base programme segment had not received the full budgeted resources required. The issue was being discussed within the Secretariat and should be addressed by Member States. At the end of each Health Assembly, when the budget had been approved, only the assessed contributions were known. The Secretariat was grateful to the donors that

had supported the Organization's work in all countries. The Director-General was assessing how alignment could be improved and resources better matched to the Organization's priorities.

Under the "partially achieved" category, the Secretariat would in future provide a breakdown by regional office as well. He had taken note of the points raised about implementation of the base programme and availability. Improvements were being made to implementation and absorption of resources.

The Director-General's report on the future financing of WHO had addressed some of the issues raised on financing and governance, and the document was still open for contributions by Member States. With regard to the reporting on and linking of inputs to outputs and outcomes and the linking of resources to results, the report showed the impact being made and the actual outcomes of WHO's contribution to national health development. For the first time, the Secretariat had been able to relate the achievement of the expected results to specific countries and locations. The full report contained the list of countries where those contributions had been made by the Secretariat. However, further improvement was still needed, as noted by the delegate of the United Kingdom.

He gave an assurance that the work on the efficiencies and harmonization between strategic objectives 12 and 13 was ongoing. It was a United-Nations-wide process. Information would be made available to Member States as soon as the Secretariat's assessment was completed.

The DIRECTOR-GENERAL said that the issue of value for money, referred to by the delegate of the United Kingdom, was one of the most difficult and important ones facing WHO. She had given the Department of Country Focus, working with the regional and country offices, the task of improving the quality of new recruits, and incumbent WHO Representatives would receive training in areas where there was scope for improvement. The question of roles and responsibilities was linked to the strategic debate and to questions such as: What was WHO's core business? What kind of WHO did Member States want? How should the core business be funded? What kind of skills mix was needed? Incumbents could be retrained to establish a new culture and work ethic and to meet Member States' expectations. WHO was engaged in many different partnerships; the role of civil society and public-private partnerships also had to be considered. Answering those questions would be important in the discussion on the way ahead, and she did not have ready answers. Over the next 12 months, the debate on the formulation of the Proposed programme budget 2012-2013 would also make a vital contribution. The Secretariat would review and reformulate the skills mix required by WHO Representatives to ensure effectiveness and efficiency at the field operational level. WHO was not, she assured, a mere implementing agency. While mindful of the need to improve efficiency and effectiveness at the country level, she observed that countries had been declining the services of good WHO Representatives.

The CHAIRMAN said that he understood that the Secretariat had taken note of the request of Member States to include discussion of the report on the provisional agendas of the thirteenth meeting of the Programme, Budget and Administration Committee and 128th session of the Executive Board.

The Committee noted the report.

Eleventh General Programme of Work, 2006-2015: Item 14.2 of the Agenda (Documents A63/30 and A63/50)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that at its twelfth meeting the Committee had taken note of the Secretariat's report on the Eleventh General Programme of Work, 2006-2015, and of the additional information provided on indicators. It had also noted the process to engage Member States in the monitoring and assessment exercise.

The Committee had endorsed a request by the Secretariat to present the interim assessment of the Medium-term strategic plan 2008-2013 to the Programme, Budget and Administration Committee

at its fourteenth meeting in May 2011 and subsequently to the Sixty-fourth World Health Assembly, which would allow adequate time for Member States' engagement and consultation in the process.

The Committee noted the report.

4. FINANCIAL MATTERS: Item 15 of the Agenda

Financial report and audited financial statements for the period 1 January 2008–31 December 2009: Item 15.1 of the Agenda (Documents A63/32, A63/INF.DOC./4 and A63/51 Rev.1)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, drew attention to the redesigned format of the biennial financial report, which was for the first time being presented for a full financial period. The Committee had noted that the report excluded from the WHO accounts those entities hosted by the Organization but not included in the Programme budget, which made the comparison between the Programme budget and the actual financial results easier to follow and was a step towards full compliance with the International Public Sector Accounting Standards.

The Committee had noted from the report that the total income for the Organization for the biennium 2008–2009 amounted to US\$ 3759 million, while total operating expenses amounted to US\$ 3866 million. The deficit of US\$ 182 million had been covered through a combination of interest earnings and a reduction in the carry forward. Member States continued to be the largest source of income through both assessed and voluntary contributions. Voluntary contributions totalled US\$ 2745 million, of which 52% came from Member States.

The Committee had expressed concern about the 7% decrease in income and 18% increase in expenditure as against the biennium 2006–2007. The Secretariat had stated that the carry forward of US\$ 1543 million also represented a decrease from the previous financial period.

Assessed contributions and core voluntary contributions accounted for about 27% of the Organization's resources. Private-sector contributions represented 5% of voluntary contributions, and 21% were from foundations. Strategic decisions had to be made on effective use of those resources to bridge gaps in funding of underfunded strategic objectives.

The Committee had expressed concern that travel costs had risen by 62% over the previous biennium, owing in part to an increased number of intergovernmental meetings and in part to higher travel costs. The Secretariat had stated that a number of cost-control measures were being taken.

The Committee had also noted that contractual services expenditure had increased by 26% over the biennium 2006–2007, owing to a higher level of outsourcing of programme activities.

The Secretariat had advised that an unfunded liability for future staff benefits of US\$ 89 million raised no immediate problem but had to be corrected in order to ensure the Organization's capacity to pay statutory employee benefits.

Non-assessed income from Member States, arising primarily from payment of arrears of prior period assessed contributions, had been exceptionally high in the financial period 2008–2009, resulting in a "one-off" balance of US\$ 32 million.

The Committee recommended, on behalf of the Executive Board, that the Health Assembly adopt the draft resolution contained in document A63/32.

Ms CHERUE (Liberia), speaking on behalf of the Member States of the African Region, noted that the cost of running headquarters accounted for 38% of total generated revenue and that recommendations made by auditors were not being reflected in the financial report.

In view of those observations, she recommended that the "70%–30%" principle for distribution of resources between regions and headquarters be taken into consideration; that the difference between the current operational cost of headquarters, 38%, and the proposed operational cost, 30%, be used to

expand regional programmes; and that the recommendations of all future audited financial statements be circulated to all Member States.

Dr LIU Peilong (China) said that the documents under the present agenda item, in combination with document A63/29, showed that strategic objectives 3, 4, 7 and 9 had received less funding than in the programme budget and had the lowest rate of financial implementation – between 37% and 56%. He pointed out that strategic objective 4, to improve child, adolescent and maternal health, sexual and reproductive health, and ageing, was closely linked to Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health). He requested the Secretariat to provide further explanation of the reasons for the variation in implementation rates and called on the Secretariat to improve the implementation of the programme and budget.

Mr JEFFREYS (Comptroller), responding to issues raised by Member States, said that the financial report was a statement of fact about actual revenues and expenditures over the financial period in question. Concerns about the allocation of resources should, he suggested, be taken up under other items and at future meetings of the Programme, Budget and Administration Committee.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Programme, Budget and Administration Committee contained in document A63/51 Rev.1.

The draft resolution was approved.¹

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 15.2 of the Agenda (Documents A63/33 and A63/52)

The CHAIRMAN informed the Committee that, since the meeting of the Programme, Budget and Administration Committee during the preceding week, Djibouti and Equatorial Guinea had paid contributions such that they were no longer affected by Article 7 of the Constitution.

Mr JEFFREYS (Comptroller) said that Côte d'Ivoire had also recently fully paid both its arrears and its 2010 assessed contribution and was no longer affected by Article 7.

Following the information provided by the Comptroller, the CHAIRMAN informed the Committee that there were therefore no Member States on which a resolution was required.

Mrs TSENILOVA (Ukraine) recalled that Ukraine had been deprived of its right to vote between 1996 and 2004, owing to its failure to meet its financial obligations, and that from 2004 to 2009 it had been making payments of its outstanding arrears in accordance with a special agreement with the Organization, detailed in resolution WHA57.6, and had been making its regular annual assessed contributions.

Resolution WHA57.6 envisaged the payment by Ukraine of half its arrears by 2011, but the economic position of the country severely constrained its ability to meet that obligation. The global financial crisis, along with socioeconomic instability in Ukraine, had led to a worsening of a number of economic indicators, including falls of 15% in gross domestic product, 22% in industrial production, 44% in capital investment and 10% in real income per capita. As a result, in 2009 Ukraine had not met its obligations with respect to its restructured arrears.

Ukraine was taking measures to stabilize its economy and was confident that the situation would soon improve, but at present financial resources were strictly limited. Ukraine took an active

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.4.

part in the work of the Organization and considered it extremely important to retain full membership. Ukraine expected to propose to the Programme, Budget and Administration Committee a review of the schedule of the repayment of its arrears, under which Ukraine would pay the remainder of its arrears, US\$ 26.4 million, over the period 2013–2022. The country would pay its assessed contributions for 2011–2012.

The Committee noted the report.

Scale of assessments 2010–2011: Item 15.4 of the Agenda (Document A63/31)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A63/31.

The draft resolution was approved.¹

Amendments to the Financial Regulations and Financial Rules: Item 15.6 of the Agenda (Documents A63/34 and A63/53)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that that Committee had noted that, in order to comply with the International Public Sector Accounting Standards, the Organization's accounts would have to be externally audited on an annual rather than biennial basis. Such a change would also be consistent with the introduction of annual accounts and would require an amendment to the Financial Regulations and Financial Rules, which would be submitted to the Executive Board for consideration at its 128th session in January 2011.

The Programme, Budget and Administration Committee had been informed by the Secretariat that the first annual financial statement to comply with the International Public Sector Accounting Standards would be issued in 2012. Full compliance with the Standards would depend on the implementation of the Global Management System in the African Region and on further work in connection with fixed assets and inventories.

The Committee noted the report.

Safety and security of staff and premises and the Capital Master Plan: Item 15.7 of the Agenda (Documents A63/35, A63/36, A63/54 and A63/55)

The CHAIRMAN invited the Committee to deal with the safety and security of staff and premises and the Capital Master Plan separately.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that that Committee had reviewed the report by the Director-General on the safety and security of staff and premises and gave an outline of its third report. The Committee had recommended that the Health Assembly adopt the draft resolution contained in document A63/35.

Mr ZIMPITA (Malawi), speaking on behalf of the Member States of the African Region, stressed the importance of ensuring a safe and secure working environment for WHO staff and supported the safety and security funding arrangements proposed by the Director-General and the Executive Board. It was important to establish mechanisms such as the centralized trust fund. Urgent

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.5.

action was needed to find a sustainable funding mechanism for the safety and security of WHO staff in the field and at headquarters.

Dr NISHIZAWA (Japan) said that, in order to avoid duplication in the provision of emergency humanitarian assistance, WHO should differentiate its role from that of other agencies of the United Nations system. In the context of a deteriorating security situation, the feasibility of continuing a project needed assessment and the fullest extent of staff evacuation should be considered. Minimum standards for safety and security incurred unavoidable expenses; those funds should be raised continuously rather than over a single year and extracted from the overall budget through elimination of waste while ensuring that operational priorities were in line with the core mandate of WHO.

Dr JAMA (Assistant Director-General) agreed that staff were increasingly working in environments where security was precarious. WHO relied, in its assessment of security situations, on intelligence provided by the United Nations Department of Safety and Security, which managed security arrangements. In 2002, the Executive Board had adopted a decision on the establishment of the Security Fund,¹ which was where the money would be managed. The Secretariat believed that the initial funds would alleviate security problems in countries where WHO was increasingly losing staff.

He expressed sadness at the death of one member of staff since January 2010.

WHO had a distinct role in humanitarian emergencies, having been designated by the United Nations system as the lead agency for the Inter-Agency Standing Committee Health Cluster. That role also required close cooperation with other agencies in other sectors. Evacuation too was managed through the United Nations system, where any decisions were made to evacuate not just specific agencies but also the entire system. Those arrangements were, he believed, being increasingly reviewed.

The draft resolution was approved.²

The CHAIRMAN invited the Committee to consider the report by the Director-General on the Capital Master Plan contained in document A63/36 and the fourth report of the Programme, Budget and Administration Committee (document A63/55).

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration, said that that Committee had reviewed the report on the Capital Master Plan and gave an outline of its fourth report. The Committee had recommended that the Health Assembly adopt the draft resolution contained in document A63/36.

Ms RUPPEN (Switzerland) said that, with reference to document A63/36, options 1 and 2 would assist preparation of the Proposed programme budget 2012–2013. She welcomed the Secretariat's proposals, which could partly cover the funding of urgent needs, and encouraged it to find other solutions for the remaining funding requirements. Her country had shown its commitment by financing the security perimeter of WHO headquarters. The report set out the mechanisms used by some international organizations for renovation and maintenance work on buildings, most of which could not be used in the case of WHO, which owned and was responsible for the maintenance of its own building. Her country had therefore always encouraged WHO to establish a renovation fund and provide for its sustainable long-term financing, and had proposed that the Organization should set aside annually a sum corresponding to 1% of the fire insurance value of the capital stock. That proposal and its implementation had been included in the report. Member States could also consider options for funding of the entire Capital Master Plan.

¹ Decision EB109(8).

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.6.

Dr JAMA (Assistant Director-General) noted the comments made by Switzerland.

The draft resolution was approved.¹

5. AUDIT AND OVERSIGHT MATTERS: Item 16 of the Agenda

Report of the External Auditor to the Health Assembly: Item 16.1 of the Agenda (Documents A63/37 and A63/56 Rev.1)

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration, said that the Committee had reviewed the comprehensive report of the external auditor on the financial operations of the World Health Organization for the financial period 2008–2009, contained in document A63/37. She outlined the Committee's observations, contained in document A63/56 Rev.1. The Committee had noted the Director-General's comments on the Secretariat's linking ongoing management reforms to many of the issues raised in the report of the External Auditor, in particular the difficulties stemming from the functioning of the Global Management System, data quality and user knowledge. The Committee had also been informed that the significant recommendations would be taken up by the Independent Expert Oversight Advisory Committee.

The CHAIRMAN invited the Deputy Comptroller and Auditor General of India to present the report of the External Auditor to the Health Assembly.

Mr KULSHRESHTHA (representative of the External Auditor), speaking on behalf of the External Auditor, introduced the Report of the External Auditor. The External Auditor had placed an unqualified opinion on the financial statements for the financial period 2008–2009.

In the area of policies and procedures, the Financial Regulations had been revised in accordance with resolution WHA62.6 in order to fulfil the Organization's commitment to implementing the International Public Sector Accounting Standards fully from 1 January 2010. However, the revision had created a conflict between Regulations XIII and XIV, concerning the frequency of financial statements and frequency of audit cycle. No provision had been made for full annual audits of financial statements, as suggested by amended Regulation XIII, at the time of submission of the amended Financial Regulations to the Executive Board in January 2009. He supported the Secretariat's proposal to present a timeline for resolving that conflict and to alter the mandate of the External Auditor to accommodate the need for annual audits. He also noted that notwithstanding Financial Regulation 13.1, which required compliance with the International Public Sector Accounting Standards, the biennial financial statement for the period 2010–2011 would be presented in accordance with United Nations System Accounting Standards.

In the area of cash management and bank reconciliation, he noted that WHO had been unable to conduct monthly bank reconciliations since the introduction of the Global Management System in July 2008, owing to various teething problems. Keeping bank statements un-reconciled posed a threat to the accuracy of the accounts and could lead to duplicate, wrong or over-payments. A strengthening of internal controls had been recommended in order to be compliant with rules and regulations, efficient and effective in operations and to ensure sound financial reporting. It had also been recommended that a long-term cash-budgeting approach should be adopted to plan receipt, payment and investment, with all the related information documented for risk assurance and audit trail. He encouraged the stated reporting enhancements on external and internal investments.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.7.

The Global Management System was used by the Global Service Centre with the aim of delivering end-to-end human resource services and making processing faster and simpler. In the management review, the database on human resources had been discovered to be incomplete, thereby affecting its accuracy and validity. System enhancements were required to capture all human resource actions in order to bring the efficiency and effectiveness of human resource processes up to the established standards and to realize the primary objectives of the Global Management System. Necessary controls were not in place to check the unique identity of individual staff, dependency status, documentation upload, modification and retrieval, and data entry. He had received assurances from the Secretariat that standard operating procedures had since been put in place to mitigate potential risks.

Some salary payments were being processed as salary advances, bypassing the built-in controls of the human resource management system and payroll modules of the Global Management System, pending completion of administrative formalities, with a consequent delay in processing. Any data discrepancy in human resources and payroll, including dependency-related issues, also appeared in the health insurance information system; the accuracy of that system data was therefore questionable and would remain linked to the issue of human resource data integrity. Where business ownership was shared, a definition of clear responsibility lines had been recommended in order to attain better efficiency and effectiveness in human resource processes.

Concerning transactions at regional and country offices, budgetary control and fund under-utilization issues had been flagged. Implementation rates in programme management had been found to be low in some cases, or not linked to the technical and financial progress of workplans. Imprest accounts continued to be a high-risk area, with delayed reconciliation. The timely recovery of personal advances remained to be reviewed and cleared in all the regional offices. The technical report and financial certification, which should be received within three months of completion of the activity, in accordance with direct financial cooperation agreements, were due in most cases. The unused amounts also remained to be refunded.

Other recommendations related to requisite cost estimations, documentation and approvals, with regard to contracts for services, technical service agreements and fellowships, all calling for stronger internal controls. Continued attention was required for those components of the Organization's activities.

In the area of personnel management, the importance of compliance with recruitment and staff appraisal reports had been reiterated.

It was essential to have controls in place for procurement. The vendor database needed to be reviewed and updated at regular intervals in order to make it more comprehensive, and for effecting transparent and equitable procurement. The creation and regular updating of a comprehensive database of non-expendable equipment had been recommended. That would ensure the basis for reporting on WHO financial statements. Efforts made on data shortfalls and discrepancies in country offices on physical verification had been encouraged.

The tracking mechanism on the implementation of the recommendations was in place and had strengthened the accountability mechanism. Efforts would continue to be made to bring value to the Organization and its stakeholders through the external audit process.

Mr LEHBIB (Mauritania), speaking on behalf of the Member States of the African Region, said that the exhaustive report covered important aspects of the Organization's activity, finances and internal controls. He welcomed the spirit of consultation and complementarity demonstrated by the external and internal auditors sharing their reports. To the Organization's credit, no weaknesses or errors material to the accuracy, completeness and validity of the financial statements as a whole had been found, and an unqualified audit opinion had thus been issued. He welcomed the Director-General's acceptance of the recommendations and urged their prompt implementation. He strongly recommended that the Health Assembly adopt the draft resolution proposed by the Executive Board.

Ms KITSSELL (United Kingdom of Great Britain and Northern Ireland) said that the report had been submitted very late, leaving little time for detailed analysis before the meeting. It was that delay, rather than a lack of interest in the issues, that explained the lack of comments on the report by Member States. She welcomed the Director-General's acceptance of the recommendations and stated that she would closely follow the progress made on their implementation. The issue of inventories needed to be addressed: it was unacceptable that attractive items and high-value assets had not been properly inventoried, especially at a time when budgets were tight. Would that failing have implications for the implementation of the International Public Sector Accounting Standards or were the assets in question not subject to those Standards?

Staff were WHO's most valuable asset. The comments and recommendations on human resources processes were therefore a cause for concern, particularly those relating to low completion rates of annual staff appraisals, since such processes were fundamental for the recruitment, rotation and promotion of staff. Managers should be held accountable for conducting their staff-management responsibilities effectively.

Mr KULSHRESHTHA (representative of the External Auditor) requested Member States to clarify how they would go about improving inventory management and other related issues.

Dr JAMA (Assistant Director-General) took note of the comments made by the Member States and assured the Committee that a tracking system was already in place, reviewed by the senior management of the Organization and presented to the Programme, Budget and Administration Committee every January. The Director-General was monitoring it herself and the first report had already been presented on tracking both internal and external audit recommendations.

Regarding the observations and weaknesses noted by the External Auditor, he stressed that much work had already been done on improving both control and accountability. It was satisfying that the External Auditor had placed an unqualified opinion on the Organization's financial report, but weaknesses would still be addressed. A project was already under way to improve human resources processes and data quality in the Global Service Centre. It was hoped that such activities, albeit time-consuming, would bring about significant progress. The Secretariat had already developed a human resources strategy, which the global policy group, the Director-General and the Regional Directors had approved. The first two-year part of the strategy was set for implementation. A tracking system was also in place for key performance indicators, under which the completion of the annual staff appraisals was being reviewed by the Director-General and other members of senior management. Managers were held accountable when appraisals were not completed. Some of the weaknesses highlighted had already been noted in Secretariat reports pending completion. Regional directors and the Director-General were taking the matter very seriously. He expected significant progress to be made, as appraisals were a fundamental means for managers to assess the performance and competencies of their staff.

The DIRECTOR-GENERAL thanked Members for their comments and fully agreed that human capital was the most important asset of the Organization. She expressed her frustration at the fact that managers were not completing the annual staff appraisals in a timely manner, particularly since she herself managed to do so. She would look at the rules and regulations to establish whether it would be feasible to suspend managers' pay if they failed to complete the appraisals on time. After all, their failure to do so was causing their subordinates to miss out on the annual salary increase. Perhaps the only way to drive home the message would be to refuse those managers their own annual salary increases. Possible rewards for performance should also be explored. She declared her determination to take action to resolve the issue. Without a fair, transparent process of staff evaluation, it would be impossible to reward good staff and sanction repeat non-performers. She also requested clarification concerning inventories.

Dr JAMA (Assistant Director-General), responding to the Director-General's request, clarified that in preparing for compliance with the International Public Sector Accounting Standards, all the Organization's assets needed to be inventoried. He hoped that, once full compliance had been achieved, the fixed assets of the Organization would also be reported.

The CHAIRMAN invited the Committee to approve the draft resolution recommended by the Programme, Budget and Administration Committee, on behalf of the Executive Board, contained in document A63/56 Rev.1.

The draft resolution was approved.¹

Report of the Internal Auditor: Item 16.2 of the Agenda (Documents A63/38 and A63/57)

The CHAIRMAN drew the Committee's attention to the Secretariat's report and the ninth report of the Programme, Budget and Administration Committee contained in document A63/57.

Dr DAHL-REGIS (Bahamas), speaking in her capacity as Chair, Programme, Budget and Administration Committee, said that that Committee had reviewed the report of the Internal Auditor at its twelfth meeting and had expressed satisfaction with the internal audit function. The Committee had reminded the Secretariat to ensure that audit recommendations were implemented and had welcomed the improved reporting on monitoring the timeliness of follow-up. Concern had been expressed about the implementation of, and continued difficulties with, the Global Management System, and about the recurring nature of the weaknesses highlighted in internal controls, notably those at the Global Service Centre and those regarding procurement and cash management in country offices. The Committee had requested the Secretariat to address those concerns and had emphasized the need to expedite the implementation of an enterprise risk-management system.

Mr BLAIS (Canada) observed that both the Internal and the External Auditor's reports had identified several areas that needed improvement, which was positive. His Government would be scrutinizing the response of the Secretariat to the various recommendations contained in the reports, and both the Programme, Budget and Administration Committee and the Executive Board would be well advised to do likewise.

Canada looked forward to the further guidance and advice from the new Independent External Oversight Advisory Committee on those matters; the new Committee should benefit from the very useful details in the existing full reports of the Internal Auditor that were still only accessible by special arrangement.

Ms KITSELL (United Kingdom of Great Britain and Northern Ireland) emphasized that the internal audit was important, and welcomed the frank report that had been provided. It was most important that Member States should be confident that WHO's oversight structures were actually working, and like the delegate of Canada she looked forward to hearing the views of the Independent External Oversight Advisory Committee on the issues raised in the Internal Auditor's report.

She asked whether the Internal Auditor considered that the period of six months in which to respond to internal audit findings was reasonable, by comparison with the one month allowed for responding to external audit findings, or whether it should perhaps be shortened.

Mr WEBB (Internal Oversight Services) responded that the current practice was that his department set a six-month limit before following up on replies expected from auditees. During that time, the department expected the individuals concerned to be taking action to implement audit

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.8.

recommendations. The audit reports included guidance regarding the priority and significance of each individual recommendation for action, and his department would work with the Independent External Oversight Advisory Committee on whether that policy should be revised.

The Committee noted the report.

6. STAFFING MATTERS: Item 17 of the Agenda

The election of the Director-General of the World Health Organization: Item 17.1 of the Agenda (Document A63/39)

Mr GWENIGALE (Liberia), speaking on behalf of the Member States of the African Region, called for an amendment to Rule 52 of the Rules of Procedure of the Executive Board, concerning the election of the Director-General. The current procedure allowed all Member States to propose one or more candidates to the Executive Board, which then decided on a shortlist. From that list, the Board selected one candidate by secret ballot and nominated that candidate to the Health Assembly. That body considered the Board's nomination at a private meeting, and reached a decision by secret ballot. In the history of the Organization there had been seven Directors-General, from three of its six regions. The European Region and the Region of the Americas had each provided two Directors-General, while the Western Pacific Region had provided three. Three of the Organization's regions had never provided a Director-General.

He drew a comparison with the election of the United Nations Secretary-General, in which the successful candidate was chosen by the General Assembly on a proposal by the Security Council, noting in particular that the accepted practice of the Security Council was to accept candidates on a rotational basis from the world's geographical regions.

The aim of the proposed amendment to Rule 52 would be to promote geographical equity by providing for the nomination of candidates for Director-General from the six WHO regions in rotation, allowing all Member States in a region to propose one or more candidates to the Executive Board. When the idea of geographical rotation had first been proposed to the Executive Board by his country, the objection had been that the person chosen to be the Director-General must be charismatic, but the overriding concern should be that the person must be competent. Since WHO was a technical organization, its leader must be competent. He was convinced that health professionals competent to lead the Organization could be found in each of the six regions.

It was expensive to campaign worldwide for the position of the Director-General, and some countries could not afford to do so. Applying a rule of geographical rotation would bring about a "level playing field".

He requested that a vote be taken on the matter.

Dr LIU Peilong (China) reaffirmed the position of the Regional Committee for the Western Pacific¹ that the status quo should be maintained. He emphasized that the election of the Director-General should be based on a candidate's competence, adding that regional rotation might in some measure reduce confidence in the election itself.

Mr BURCI (Legal Counsel) asked whether the African Region's proposal to amend Rule 52 was couched in specific language, which the Health Assembly could consider.

Observing that the issue of the election of the Director-General had been discussed over several years in the Executive Board, he identified the two main considerations. First, there was a

¹ Document A63/39, paragraph 8.

constitutional requirement that the person selected should be the most qualified for the job. Secondly, there was a feeling in some quarters that the current selection method was not equitable. The Secretariat had been requested to investigate and report on possible options for resolving the issue. Information on that work was contained in document A63/39.

Mr JÖRGENSEN (Denmark) fully agreed with the position of the delegate of China.

Mr MCKERNAN (New Zealand) said that his country had always held the view that the post of Director-General of WHO was a crucial position in public health that demanded outstanding personal and professional skills in order to provide global health leadership. He supported the views expressed by the delegates of China and Denmark.

Mr SEADAT (Islamic Republic of Iran) said that the issue was of considerable importance to the Eastern Mediterranean Region. The existing system, in which the personal and professional competencies and qualifications of the candidates were the primary consideration in the selection of the Director-General, had been in place for many years. The discussions in the Executive Board reflected the concern of many Member States in regard to deficiencies in the present system. Remedies were called for.

The adoption of the principle of rotation of the post of the Director-General among the regions was not intended to ignore the importance of the personal and professional qualifications of the candidate. Rather, rotation would bring greater justice and equity to the system and afford all regions the opportunity to be represented at the highest level of governance of the Organization.

The matter had been considered at the Sixty-second World Health Assembly and several meetings of the Executive Board and should not be postponed any further. He recalled that the Regional Committee for the Eastern Mediterranean Region had supported the principle of regional rotation.¹

Mr GWENIGALE (Liberia) said that the matter was very important for numerous Member States, but that the timing of the present discussion had not been properly announced. Consequently, some of the delegates who were prepared to speak on it were not present. He requested that consideration of the item should be suspended, and the timing of the discussion announced.

The DIRECTOR-GENERAL explained that the reason the Committee had departed from its published timetable was simply that its work was advancing faster than expected owing to the decision of the General Committee to move agenda item 13 to Committee A.

The CHAIRMAN suggested that consideration of the item should be suspended, with discussion resuming at the Committee's third meeting, at 18:00 that same day. He also proposed that, if all delegations were in agreement, the second meeting should start its work by considering agenda item 17.2.

It was so agreed.

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

The meeting rose at 12:15.

¹ Document A63/39, paragraph 5.

SECOND MEETING

Wednesday, 19 May 2010, at 14:45

Chairman: Dr W. JAYANTHA (Sri Lanka)

1. STAFFING MATTERS: Item 17 of the Agenda (continued)

Human resources: annual report: Item 17.2 of the Agenda (Document A63/40)

Mr IFLAND (Germany) welcomed the Secretariat's efforts to improve human resources management, in particular through implementation of the human resources strategy, the establishment of standard operating procedures and the data quality strategy. Collaboration with the regional offices had contributed to the progress made, and he urged the Secretariat to continue its efforts in that direction.

Ms ELLIOT (Australia) asked whether a document on the human resources strategy was available.

Dr ALI (Bangladesh) noted that the report described efforts by the Secretariat to increase the representation of underrepresented and unrepresented countries on the Organization's staff. However, it did not include any information on the distribution of short-term staff by country, and such information was needed in order to determine how many short-term staff were being recruited from well-represented or overrepresented countries. That information should also be provided by the regional offices at their annual regional committee meetings.

He questioned the practicality of selecting WHO Representatives from a global roster; Regional Directors, in consultation with receiving countries, should always have the last word in the selection of WHO Representatives, who might not necessarily be on the roster. WHO Representatives must have a thorough understanding of the priorities, needs and cultural sensitivities of the country in which they would be serving. Only then would they be accepted by the receiving country. That would be more likely to occur if Regional Directors and countries played a leading role in their selection.

An informal assessment had revealed that the contribution of international staff members in the Bangladesh country office tended to be less than that of national professional officers, and, furthermore, that, when the contribution was of value, the international staff members in question were being withdrawn. The normative function of international staff at country level in, for instance, developing guidelines and manuals for different programmes was also questionable. In order to clarify whether the number of international staff working in Bangladesh was commensurate with the country's needs, his Government sought an evaluation by external experts with immediate effect. Furthermore, the national professional officer system should be strengthened with a view to ensuring effective support to the country and freeing up more funding for activities.

With regard to the overall management of human resources in WHO, it was regrettable that the vision of former Director-General Halfdan Mahler – that of keeping headquarters small and strengthening the regional offices to provide support to countries – had not been realized. Staff at headquarters far outnumbered staff in the regional offices, and more than a quarter of WHO's total resources were spent at headquarters. Unfortunately, the Regional Office for South-East Asia was unable to provide effective technical support to Member States, mainly because some senior managerial positions had remained vacant for long periods. Action should be taken urgently to strengthen the Regional Office.

Mr ALLO (France) welcomed the increase in the proportion of posts occupied by women. Noting that from 1999 to 2009 the average length of service had fallen from 11.5 to 7 years, he asked whether that trend was the result of a policy decision or simply an effect of growth in staff numbers. He also questioned how the projections for retirement of staff might affect recruitment policies in the coming decade. The detailed report could have included figures to illustrate 10-year trends in staffing and salaries and the total wage bill at the three organizational levels.

Dr LIU Peilong (China) expressed satisfaction that most Member States had reached or exceeded their desirable range of geographical representation and that more posts were occupied by women. He urged the Secretariat to take specific measures to reduce the number of vacancies.

Dr JAMA (Assistant Director-General) confirmed that an internal document on the human resources strategy was available. Its contents included recruitment, talent management and staff training, development and retention, and would be discussed by the Programme, Budget and Administration Committee at its thirteenth session.

He suggested that the issues raised by the delegate of Bangladesh should be discussed with the Regional Director. He recalled that the Director-General had recently described the transparent process by which WHO Representatives were being assessed with a view to ensuring that they had specific technical and managerial competencies. External assessors and all regional offices participated in that process. He assured the Committee that the roster included highly qualified professionals of all nationalities.

Ms ALTMAIER (Human Resources Management) said that the overall number of national professional officers had increased from 127 in 2001 to 907 in 2010 and that Bangladesh had four times as many as in the past. The information requested by the delegate of Bangladesh on short-term contracts would be provided in future reports and the other improvements suggested would also be incorporated. With regard to future retirement levels, she said that the Organization had a clearly defined succession plan detailing the exact number of retirements expected, with information on budgetary implications. Recruitment policy took account of new developments and encompassed a global outreach strategy aimed at meeting geographical representation targets. Retirements had been largely responsible for the decrease in the average length of service.

Progress had been made in introducing standard operating procedures, which had been implemented by headquarters and regional offices in most areas of human resources management. The next step would be to implement them jointly with the Global Service Centre and ensure that they were consistently applied across the Organization. Data quality was also being more rigorously validated in order to improve the standard and timeliness of reports.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that information relating to the geographical distribution of WHO staff by country in the South-East Asia Region would be made available during the sixty-third session of the Regional Committee for South-East Asia. He assured the delegate of Bangladesh that the WHO fixed-term and temporary staff members assigned to work in his country had been selected through a competitive process and after discussions with the Government. Every effort was made to ensure that country office staff had the knowledge and skills needed to serve the country effectively.

The Committee noted the report.

Report of the International Civil Service Commission: Item 17.3 of the Agenda (Document A63/41)

Ms NYONI (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, noted that decisions taken by the United Nations General Assembly in 2009 had

resulted in revisions to WHO's Staff Rules and welcomed the confirmation by the Executive Board of amendments concerning conditions of service for some staff.¹

The Committee took note of the report.

Amendments to the Staff Regulations and Staff Rules: Item 17.4 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R10, and A63/42)

Dr NETO (Angola), speaking on behalf of the Member States of the African Region, supported adoption by the Health Assembly of the resolution contained in resolution EB126.R10.

The draft resolution was approved.²

Appointment of representatives to the WHO Staff Pension Committee: Item 17.6 of the Agenda (Document A63/43)

The CHAIRMAN proposed the nomination of Dr. A.A. Yoosuf (Maldives) as a member and Mr R. Chacón (Guatemala) as an alternate member to the WHO Staff Pension Committee for a three-year term until May 2013.

It was so decided.³

2. MANAGEMENT AND LEGAL MATTERS: Item 18 of the Agenda

Partnerships: Item 18.1 of the Agenda (Documents A63/44, A63/44 Corr. 1 and A63/44 Add.1)

Mr JÖRGENSEN (Denmark) observed that the global health landscape was changing, with many new actors and new possibilities for cooperation. Partnerships created new opportunities to meet global health challenges but the overall system might become too complex, raising concerns about governance and accountability. The draft policy in the Secretariat's report⁴ was a significant tool in that regard. He welcomed the emphasis on the identification of clear roles for partners, and on the necessity of avoiding duplication of work and ambiguity in relation to responsibilities.

He proposed several amendments to the draft resolution contained in document A63/44. In the final preambular paragraph, the words "extensive" and "multiple" should be deleted; the words "based on clear distinction of roles" should be inserted after "stakeholders" and the words "added value," should be inserted after "creates"; in paragraph 1, the words "(as annexed)" should be inserted after "policy"; and in subparagraph 4(1), the word "increase" should be replaced by "continue".

Ms BLACKWOOD (United States of America) welcomed the draft policy and supported the amendments proposed to the draft resolution by the delegate of Denmark. The establishment of new partnerships and the maintenance of existing ones must be considered carefully with an eye to ensuring that such arrangements furthered WHO's strategic objectives and public health goals, streamlined global health structures and avoided duplication of efforts. The draft policy provided

¹ Resolution EB126.R9.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.9.

³ Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA63(8).

⁴ Documents A63/44 and A63/44 Corr.1.

clarity with respect to the roles of partners and hosting arrangements and transparency with respect to transaction costs. Properly structured partnerships could reduce the management burden on both national administrations and the Secretariat.

She welcomed the requirement that the Director-General must consult the Executive Board on proposals for WHO to host formal partnerships. Scrutiny was needed to ensure that hosting was the best option for all parties. A full cost assessment of formal hosting arrangements should include administrative, legal, financial management and technical support implications. She also commended the requirement that partnerships operate on the basis of cost-recovery so that WHO did not incur unreimbursed costs, as had occurred in the past.

Dr LIU Peilong (China), affirming that partnerships could help WHO to achieve its aim of promoting public health, said that a policy was needed in order to ensure the success of such partnerships. He therefore welcomed the criteria for partnerships set out in the policy. In order to strengthen the role of the Executive Board in deciding whether WHO should enter into partnerships, he proposed that subparagraph 4(4) of the draft resolution should be amended to read “to submit to the Executive Board any proposals for WHO to host formal partnerships for its review and decision”.

Mr IFLAND (Germany) endorsed the statement made, and the amendments proposed, by the delegate of Denmark.

Mr BLAND (United Kingdom of Great Britain and Northern Ireland) said that global health partnerships could help to improve coordination and provide a common platform for pooling efforts and strengths, but their success was not guaranteed. The criteria on which they were based, effective governance and implementation were all crucial. He welcomed the policy’s inclusion of provisions for evaluation and sunset clauses and the importance attached to adherence to the Paris Declaration on Aid Effectiveness (2005) and the Accra Agenda for Action (2008). He strongly supported the joint WHO–World Bank International Health Partnership aimed at increasing efficiencies in global health, and the Secretariat’s role in providing support to Member States in their negotiations with multiple partners. He welcomed the progress made on joint assessment processes and the joint platform with the GAVI Alliance. He supported the draft policy and the draft resolution as amended by the delegate of Denmark.

Dr SOPIDA CHAVANICHKUL (Thailand) expressed concern that global health partnerships were often not aligned with countries’ priorities. WHO must play a leading role in ensuring that an agreed set of country-driven priorities was established in order to avoid competing interests. The increasing demand for WHO’s technical support was also cause for concern, as funding from donor agencies might not be sufficient to cover the additional cost.

Mr AL-TAAE (Iraq) said that partnership was essential to primary health care activities. It also avoided wastage of resources. The United Nations Development Assistance Framework had been an important element in the partnership approach. He looked forward to the continued growth of WHO partnerships for the benefit of national objectives and progress in achieving the Millennium Development Goals.

Ms TRENOU (Togo) expressed concern as to what was expected of the Secretariat and of Member States in developing partnerships and how partnerships could be expanded when financial contributions were declining.

Ms ELLIOT (Australia) supported the draft resolution and looked to WHO to continue to engage and coordinate with diverse players in advancing the global health agenda. She urged WHO to emphasize maintenance of existing partnerships over the creation of new ones, particularly initiatives

such as the International Health Partnership, which were critical for achieving the health-related Millennium Development Goals.

Mr BLAIS (Canada) welcomed the draft policy and emphasized that the Secretariat and the Executive Board would need to be very proactive to bring life into the new policy once the appropriate reviews of existing partnerships had been conducted. He encouraged the Secretariat to work with other organizations, such as UNICEF and the World Bank, to put in place joint processes for managing partnerships in order to enhance efficiency.

Ms PRADHAN (Assistant Director-General) said that the draft policy reflected the Secretariat's efforts to address Member States' concerns about such issues as avoiding duplication and mandate creep, clarifying roles and responsibilities, and increasing accountability. She agreed that there was a need for greater transparency and scrutiny with regard to hosting arrangements. WHO currently hosted some 17 formal partnerships and any proposals for hosting new ones would be submitted to the Executive Board for consideration. Responding to the delegate of Thailand, she said that the Secretariat recognized that countries must drive partnership work. She acknowledged the additional costs that meeting the growing expectations placed on WHO might entail and said that the policy was intended to help the Secretariat to be realistic about the costs to WHO of implementing partnerships.

The CHAIRMAN said that, if he heard no objection, he would take it that the Committee was prepared to approve the draft resolution, as amended by the delegates of China and Denmark.

The draft resolution, as amended, was approved.¹

Method of work of the governing bodies: Item 18.2 of the Agenda (Document A63/45)

Dr KESKİNKILIÇ (Turkey) supported the proposal to close the debate on the Director-General's opening address by the end of the first day of the Health Assembly and not to allow delegates to speak later if they were not present when called upon. However, some flexibility was important in order to accommodate the busy schedules of ministers. He agreed that limits should be placed on the duration of statements in plenary and welcomed the proposed "traffic light" system in Committee meetings. He also agreed with the approach to rationalizing reporting processes outlined in the report and supported the proposal not to dispatch hard copies of documents to all governments before governing body sessions, although printed documents should continue to be distributed during sessions. The use of new technologies should be considered when preparing official records.

Dr LIU Peilong (China) supported the proposals for improving the efficiency of discussions and access to documents. He welcomed the proposed limits on speaking time, but noted that it was important to allow flexibility in the discussion of resolutions. Reducing the number of documents submitted to the Health Assembly for consideration would enhance the efficiency of its work. He supported the use of digital recording methods for the production of governing body records, but questioned whether there were any legal ramifications of such an approach. He urged the Secretariat to provide records of meetings in a timely manner.

Dr YOUNES (Office of Governing Bodies) agreed on the need for flexibility in time limits depending on the nature of discussions, and welcomed the overall agreement on the recommendations made in the report.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA63.10.

Ms GRANZIERA (Office of the Legal Counsel) said that the Rules of Procedure of the World Health Assembly required the production of verbatim and summary records but did not specify what technologies were to be used for producing those records. Records of meetings were provided at the earliest opportunity, following the requisite processes for their production.

The Committee noted the report.

Agreements with intergovernmental organizations: Item 18.3 of the Agenda (Document A63/46)

Mr IFLAND (Germany) welcomed closer cooperation between WHO and OIE, which would enable the development of international standards for animal husbandry as it related to food safety, in line with the “One Health” approach endorsed by the International Ministerial Conference on Animal and Pandemic Influenza (Hanoi, 19-21 April 2010). Trilateral meetings of FAO, WHO and OIE would help to avoid duplication of work.

Ms ELLIOT (Australia) supported the draft resolution contained in document A63/46. The proposed amendment to Article 4 of the Agreement between the Office International des Épizooties and the World Health Organization would formalize, and therefore improve, the existing collaboration between the two organizations. In the interests of ensuring food safety, she urged Member States to promote similar collaboration at the national level between animal health officials and public health and food safety officials.

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A63/46.

The draft resolution was approved.¹

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 19 of the Agenda (Document A63/47)

Mr SEADAT (Islamic Republic of Iran), observing that “Delivering as One” pilot initiatives were continuing, welcomed the fact that the report did not draw any premature conclusions on the outcome of that process.

Dr NETO (Angola), speaking on behalf of the Member States of the African Region, noted the importance of intergovernmental, interagency and regional/country collaboration for the achievement of the health-related Millennium Development Goals and for promoting health, strengthening health systems and furthering social and economic development. He welcomed the harmonization of work in the African Region and the collaboration between the regional offices for Africa and the Eastern Mediterranean, and emphasized the Africa Health Strategy 2007–2015. However, challenges remained, especially in expanding partnerships and improving the United Nations Resident Coordinator system. He called on the Secretariat to improve the functioning of that system.

Mr AL-TAAE (Iraq) said that collaboration within the United Nations system was crucial in order to improve the provision of primary health care, and attain the Millennium Development Goals. Partnerships should be strengthened in the interrelated areas of health, the environment, and economic,

¹ Transmitted to the Health Assembly in the Committee’s first report and adopted as resolution WHA63.11.

social and human development, areas that were essential for sustainable development. He encouraged the Secretariat to continue increasing interagency collaboration on all its strategies.

The Committee noted the report.

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

Leishmaniasis control: Item 11.13 of the Agenda (Document A63/16)

Mr AL-TAAE (Iraq) expressed support for initiatives to prevent and control leishmaniasis. Cases of both visceral and cutaneous disease continued to occur in Iraq, and WHO's support was needed in relation to prevention and early detection of cases, individual and institutional capacity building and research on the residual effects of insecticides.

Ms BLACKWOOD (United States of America) reaffirmed her Government's commitment to reducing the burden of neglected tropical diseases, including leishmaniasis. She highlighted the importance of better diagnostics, improved therapies, comprehensive vector control, enhanced surveillance and greater access to health care as components of an effective and sustainable leishmaniasis control strategy. Her Government continued to provide support for, and encourage, research into: disease transmission; the development of safe and effective treatments, including therapeutic and prophylactic vaccines; complications arising from coinfection with HIV; and ecological and integrated vector management. She expressed support for the work of the Expert Committee on Leishmaniasis and appreciation of the Organization's efforts to raise global awareness of the need to control and eliminate the disease.

Dr ALI (Bangladesh) said that in South-East Asia around 60 000 people died annually as a result of visceral leishmaniasis, primarily in Bangladesh, India and Nepal, where some 200 million people were at risk of infection. A small focus of the disease had recently been identified in Bhutan. Poor and marginalized people were disproportionately affected. The prospects of eliminating leishmaniasis had been enhanced by effective diagnostics and oral medicines, such as the newly developed miltefosine. In 2005, the health ministers of Bangladesh, India and Nepal had signed a memorandum of understanding pledging to eliminate visceral leishmaniasis from their countries by 2015. A strategic action plan had already resulted in substantial progress, and would be extended to all 109 affected districts.

Greater efforts and more resources were needed to expand elimination activities; and to research and develop new interventions and improve the efficacy of existing ones. WHO had been closely involved at country, regional and global levels; valuable technical support had been provided by WHO's Regional Technical Advisory Group on Elimination of Kala-azar. Nevertheless, additional support from international development partners would be needed to eliminate the disease from the region by 2015.

Dr GOUYA (Islamic Republic of Iran) said that cutaneous leishmaniasis remained a serious problem in the Eastern Mediterranean Region and emphasized the need for common commitment and coordination in order to control it. Although new treatments such as liposomal amphotericin B and paromomycin showed promise, success rates had varied between and within countries. In the Middle East, insufficient data resulted in an incomplete epidemiological picture and incidence of the disease had been underestimated. The various national epidemiological studies undertaken should be evaluated and meta-analysed by an expert group. At regional level, measures for vector control should focus on border areas and areas of high concentration. Active case-finding in the outbreak zones and public education had been crucial to leishmaniasis control thus far, almost halving the number of cases

over a two-year period in one area. Technical meetings between Member States should be held to share experiences.

Dr NAKATANI (Assistant Director-General) recognized that leishmaniasis was one of the six main neglected tropical diseases, with about two million new cases per year. To support capacity building, particularly in the area of epidemiology, the Secretariat was working with regional offices to organize training courses and other activities. Case-finding was a challenge, given the primarily rural distribution of the disease, but could be improved through capacity building. The Expert Committee meeting for the control of leishmaniasis (Geneva, 22–26 March 2010) had highlighted many relevant issues, including evidence-based treatments, nutrition and coinfection with HIV, and had helped to raise the profile of neglected tropical diseases. The Secretariat would spare no efforts to support regional initiatives such as the memorandum of understanding signed by Bangladesh, India and Nepal.

The Committee noted the report.

5. ORGANIZATION OF WORK

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the Member States of the European Union, recalled that following an agreement between WHO and the European Commission in 2000, the European Union participated in the Health Assembly as an observer. He requested that it should also be invited to participate as an observer, without vote, in meetings of subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Union.

It was so agreed.

6. TECHNICAL AND HEALTH MATTERS: Item 11 of the Agenda (resumed)

Chagas disease: control and elimination: Item 11.14 of the Agenda (Documents EB124/2009/REC/1, resolution EB124.R7, A63/17, and A63/17 Add.1)

Dr NAGAI (Japan), acknowledging the Secretariat's efforts to tackle Chagas disease, said that her Government had been providing support for control of the disease to El Salvador, Guatemala and Honduras since the early 1990s and to Nicaragua since 2009. Through insecticide treatment of some 460 000 houses, as many as 2.3 million people had been protected against the risk of infection. In 2008, WHO had recognized Guatemala as the first country in Central America in which transmission of the disease had been interrupted, which was a source of pride for her Government. It was important to establish a sustainable surveillance system to monitor vectors and infected people and to provide comprehensive education activities. In view of the global spread of Chagas disease, which had affected her country, WHO should continue to exercise active leadership on the issue. She supported the draft resolution contained in resolution EB124.R7.

Mr ROSALES LOZADA (Plurinational State of Bolivia) emphasizing the importance of Chagas disease, said that it was a public health issue in his country, where around 25% of the population was affected and where the disease had recently re-emerged in some regions. He therefore welcomed the draft resolution, but suggested that, to broaden its scope, an additional provision should be introduced, calling for the formulation or strengthening of comprehensive care strategies to ensure access to diagnosis and treatment for all patients with Chagas disease.

Ms BLACKWOOD (United States of America) applauded the Secretariat's efforts to tackle Chagas disease and encouraged further technical support for countries that attempted to control triatomine bug infestations. However, the Secretariat should ensure that its activities augmented rather than duplicated existing efforts. Given the increase in cases of Chagas disease outside regions where it was currently endemic, her Government strongly supported blood screening in non-endemic countries in order to prevent transmission through blood transfusions, and urged countries where the disease was endemic to focus on vector control and population screening, especially of pregnant women so as to reduce the risk of vertical transmission. She endorsed the draft resolution, but suggested two amendments: in subparagraph 1(1), the words "especially in areas where Chagas disease has re-emerged" should be inserted after "control programmes"; and after subparagraph 2(5), a new subparagraph should be inserted to read: "to integrate diagnosis and treatment of Chagas disease at the primary health care level to patients both in the acute and chronic phase of the disease".

Mr AL-TAAE (Iraq) stressed the importance of preventive measures, including vector control, improved surveillance, early diagnosis and treatment, health education and training of health personnel in prevention and treatment within the primary health care system. Community participation in prevention activities was crucial.

Dr CHAWETSAN NAMWAT (Thailand) said that halting transmission by insect vectors and blood transfusions should be the primary approach for control of Chagas disease. Research should focus on developing new vector-control strategies, with the aim of eliminating the disease in Member States where it was endemic. Welcoming the draft resolution, he proposed three amendments: at the end of subparagraph 1(2), the words "together with strengthening community participation" should be added; in subparagraph 1(4)(a), the words "to control and/or eliminate domestic vector populations" should be inserted before "to interrupt transmission"; and in subparagraph 1(4)(e) "appropriate consideration to implementing screening procedures in" should be inserted before "non-endemic countries".

Mr TOBAR (Argentina) said that, although vector transmission of *Trypanosoma cruzi* had been halted in five provinces of his country, there were still several high-risk areas; acute cases of vector-borne disease had been reported between 2000 and 2007. Virtually all donated blood was screened. The prevalence of infection detected among donors was 3.2%, and continued screening was therefore essential in order to prevent transmission of *T. cruzi* through blood transfusions.

Dr MMBUJI (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, said that the African continent was not currently affected by Chagas disease, but it was at risk from transmission either from mother to child or through population movements, blood transfusion and organ transplantation. He therefore supported the draft resolution. Chagas disease was one of several neglected tropical diseases associated with poverty and disadvantage. Other such diseases that did affect the African Region had received little global attention, including onchocerciasis, schistosomiasis, soil-transmitted helminthiasis and trachoma. Diseases such as chikungunya fever, dengue and o'nyongnyong fever also posed a growing threat. If the same strategies used to control Chagas disease were applied to those diseases, it was likely that the associated disease burden could be reduced dramatically. He urged WHO and the international community to continue to provide Member States in the African Region with technical and financial support in order to enhance action to control and eliminate neglected tropical diseases; he requested that progress updates on that topic should be presented at future Health Assemblies.

Dr NAKATANI (Assistant Director-General) underlined the importance of several of the issues raised by the Committee, including the emergence of Chagas disease in non-endemic areas, access to diagnosis and treatment, and coordination and partnerships in combating neglected tropical diseases.

The CHAIRMAN, in response to a request from Mr TOBAR (Argentina), suggested that discussion of the draft resolution should resume at a subsequent meeting, following the circulation of a revised version that incorporated the various amendments.

It was so agreed.

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

Global eradication of measles: Item 11.15 of the Agenda (Document A63/18)

Dr ABEYKOON (Sri Lanka), speaking on behalf of the Member States of the South-East Asia Region, said that routine immunization coverage in the Region had increased from 61% in 2000 to 75% in 2008 and the reported incidence of measles had halved. India had accelerated implementation of elimination strategies and the Region would pursue the target of measles elimination by 2020. Political and social commitment to reduce measles mortality, involvement of all parts of the health infrastructure, and availability of human resources contributed to progress. The financial support of the Measles Initiative had enabled Member States to conduct catch-up campaigns and carry out surveillance of measles.

However, the Region faced challenges that included: the vaccination of some 1000 million children, well above the number that currently received routine and supplementary immunization; collaboration with governments and vaccine manufacturers in order to ensure vaccine security; and the financing of an elimination campaign, which was currently estimated at US\$ 2000 million. High standards of injection safety must also be maintained and a system to monitor adverse effects established. Interim milestones encouraged greater efforts and the Region supported the proposed global measles targets for 2015.

Professor MOYEN (Congo), speaking on behalf of the Member States of the African Region, said that measles mortality remained high and a major concern for many African countries. A strategic plan for immunization in the Region aimed to reduce measles mortality by about 90% by 2009 through strengthening of national vaccination programmes, supplementary vaccination, awareness-raising and catch-up campaigns, and case-based surveillance with laboratory confirmation. Positive results included significant increases in vaccination coverage. Nevertheless, epidemic outbreaks continued to occur in some Member States owing to factors such as weak political commitment, limited access to vaccination services, and insufficient mobilization of resources. The shortfall in funding was estimated at US\$ 60 million globally and US\$ 16 million within Africa.

Member States should carry out follow-up campaigns every two to four years until their health systems were in a position to provide two doses of vaccine to all children and to treat all cases of the disease. Routine coverage and epidemiological surveillance systems needed to be strengthened in order to detect and counter epidemic outbreaks quickly. The objective of eliminating measles in the African Region by 2020 was possible, but would depend on strengthened partnerships, political commitment and adequate funding.

Dr LIU Xia (China) affirmed her Government's commitment to eliminating measles by 2012. To achieve that goal, it had formulated a national plan of action for measles elimination (2006–2012) and was regularly conducting supplementary immunization activities and laboratory-based surveillance. As China's population represented a large proportion of that of the Western Pacific Region, its achievements in respect of measles elimination would have a considerable effect on achievement of the regional elimination goal. However, to reduce incidence of measles to no more than one case per million population and maintain that level would be a challenge. She therefore urged the Secretariat to provide Member States with further guidance on measles elimination strategies and

on evaluation and performance indicators, and with increased support for supplementary immunization activities and strengthening of case monitoring.

Ms GIBB (United States of America) expressed support for the global measles targets for 2015 proposed in the Secretariat's report. Those milestones were reasonable and achievable and would have a direct link to efforts to achieve Millennium Development Goal 4 (Reduce child mortality). Substantial progress had been made towards global measles eradication, but challenges remained, notably in the mobilization of sufficient resources. Her Government provided considerable technical and financial support for that purpose to WHO and UNICEF and to country immunization programmes; it would contribute US\$ 50 million during 2010.

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

The meeting rose at 17:20.

THIRD MEETING

Wednesday, 19 May 2010, at 18:00

Chairman: Dr W. JAYANTHA (Sri Lanka)

STAFFING MATTERS: Item 17 of the Agenda (continued)

The election of the Director-General of the World Health Organization: Item 17.1 of the Agenda (Document A63/39) (continued from the first meeting, section 6)

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that the election of the Director-General had been under discussion for four years with no solution found because of the opposing views held by Member States. He supported the principle of regional rotation provided that the successful candidate, regardless of his or her region of origin, was able to fulfil all the conditions.

Mr NKOU (Cameroon), speaking on behalf of the Member States of the African Region, acknowledged the particular contribution to his statement made by the delegation of Liberia. In addition to the high degree of technical and administrative competence required of a Director-General of WHO, the incumbent was also the figurehead of the Organization. The African Region believed that the rules and methods relating to the professional and personal qualities of successful candidates were not negotiable, and that all candidates that possessed the right qualities should be equally eligible regardless of the region that they represented. However, the current rules were neither sufficiently transparent nor fair enough to guarantee the outcome in a manner acceptable to all regions. Since WHO's inception the post of Director-General had been more accessible to candidates from three regions: two Directors-General had been from the Region of the Americas, two from the European Region and three from the Western Pacific Region. Candidates from the other three regions were not specifically excluded from applying for the post but the costly, global election campaign that was required would in effect preclude candidates from regions that were unable to afford such campaigns. Regional rotation would achieve the fairness that was currently missing in the election process without undermining the status attached to the post. Indeed, to restrict the latter to candidates from the same regions would serve to devalue the regional concept.

He recalled that the amendment to Rule 52 of the Rules of Procedure of the Executive Board, which aimed at greater fairness in the process of submitting candidatures for the post of Director-General by introducing regional rotation, reflected the perfectly legal practice already followed in some organizations of the United Nations system. In fact, in recent years the United Nations Secretary-General had been elected according to the same principle.

The matter had remained unresolved since 2007 and the current Health Assembly must find a solution.

Dr RASAE (Yemen) concurred with the previous speaker. The heads of several organizations of the United Nations system were elected in accordance with the principle of regional rotation and WHO should accept that principle.

Mr ZANGPO (Bhutan) preferred the fourth option: a shortlist of one candidate from each region. The prime consideration for selection should be the merit and standing of candidates.

Dr WIBISONO (Indonesia), recalling that WHO's goal was the attainment by all people of the highest possible level of health, said that that could only be achieved if WHO remained responsive to global health challenges. The effectiveness of an international organization depended on its modern organizational structure, and more importantly, on its legitimacy, which derived in large part from its representativeness. That representativeness extended beyond membership to the leadership of an organization.

WHO's Constitution stated that the Organization should work in conformity with the United Nations. The need for coherence between the two organizations was reflected in Article 36 of the Constitution. Consequently WHO should: note the applicable provision in the United Nations Charter; model its own election process on that followed for the United Nations Secretary-General; and thus respect the principle of equitable geographical representation. Other international organizations including ITU used the same model. WHO should adopt the principle of regional rotation and thus enhance its reputation as an effective and responsive global health organization.

Dr LEE Duk-Hyung (Republic of Korea) said that the WHO's importance and mandate meant that competence should be the main consideration in the election of its Director-General. The question was not one of providing equal opportunities on the basis of regional rotation. He supported the views expressed by the delegates of China and Denmark.

Mr BLAIS (Canada) supported a process based on merit for the election of the Director-General. That process was best conducted other than by regional rotation since the most suitable candidates for the post were not necessarily available in accordance with the pre-determined cycle of regional rotation. He nonetheless agreed with the delegate of Cameroon that the current campaign process created inequities and therefore further discussions might be advisable.

Mr AL-TAAE (Iraq) supported the principle of regional rotation in order to ensure the inclusion of all regions, provided that the criterion of competence was satisfied. If a region had no available candidate, the post should be transferred to another region in so far as persons with the requisite scientific qualifications were to be found in all regions. The result would be a fair and equitable process and strengthen the principle of participation that WHO sought to achieve.

Dr TANGI (Tonga) repeated the consistent view of his Government that the status quo should continue. The Director-General's term of office was five years, which meant that each region would have to wait at least 30 years under a rotating system before any of its candidates could contend and possibly even 60 years should a Director-General remain in office for two terms. Whole generations would consequently be denied the opportunity to be considered for the post. Having observed the most recent selection process and been satisfied with the outcome, he was in favour of a continuation of the current practice.

Mr PARRONDO (Spain), speaking on behalf of the Member States of the European Union, said that it had emerged from the complex discussions that members of the Executive Board unanimously shared the view that the candidate appointed as Director-General must meet the requirements set by the Board.

In the regional consultations on the matter, the Member States of the European Region had considered that the personal and professional qualifications of the candidate should be the primary consideration in the selection of the Director-General and they continued to hold that belief. They had also stressed the need for a close analysis of the possible political and legal implications of introducing the principle of geographical rotation in order to give the Executive Board a clearer understanding of the implications of such a decision. No such analysis had yet taken place. The question involved issues far more complex than just the legal introduction of the principle of geographical rotation. Procedural change was not the solution but he nevertheless encouraged WHO to consider means of addressing the issue under the existing rules. He preferred to retain option 1: maintaining the current system of nomination.

Mr GWENIGALE (Liberia) said that any Director-General who had performed well during his or her term of office would not be prevented from seeking a second term if the principle of geographical rotation was introduced. He proposed that acceptance of that principle be put to the vote, following which it would be the task of the Executive Board to determine the next steps.

Dr AL SHATI (Kuwait) supported the principle of regional rotation, which would not mean, under any circumstances, the abandonment of the personal and professional qualities required of any Director-General. Leadership was instrumental to the achievement of WHO's aims and to communication with all regions. It was not a skill confined to representatives of any particular region.

Ms BLACKWOOD (United States of America) said that her Government maintained its previously expressed view that all relevant factors, including those relating to regional representation, should be taken into account when candidatures for the post of Director-General were examined. The personal and professional qualifications of the individuals concerned should nevertheless remain the primary consideration. The current procedure was consistent with that followed by other specialized organizations of the United Nations system. The important point was to select the individual best qualified for the post, regardless of regional considerations.

Mr LARSEN (Norway) aligned himself with the statement made on behalf of the Member States of the European Union.

Dr MOHAMED (Oman), referring to the information contained in paragraph 3 of the report, asked first whether the Directing Council of PAHO, which had not yet discussed the possible options in regard to rotation of the post of Director-General among the regions, intended to do so at its next meeting. Secondly, in so far as the regional consultations would be incomplete until that discussion had taken place, would the issue again be referred to the Executive Board or the Health Assembly for further discussion once the Directing Council was in a position to express its views on the subject? He also asked whether the current rules on the term of office of the Director-General would continue to apply in future. The answers were essential to informing the discussion and vital to decision-making.

Mr SEADAT (Islamic Republic of Iran) said that, after careful consideration of the six options in connection with the regional rotation of the post of Director-General, at least four options did not adequately reconcile the divergent views; they continued instead to regard the principle of regional rotation and selection on the basis of qualifications as alternatives to each other. Work on the subject should be governed by efficiency and equity. The current system of selecting the Director-General solely on the basis of qualifications did not meet either the expectations or the legitimate concerns of many Member States. A comprehensive list of criteria should therefore be developed in which the important principle of regional rotation was afforded equal treatment.

Dr INNIS (Barbados) said that the Member States of the Region of the Americas had not deliberated on the issue of the election of the Director-General and could not therefore be said to have a common position. Consequently he asked first, how far had any region been disadvantaged by the current arrangements? Secondly, if the Member States were truly part of a global village, would the election of a Director-General from one particular region disadvantage any other? He further asked whether shortening the duration of the Director-General's mandate would positively affect the chances of candidatures from other regions; and whether small developing countries could realistically afford the international campaign required for the consideration of their candidate, a situation of inequity.

Ms PATTERSON (Australia) said that it was important that WHO was led by an individual who had the necessary professional qualifications, personal attributes and skills. She supported a fair and transparent selection process based on merit to ensure that the most qualified and suitable person was chosen. Her preference was to retain the present global, rather than regional, process of selection.

Mr GWENIGALE (Liberia) observed that, when he had spoken for a second time on the issue, he had said that more work might be needed but had ended by requesting a roll-call vote on the principle of geographical rotation. If that principle was accepted, more work might be required; if it was not, the matter would be closed. He therefore reiterated his request for a roll-call vote.

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that the importance of personal and professional qualifications was not in question: however, the African, South-East Asia and Eastern Mediterranean regions should at least be given the chance to put forward nominations. There seemed to be a kind of monopoly or veto power with regard to the position of Director-General that undermined the principle of equity and implied that the regions in question were not sufficiently developed to provide a competent candidate. There was no justification for limiting the choice of Director-General to just three regions. He supported a system based on both rotation and merit.

Dr ABAY (Eritrea) said that everybody agreed that personal and professional qualifications should take priority, but using them as the sole criterion had led to gross inequity. Rotation would not preclude that priority, since every region was able to provide highly capable and qualified candidates, but rotation was the only way to ensure equity.

Dr GAD (Egypt), emphasizing the importance of regional rotation, said that three of the six WHO regions had never been represented in the post of Director-General, a post which represented the views of all the Member States; that meant that the background, disease profile and health environment of half the membership had not yet been represented, as it were, in the Organization's highest position. Rotation was vital to ensure that the specificities of each region were reflected in the post of Director-General. There was no contradiction between rotation and the requisite personal and professional qualifications, which could be found in all six regions.

Mr BURCI (Legal Counsel) said that there needed to be clarity about what the Committee was called to vote on, and about what a vote on the principle of rotation would imply, as the principle had many aspects and its application could lead to many different results. Furthermore, given that the procedure for selecting the Director-General was shared between the Executive Board and the Health Assembly and in view of the fact that some delegations had already raised issues about the number and duration of mandates that fell within the competence of the Health Assembly, if the principle were accepted, who would work on amplifying the proposal? Moreover, taking a decision on the principle seemed to presuppose that WHO would agree on the details of rotation, but what if no agreement was reached? If most delegations still wished to vote in favour of the principle, he wondered whether it might be preferable to draft a more specific proposal addressing some of those issues. Otherwise, the implications of a possible vote would be unclear and might lead to problems in its implementation. The Secretariat would, of course, be guided by the Member States.

Mr GWENIGALE (Liberia) said that the issue had been under discussion since 2008 and there would clearly be no consensus agreement on the principle of rotation of the post of Director-General among regions. The detailed procedures for rotation might prove complicated to establish; however, Member States must first agree to the principle of rotation and should vote on that first. He reiterated his request for a roll-call vote.

Dr RAMAPATLENG (Lesotho) requested further clarification from the Legal Counsel as to why he considered that regional rotation of the post of Director-General might raise complicated issues and affect the work of the Secretariat.

Mr AL HIGAZI (Libyan Arab Jamahiriya) also requested clarification from the Legal Counsel, who had appeared to imply that the current process of selection was the best. It was not clear why allowing all six regions, instead of only three as at present, to nominate candidates for the post of

Director-General might lead to problems. He proposed that a roll-call vote be held in order to resolve the issue.

Mr BURCI (Legal Counsel) said that he had not said or implied that the principle of rotation would affect the work of WHO or that the status quo was the best option. He had merely wished to raise some of the implications of a vote on the principle of rotation of the post of Director-General among regions as such. For example, which countries would be entitled to propose a candidate, only the countries of a certain region or the countries of all regions? According to what pattern would the post of Director-General rotate? What impact would it have on the number of terms of office? What would happen if, after one term, the incumbent did not stand again? The Executive Board might find it difficult to adhere to the principle of geographical rotation should it not be given sufficient details by the Health Assembly to understand the full implications of a procedure involving rotation.

Mr GWENIGALE (Liberia) said that he was puzzled by the last point made by the Legal Counsel as the Executive Board worked for the Health Assembly and could be instructed to give effect to its decisions. The screening procedure currently followed by the three regions to assess a candidate's suitability for the post of Director-General would be used by all the regions, irrespective of the number of candidates nominated by any particular region.

Dr NCHABI KAMWI (Namibia) said that the procedure for selecting candidates for the post of Director-General would be the same as that followed by the six regions for selection of Regional Directors. Candidates nominated in the African, South-East Asia and Eastern Mediterranean regions would be as highly qualified as those nominated in the other three regions, and therefore the principle of geographical rotation should be accepted.

Mr BLAIS (Canada) said that if the Health Assembly held a vote many Member States that were not ready to decide on the issue might then abstain, which would distort the result. Member States should first be consulted on whether they wished a roll-call vote to be held.

The DIRECTOR-GENERAL observed that it was the right of a Member State to request a roll-call vote. In the absence of a text, however, Member States might be uncertain about the exact nature of the issue on which they were being asked to vote. She had consulted the delegate of Liberia, who had agreed to allow the Secretariat to assist the members of the African group in drawing up a draft text, which would be made available to Member States in all six languages as soon as possible and on which Member States would be able to vote on during the current session, either on Thursday 20 May or on Friday 21 May.

Mr GWENIGALE (Liberia) requested that Member States of the South-East Asia and Eastern Mediterranean regions, as well as Member States of any of the other regions that might have an interest in the issue, should be invited to participate in the work of the drafting group alongside the African group, which would be represented by the delegation of Cameroon.

Dr KOMBA-KONO (Sierra Leone) expressed annoyance at the unequal treatment given to particular regions, and questioned on what criteria a particular person was deemed more capable than others with similar educational and professional qualifications. Furthermore, he expressed disappointment that an organization like WHO, which had made great progress under the leadership of the current Director-General, should be threatened by divisions for which Member States would be held accountable to themselves, and to the wider world whose interests they served. The delegates of Cameroon and Liberia had expressed the position of the entire African Region.

He called for calm and suggested that a smaller working group be set up, with representation from every region, to strive for a common position and to present recommendations to the Health Assembly. The election of a Director-General was a sensitive matter that must not be rushed, and WHO must not find itself in the same position as other United Nations bodies from which funding and

support had been withdrawn when an African had been elected to lead them. The challenges it faced far outweighed considerations of whether one person was more qualified or suitable than another.

Mr SEADAT (Islamic Republic of Iran) said that his delegation was willing to engage either in talks aimed at producing a clear text that could be put to the vote, as proposed by the Director-General, or in discussions in a smaller group, as suggested by the previous speaker. Either way, the African, South-East Asia and Eastern Mediterranean regions must be duly represented.

Mr SILBERSCHMIDT (Switzerland) asked whether the Committee was being required to choose between either a meeting of cosponsors to work with the Secretariat on the issues on which the delegate of Liberia had requested a vote, or a consultation that involved all the regions.

The CHAIRMAN replied that the options were to produce a text cosponsored by various Member States, or to convene a working group of representatives of every region to work on and submit a draft resolution. As the delegate of Liberia had requested a vote, he was invited to give his views.

Mr GWENIGALE (Liberia) said that, although he had requested a roll-call vote on the issue of regional rotation, the decision on how to proceed must be made by the Health Assembly. A vote could not take place without a text that set out the issues. Wider regional consultations had already been held on the matter, which the Region of the Americas had declined to discuss, and the views expressed were reflected in document A63/39. The text in question should therefore be drafted by a small group of interested parties from every region, not just the African Region.

The CHAIRMAN proposed that a small working group be established, as described by the delegate of Liberia.

Mr BLAIS (Canada) expressed concern that the Health Assembly might face a similar draft resolution at its next session if the issue was settled by a very close vote.

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that every delegate should be aware that the vote concerned equal treatment for all regions, especially the three regions that had yet to produce a successful candidate for the post of Director-General. The Secretariat should be asked to prepare a draft resolution taking account of the two key components of regional rotation and the criteria to be met by candidates. That would settle the concerns of those three regions regarding the Organization's methods of work and the apparent tendency not to consider those regions. The conditions must be the same for all candidates, who should be effective and efficient managers, regardless of origin. The use of personal and professional qualities as an argument against rotation was just an excuse. The question could not be postponed further and must be dealt with by the current Health Assembly.

Mr ABOUBAKER (Djibouti) said that the Committee must vote on whether to accept the principle of regional rotation or continue with the status quo; that would require one draft resolution. A separate draft resolution would be required in regard to selection criteria, and the Executive Board might focus on that aspect.

Dr RAMAPATLENG (Lesotho) said that she had every confidence in the Director-General and the Secretariat as currently constituted and appealed to delegations to focus on the issue and not to open up such other matters as the composition of the Secretariat. The African Region had endorsed the principle of rotation and would like to see a draft resolution on that principle put to the vote at the current session.

Ms HAMILTON (Canada) said that she would have liked to be able to discuss the issue further, as proposed by the delegate of Sierra Leone, before proceeding to a vote. There were many ways of ensuring greater equity other than by the introduction of regional rotation.

The CHAIRMAN noted that any delegation had the right to request a vote. At the same time, the Director-General had suggested that a draft resolution would be preferable in order to clarify what that vote entailed. He proposed that the open-ended working group should draft a resolution for submission to the Committee the following day.

Dr KHADRA (Syrian Arab Republic) supported the proposal to draft a resolution and to vote on it the following day.

Mr SEADAT (Islamic Republic of Iran) said that his delegation would collaborate with others on a draft resolution in an honest attempt to find a solution acceptable to all Member States. However, if the aim was simply to delay action further on the issue, the option of requesting a vote would remain.

Ms MATSAU (South Africa) said that she would have preferred an immediate vote on the principle of rotation. She asked what process would follow the adoption of the resolution, which she trusted would take place without delay.

The DIRECTOR-GENERAL explained that the delegate of Liberia had requested a roll-call vote on adopting the principle of geographical rotation, not on retaining the status quo. The Secretariat would help the working group to draft simple wording on the principle of rotation, but follow-up measures needed to be considered in order to clarify the implications of voting on the principle. For instance, a decision would have to be taken to which body should be entrusted the elaboration of the details of rotation and within what time frame. She suggested that, subject to the Committee's approval, work on detailed rules and regulations should be referred to the Executive Board, which, with Secretariat support, should look at the existing rules and report back to the Health Assembly.

Professor LOUKOU (Côte d'Ivoire) asked whether the delegate of Liberia could have drafted a resolution for submission to the Secretariat before the current meeting, in which case the Committee could have voted already.

The DIRECTOR-GENERAL said that that was indeed the case. When the issue had first been raised, she had asked whether the sponsors would submit a draft resolution, but none had been received.

Mr AL HIGAZI (Libyan Arab Jamahiriya) suggested that, if the Secretariat was not prepared to draft a resolution, it could work with the delegate of Liberia to produce a text that would enable the Committee to take a final decision on the principle of regional rotation. Had the Secretariat been well organized, the issue would not have been under discussion for four years and a resolution would have been voted.

Mr GWENIGALE (Liberia) recalled that the Executive Board had requested that each region discuss the issue and report back to the Secretariat. That was the basis of the report currently before the Committee. The Secretariat had not been instructed to draft a resolution. He had requested a vote because discussion of the issue had continued for so long. The request, he understood, had to be in writing and state the subject of the vote. In his view, a paragraph should suffice to say that, in consideration of all other criteria for selection of the Director-General, the position should be rotated. According to the Director-General, the draft resolution should also indicate the subsequent procedures to be followed and how long those should take. Procedures to amend the Constitution of WHO should

of course be followed. He was sure that the Secretariat would assist in the wording of the draft resolution.

The CHAIRMAN suggested that, since the Secretariat had allocated services for a working group meeting that evening, the Committee should take advantage of those, which should nevertheless not be seen as a delaying tactic. The delegate of Liberia could even draft his own paragraph for consideration the following day. The draft resolution should enunciate the principle of regional rotation, stipulate follow-up action and set time limits.

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

The meeting rose at 20:25.

FOURTH MEETING

Thursday, 20 May 2010, at 09:30

Chairman: Dr W. JAYANTHA (Sri Lanka)

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

Chagas disease: control and elimination: Item 11.14 of the Agenda (Documents A63/17 and A63/17 Add.1) (continued from the second meeting, section 6)

The CHAIRMAN invited the Committee to consider the following draft resolution, which incorporated amendments proposed on the previous day:

The Sixty-third World Health Assembly,

PP1 Having considered the report on Chagas disease: control and elimination, **and understanding the elimination as stable interruption of the domestic transmission [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**

PP2 Expressing its satisfaction at the considerable progress achieved by countries towards the goal of eliminating Chagas disease ~~by 2010~~, as recommended in resolution WHA51.14;

PP3 Underlining that 2009 ~~will remark~~ **marked [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]** the centenary of the description of this disease by Dr Carlos Chagas;

~~PP4 Acknowledging the progress made with vector control strategies;~~

PP5 Recognizing the success achieved through the intergovernmental initiatives in Latin America; **through acknowledging the progress made by vector-control strategies [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay];**

PP6 Taking into account the need for the harmonization of diagnostic and treatment procedures;

PP7 Recognizing the need for the provision of ~~adequate~~ **appropriate medical care for affected persons with all clinical presentation of Chagas disease late-severe-clinical manifestations [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay];**

PP8 Underlining the need for more effective, safe and adequate ~~drugs medicines~~ **[Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**, including paediatric formulations, and for better coverage and distribution of those currently available;

PP9 **Recalling resolution CD49.R19 adopted by the 49th Directing Council of PAHO in 2009, which urges Members States to commit themselves to the elimination or the reduction of neglected diseases and other related poverty diseases, including Chagas disease, with the aim that Chagas disease no longer represents a public health problem in 2015; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**

~~PP10 Recognizing that the risk of transmission through blood transfusion and organ transplantation and of congenital transmission is increasing [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]~~

PP11 Acknowledging the significant collaboration and support among Member States and the support of other partners and appreciating their continuous assistance,

1. URGES Member States:
 - (1) to reinforce efforts to strengthen and consolidate national control programmes **especially in areas where Chagas disease has re-emerged, [USA] in endemic and non endemic countries and to establish them where there are none [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**;
 - (2) to establish mechanisms to ensure broad coverage of adequate control measures, including the promotion of decent and healthy living conditions, prevention and the integration of specific actions within health services based on primary care, **together with strengthening community participation [Thailand]**;
 - (3) to harmonize systems and strengthen capacities for surveillance, data collection and analysis and dissemination of information;
 - (4) **to integrate the care of patients with acute and chronic clinical forms of Chagas disease into primary health services; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**
 - (5) **to reinforce the provision of existing treatments in endemic countries with the aim of making access universal; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**
 - ~~(4)~~(6) to promote and encourage operational research on control of Chagas diseases in order:
 - (a) **to control and/or eliminate domestic vector populations in order [Thailand]** to interrupt transmission by domestic insect vectors;
 - (b) to develop more suitable, safer and more affordable medicines;
 - (c) **to develop a valid and accessible test of cure; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**
 - ~~(e)~~(d) to reduce the risk of late complications of the infection;
 - (d)(e) to establish systems of early detection, in particular for the detection of new infections, of congenital infections in newborns and the reactivation of the disease in immunocompromised patients;
 - (e)(f) **to optimize blood transfusion safety and screening procedures in endemic countries and to give appropriate consideration to implementing screening procedures in [Thailand]** non endemic countries with special focus on areas where the disease is endemic;
 - ~~(5)~~(7) ~~to develop public health measures in endemic and non-endemic countries, with special focus on endemic areas, for the prevention of transmission through blood transfusion and organ transplantation, early diagnosis of congenital transmission and management of cases; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]~~
2. REQUESTS the Director-General:
 - (1) to draw attention to the burden of Chagas disease and to the need to provide equitable access to medical services for the management and prevention of the disease;
 - (2) to strengthen implementation of vector-control activities in order to achieve interruption of **domestic [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] transmission of *Trypanosoma cruzi* [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]** and to promote research to improve or develop new prevention strategies;
 - (3) **to promote in areas endemic for Chagas disease action to detect infected donors at blood banks in order to integrate strategies for safe blood; [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay]**
 - (3)(4) to provide support to the countries of the Americas in order to strengthen intergovernmental initiatives and **the technical secretariat of [Argentina, Bolivia**

(Plurinational State of), Brazil and Paraguay] the Pan American Sanitary Bureau as a successful form of technical cooperation among countries;

(4) (5) to collaborate in order that countries and intergovernmental initiatives set objectives and new goals for the ~~elimination~~ **interruption** [Paraguay] of the **domestic transmission, in other words the elimination of Chagas disease of the parasite** [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay];

(5) (6) to support the mobilization of national and international, public and private financial and human resources to ensure achievement of the goals;

(6) (7) **to integrate diagnosis and treatment of Chagas disease at the primary health care level for patients both in the acute and chronic phases of the disease;** [USA]

~~(6)~~ (8) to promote research **related to prevention, control and care** [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] ~~on elimination~~ [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] of Chagas disease;

~~(7)~~ (9) to support **intersectoral** efforts at collaboration, **the network between organizations and partners interested in supporting the development and the strengthening among multisectoral actors, networking among organizations and other interested parties to support the development and implementation** [Argentina, Bolivia (Plurinational State of), Brazil and Paraguay] of Chagas disease control programmes;

~~(8)~~ (10) to report on progress in the elimination of Chagas disease to future World Health Assemblies.

Ms BRANCHI (France), speaking also on behalf of Italy and Spain, stressed that Chagas disease was a global problem and that the definition of elimination could not be limited to “the interruption of domestic transmission”, as stated in the first preambular paragraph. Therefore, she proposed that the definition should include organ transplantation, blood transfusion, vertical transmission and oral transmission and that a new preambular paragraph should recognize the growing number of cases of Chagas disease in regions where the disease was not endemic.

Further, in paragraph 1, Member States should be urged “to strengthen and harmonize their activities in order to prevent and control Chagas disease in regions where it was not endemic”. The wording of a new subparagraph in paragraph 2 should request the Director-General, in addition to the support provided to intergovernmental initiatives in Latin America, to promote an intergovernmental initiative to prevent and control Chagas disease in regions where it was not endemic.

Dr MILLER (United States of America) requested that subparagraph 2(7): “to integrate diagnosis and treatment of Chagas disease at the primary health care level for patients both in the acute and chronic phases of the disease”, which had been proposed by his delegation, should be moved to paragraph 1, as it applied to Member States.

Dr RODRIGUEZ (El Salvador) said that Chagas disease was highly endemic in El Salvador, which was participating in regional efforts to eliminate *Rhodnius prolixus*; the draft resolution should also mention *Triatoma dimidiata*.

Argentina, Bolivia (Plurinational State of), Brazil, Paraguay and her own country would find that the commitment set out in preambular paragraph 9, to eliminate or reduce Chagas disease by 2015, was unrealistic. The targets set for 2010 had not yet been achieved and she suggested that 2020 represented a more realistic target.

Mr TOBAR (Argentina), noting that some minor editorial amendments were required in the Spanish version of the text, said that in preambular paragraph 9 he would prefer use of the word “recognizing” rather than “recalling”. He agreed with the delegate of El Salvador that the target date of 2015 was unrealistic, but since it had been established in resolution CD49.R19, it would not be appropriate to change the reference.

He proposed that the wording of subparagraph 1(6)(a) be rearranged to read: “to interrupt transmission by domestic insect vectors in order to control and/or eliminate domestic vector populations;”.

Dr NAGAI (Japan) was concerned that in preambular paragraph 1, the definition of the term “elimination” differed from the standard understanding of that term. To avoid further confusion, the standard definition of elimination should be used, or the proposed amendment should be removed and the original text contained in resolution EB124.R7 retained.

Chagas disease was a global threat that also affected Japan. The draft resolution should take into account routes of transmission such as blood transfusion and organ transplantation. She therefore proposed that the tenth preambular paragraph and subparagraph 1(7), which were both shown as deleted in the amended text, should be restored.

Mr GAVARELL (Plurinational State of Bolivia) recalled that his delegation had joined others on the previous day in proposing that the text of subparagraph 1(4) should be amended to read: “to integrate the diagnosis and treatment of patients with acute and chronic clinical forms of Chagas disease into primary health care services;”. He supported the proposals by the delegate of Japan regarding the use of the term “elimination” in the first preambular paragraph and in subparagraph 2(5), since interruption of the domestic transmission of Chagas disease should not be equated with its elimination.

Mr HAGE CARMO (Brazil), seeking to clarify the use of the term “elimination” in the draft resolution, acknowledged that elimination generally meant a reduction in the number of cases of a disease to zero. However, for some diseases, including Chagas disease, elimination in those terms was impossible, since no practical mechanism existed for the elimination of wild transmission, for example in the Amazon rainforest. In 1999, the countries of the Southern Cone subregion had agreed on a target for elimination of the disease from the countries in which it was most endemic, with elimination being understood to mean the interruption of domestic transmission by the predominant vector. That agreement had been reinforced in 2009 by a resolution of the PAHO Directing Council, and many Member States in the Region of the Americas were working towards elimination of the disease on that basis.

Dr RODRIGUEZ (El Salvador) expressed concern that the draft resolution did not take into account the serious problems that Chagas disease posed for Central American countries, such as the increased contamination rates in blood banks. Consequently, she reiterated her proposal that more time should be allowed for elimination or reduction of the disease by changing the target date to 2020.

The CHAIRMAN suggested that those Member States that had proposed amendments should meet in an informal drafting group in order to agree on, in cooperation with the Secretariat, a new amended draft resolution for consideration at a later meeting.

It was so agreed.

(For continuation of the discussion and approval of the draft resolution, see the summary record of the eleventh meeting of Committee A, section 3.)

Global eradication of measles: Item 11.15 of the Agenda (Document A63/18) (continued from the second meeting, section 6)

Dr GOUYA (Islamic Republic of Iran) said that the Member States of the Eastern Mediterranean Region had agreed on a target date of 2010 for elimination of measles and his country had fully implemented the recommended global and regional strategies to that end. However,

eradicating measles before poliomyelitis appeared an ambitious target, especially since many Member States were directing their efforts towards the eradication of the latter disease. Measles outbreaks had continued in the Region despite a wide range of campaigns against the disease. He proposed that a new target date of 2020 should be set.

In his country, a vaccination campaign in 2003 had achieved a 99% rate of coverage for those aged between 5 and 25 years. National disease surveillance had registered fewer than 200 cases from 2004 to 2008. However, elimination in his country would also depend on the success of programmes for measles control and elimination in the neighbouring countries that were affected by long-term conflicts.

Mr AL-TAAE (Iraq) said that his country had increased the coverage rate for routine measles immunization to 96% in 2009, compared with 91% in 2008. It had also controlled local increases in the number of cases through improved disease surveillance and mopping up activities; more than 10 million children aged between 6 months and 12 years had been vaccinated in 2009. Through enhanced laboratory work, the rate of sampling of suspected cases of measles had attained 80%. Public education on the benefits of vaccination, capacity building and the application of quality assurance standards to measles control had all been improved.

Mrs TZIMAS (Germany) said that her country had made significant progress towards measles elimination thanks to mandatory reporting of measles, nationwide surveillance of vaccination coverage and additional laboratory capacities. Despite increased uptake of vaccine in recent years, regional outbreaks had occurred, particularly among those groups that had chosen not to be vaccinated. As in other countries, the distribution of cases of measles had shifted towards older age groups. Continued political support was important, as were public awareness campaigns, which must explain the benefits and risks of vaccination and the much greater risks of not being vaccinated.

Dr MELNIKOVA (the Russian Federation) said that her Government was making major efforts to eradicate measles through immunization programmes for children and adults. The criteria set by WHO for the elimination of measles had been met in almost every region in the country. Careful monitoring of the disease and of people at risk of the disease had enabled an objective assessment of the circulation of the virus in the country. Surveillance data indicated that the epidemiological situation was improving despite a rise in the number of imported cases. Her country would be happy to share positive experiences recorded and offer technical support. She supported the global measles targets for 2015.

Dr BAHAR (Brunei Darussalam) said that achievements in both reduced mortality rates and routine coverage of first dose vaccinations reflected the global commitment to eradicate measles. The situation in the Region of the Americas demonstrated that eradication was feasible. She commended the Secretariat's analytical work on measures to strengthen immunization systems and on the economic aspects of measles eradication. She supported the global measles targets for 2015.

Dr YUMA RAMAZANI (Democratic Republic of the Congo) advocated strengthening the integrated monitoring system in the countries of the African Region in order to meet the pre-elimination targets for measles. That system should also be bolstered by a strong and effective health system.

Dr CHAWETSAN NAMWAT (Thailand) said that measles eradication activities posed numerous challenges, particularly in developing countries that faced competing health priorities, conflicts, migrant workers, hard-to-reach populations and potential shift of outbreaks to the adult population. High mortality rates continued despite the availability of effective vaccine; however, all challenges could be overcome through a global effort, undertaken in the spirit of public health through strong partnerships. He supported the regional elimination of measles by 2020.

Dr OBARA (Japan) said that the annual incidence of reported cases of measles in her country had decreased by 93% from 11 000 cases in 2008 to 741 cases in 2009. The decrease had been achieved by improved coverage of the Expanded Programme on Immunization; a measles vaccination campaign for 13–18 year olds; surveillance and preventive measures; and collaborative partnerships, exemplified by the elaboration of guidelines on prevention and treatment, undertaken jointly with the Ministry of Education, and for use in schools. Her Government was working towards the elimination of measles by 2012, and was encouraging laboratory diagnosis of all suspected cases; it had also provided bilateral aid that which included the transfer of vaccine development technology, and was involved in measles elimination programmes in the Western Pacific Region and throughout the world.

Dr BAE Geun-Ryang (Republic of Korea) agreed with the proposal to set global measles targets for 2015. His country had collaborated with neighbouring Member States on measles elimination programmes and would continue to offer education programmes and technical support around the world. The role of neighbouring countries was crucial to control the disease. He appreciated the discussions on the verification process for measles elimination that had recently started in the Western Pacific Region.

Dr MOHAMED (Oman) said that vaccines had played a crucial role in the reduced incidence of measles over the previous 20 years and efforts to attain Millennium Development Goal 4 (Reduce child mortality). New blood techniques had increased detection rates in the adult population; however, a lack of financial resources to combat measles would prevent his country from achieving the measles targets by 2015. In particular, paragraphs 30 and 31 of the report were relevant as guidance for the eradication of measles.

Dr AL NASSER (Kuwait) said that his country had achieved a 99% immunization coverage rate and was helping to combat measles in the Eastern Mediterranean Region in order to attain the 2015 targets. His Government had introduced a range of measures, notably a two-dose immunization campaign that he recommended to Member States as essential for the eradication of measles at the global level.

Dr MUSTAFA (Sudan) said that measles posed a serious health threat, although the annual incidence of reported cases had been significantly reduced in his country. The International Finance Facility for Immunisation had provided crucial support to the attainment of measles eradication by 2020.

Dr HYDER (Pakistan) said that as a part of the global effort to reduce mortality and morbidity due to measles, his Government had implemented a catch-up campaign and provided a second opportunity to all children, in collaboration with the WHO/UNICEF Global Immunization Vision and Strategy, and with other partners. Case-based surveillance had also been introduced and a follow-up campaign was planned for 2011.

Dr WAMAE (Kenya) said that in his country outbreaks of measles still occurred and cross-border transmission presented a challenge. His Government was committed to eradication but requested technical and financial support to enhance surveillance and cross-border control.

Mrs APA (New Zealand) said that her Government had set a target of 95% immunization of all children at two years of age by 2012. Delivery of the district health services was monitored by regular published reports. Despite collective improvements it was necessary to remain vigilant.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that mortality rates had dropped significantly thanks to effective and inexpensive interventions, a proven strategy, adequate funding and global partnerships.

Routine vaccination campaigns, retraining of health workers, improved cold chain and waste management systems and strengthened disease surveillance had contributed to rapid detection and effective control of outbreaks. Moreover, measles vaccination campaigns contributed to the reduction of child mortality through integration with other health programmes.

However, a resurgence in measles would most likely prevent the attainment of Millennium Development Goal 4 (Reduce child mortality). She called on Member States to show continued commitment; to increase donor support; to strengthen routine immunization campaigns; and to demonstrate cooperation and partnership in order to achieve regional elimination goals. Her Federation and its network of national societies gave support to Member States and the Measles Initiative through their community-based volunteers.

Professor Feng-Yee CHANG (Chinese Taipei) recalled that in 2005 the Regional Committee for the Western Pacific Region had established a target date of 2012 for regional measles elimination. Measles had not been endemic in Chinese Taipei since the introduction of two-dose measles vaccination under the Expanded Programme on Immunization in 1978. Vaccination coverage of measles, mumps and rubella had reached more than 95%, the incidence of indigenous measles was less than 0.5 cases per million population.

However, cross-border importation had accounted for a significant percentage of confirmed cases requiring prevention policies such as the recommendation to give an extra dose of measles vaccine to infants aged 6–12 months who travelled with their parents to an endemic area. Chinese Taipei would continue to support and follow the Global Immunization Vision and Strategy in order to achieve the goal of eradication of measles worldwide.

Dr VON SCHOEN-ANGERER (MSF International), speaking at the invitation of the CHAIRMAN, said that, despite global progress in measles control since 2000, the disease remained endemic in many countries. He welcomed the Secretariat's call for new, ambitious measles targets for 2015 but was concerned about the inadequate response to current outbreaks, and the measles funding crisis. Resurgence of measles outbreaks throughout southern Africa continued to be reported even several months after the beginning of the epidemic. The epidemics could have been contained through appropriate response and deaths avoided.

The need to reinforce outbreak response immunization was recognized by WHO, although that approach was difficult to implement and not always accepted by public authorities. Responding to measles outbreaks with vaccination and provision of treatment free of charge also enabled children not reached by the routine system to receive their first dose, and others their second dose.

Prevention and treatment of measles were core activities of his organization, which in 2009 had vaccinated more than 1.5 million children in response to outbreaks in more than 10 countries. Funding and support both for routine services and for outbreak response had been declining in favour of investment in new vaccines and technologies. His organization supported strengthened childhood immunization through new vaccines, but those investments should not come at the expense of proven, cheap and essential vaccines.

The Measles Initiative estimated that some 164 000 people had died from measles in 2008. At a cost of less than US\$ 1 to vaccinate a child, the measles control strategy represented a health intervention that was highly cost-effective.

Ms MAFUBELU (Assistant Director-General) thanked participants for their comments and guidance, and commended their efforts and achievements in controlling measles and reducing measles mortality. She thanked Member States for their overwhelming support and commitment: measles eradication was a worthy public health goal that all countries could eventually achieve; it was biologically and technically feasible. Underscoring the need for regional measles elimination, as an important step towards global measles eradication, she said that she had been greatly encouraged to hear about the regional efforts in hand, including the technical support provided by Japan for the manufacture of measles vaccines in other countries.

The Secretariat had taken note of the concerns that had been raised and the major challenges still facing countries as they strove for global measles eradication, including the need to provide adequate surveillance and programme monitoring, and to strengthen immunization systems and health systems. It had also taken note of concerns about cross-border importation, and urged vigilance and controls in order to prevent importation into measles-free countries.

WHO would continue to work with its partners to provide technical support in order to ensure that the gains achieved were not lost. She expressed appreciation for the support that WHO was receiving from its partners.

The Committee took note of the report and the proposed 2015 targets.

Smallpox eradication: destruction of variola virus stocks: Item 11.16 of the Agenda (Document A63/19)

Dr AL-RUBAIE (Iraq) considered that it was essential to continue research into the ramifications of smallpox, and for that purpose stocks of variola virus, held in safe and secure conditions, were needed.

Dr NARONG WONGBA (Thailand) observed that the report highlighted significant advances in smallpox research, notably the third-generation smallpox vaccine licensed in Japan. He appreciated the efforts made to build up a global reserve of smallpox vaccine but also noted that the WHO stockpiles of 32.6 million doses, and the 27 million doses pledged, were still far from the 200 million doses recommended by the Ad Hoc Committee on Orthopoxvirus Infections in 2004.

The world had successfully eradicated smallpox three decades before. There had been many advances in research and the threats posed by stocks of live variola virus outweighed the benefits, and continued to put the world at risk. The solution was the total destruction of the variola virus stocks.

Dr NICKNAM (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, recalled that in resolution WHA52.10, the Health Assembly had authorized temporary retention until no later than 2002 of existing stocks of variola virus at two locations for the purpose of further international research. Research activities had been approved as long as they remained outcome-focused, time-limited and periodically reviewed. The world had recorded considerable success in elucidating different aspects of the virus, including sequencing of the genomes of viruses from numerous different strains. All essential research that required live variola virus stocks for the purposes of sequencing and development of diagnostics and vaccines had been completed, and further sequencing might not be justified from a public health perspective. Consequently, he strongly recommended that a date for the destruction of the variola virus be set as soon as possible.

Dr LIANG Wannian (China) observed that in the past year the WHO Advisory Committee on Variola Virus Research and the Secretariat had carried out significant work on the management of smallpox virus strains. With support from WHO, designated agencies in certain countries had made progress in research on the smallpox virus and antiviral agents and in the development of early diagnosis tools. The Advisory Committee should continue to monitor the relevant projects, including their feasibility and timetable, so that by the Sixty-fourth World Health Assembly there might be consensus on the steps to take concerning the variola virus stocks.

The repositories designated by the Health Assembly should take the strictest measures to guarantee the biosafety of the laboratories, and the Advisory Committee should ensure that the research was transparent and properly reviewed, and that regular reports were given on the progress and the results. The Secretariat should inform Member States of progress and results achieved so that they too could benefit from the research.

Dr SULAIMAN (Malaysia) said that, even though smallpox had been eliminated, it still remained a public health concern. Unknown stocks of live variola virus might exist and could even be deliberately released as a biological weapon, which would result in catastrophe for the global community.

The findings and report of the eleventh meeting of the WHO Advisory Committee on Variola Virus Research showed that major progress had been made in the development of anti-variola agents, improved and safer vaccines, and specific and sensitive diagnostic assays. As suggested by the Advisory Committee, the capability to perform work with live variola virus must be maintained at least until two antiviral agents with different mechanisms of action had gained regulatory approval. Thus, research needed to continue before consensus could be reached on a date for the destruction of the remaining stocks of the virus. However, as recommended by the Committee at its seventh meeting, it was important to review all proposals for further research using live variola virus against the considerable progress made to date and also to ensure that approved research was outcome-oriented and time-limited.

Dr MELNIKOVA (Russian Federation) drew attention to the description in the report of the satisfactory inspection of the VECTOR laboratory by the WHO biosafety inspection team using the new WHO protocol for such inspections. There would be a need for an instrument with detailed regulations for the implementation of that protocol, and the Russian Federation would support any steps taken by the Secretariat to develop such an instrument.

At present, the Russian Federation was working on prophylactic and treatment measures and vaccines against smallpox in accordance with the relevant resolutions and it had already completed the first stage of the work on an oral vaccine. However, international research and research in her country was far from complete and the supply of new generation vaccines and medicines remained uncertain.

She argued for the need to assess the risks associated with synthetic biology and the possibility of reconstructing wild variola virus or fragments of it. National and international research with live variola virus, on vaccines, antiviral agents, diagnostics and animal models, should continue. Continued storage of stocks of variola virus strains in the two official WHO repositories was therefore essential, and she remarked on the existing fruitful collaboration between the two centres. The position of the Russian Federation remained unchanged: the moratorium on the destruction of the stocks of wild smallpox virus should continue until such time as the work had produced effective and safe treatments and vaccines, and proper diagnostic tools. She welcomed the report and greatly appreciated the coordinating role played by the Secretariat.

Dr RAMAPATLENG (Lesotho), speaking on behalf of the 46 Member States of the African Region, recalled that, although smallpox had been eradicated for more than three decades, stocks of the variola virus had been kept in two WHO-approved repositories for the purposes of essential global public health research. Resolutions WHA49.10, WHA52.10 and WHA55.15 had respectively recommended a date for the destruction of the remaining stocks of variola virus, authorized temporary retention of existing stocks up to 2002, and authorized further, temporary, retention for the purpose of conducting further research, on the understanding that all approved research would remain outcome-oriented and time-limited.

Considerable progress had been made in the development of antiviral agents and the WHO-led inspection of the two repositories had reaffirmed the safety and security of the virus stocks. She noted the approved research proposals, review process and updates contained in document A63/19, and strongly supported reporting WHO-approved and -controlled research to the Organization in an open and transparent manner, according to the established protocol.

Remaining stocks of variola virus should be destroyed and a new date for destruction agreed. Since all essential research requiring live variola virus stocks for the purpose of sequencing and development of diagnostics and vaccines had been completed, further temporary retention at the current locations should only be authorized for the purpose of research into antiviral agents, up to 30 June 2010. The WHO Advisory Committee should continue its work on variola virus research but

review its membership and meetings in order to ensure balanced geographical representation and the inclusion of experts from developing countries. There should be substantial representation of public health experts and members should be independent of the two repositories.

Resolution WHA52.10 should be reviewed in the light of the recognition by the Advisory Committee that it was possible to synthesize the full-length genome of variola virus, since it could no longer be ensured that the genomes would only exist in the two repositories. Ethics and biosafety committees should be aware of, and responsible for implementing, guidelines at the local level.

Dr MILLER (United States of America) said that the National Academies of Science's Institute of Medicine had also conducted a review of progress made in research since 1999, with recommendations for further research: he was willing to share the findings with Member States.

His Government remained committed to the full implementation of resolution WHA55.15, which authorized further retention of the existing stocks for continued research. Contrary to the statements of other delegates, not all essential global public health research had been completed. The research agenda was focused on the development of new antiviral agents and safer, less reactogenic vaccines; it was based on recommendations from world-renowned scientists and was being undertaken for the good of all, following strict biosafety standards. As stated during the 117th session of the Executive Board in 2006 by the then Director-General, unauthorized stocks of the virus did almost certainly exist and the potential for deliberate misuse remained. He firmly disagreed that stocks should be destroyed on 30 June 2010.

Dr KARAGULOVA (Kazakhstan) welcomed the thirtieth anniversary of smallpox eradication. Disease, however, was unpredictable, as exemplified by the fact that poliomyelitis had experienced a re-birth in previously poliomyelitis-free regions. Since it was impossible to know what the future would bring, the moratorium on the destruction of variola virus stocks should be maintained so that effective remedies could be developed.

Mr GARCIA DE ZUNIGA (Paraguay) appealed to Member States, in the light of the recent experience with pandemic influenza, to establish procedures for the immediate destruction of all existing stocks and to bring to an end all ongoing research.

Ms LAWLEY (Canada) agreed that remaining stocks should be destroyed once they were no longer required for public health research, provided there was no concern over their possible proliferation and use in offensive biological weapons programmes. She welcomed the work conducted by the WHO Advisory Committee to examine new variola virus research proposals, to identify laboratories known to be involved in research using portions of variola virus DNA, and to increase awareness of the regulations and guidelines governing the use and distribution of the DNA, in particular to third parties. She supported the development of that work into a report for presentation at the Sixty-fourth World Health Assembly, with a view to establishing a global consensus on the timing of the destruction of existing variola virus stocks.

Dr RYAN (Global Alert and Response), responding to comments made, joined the delegate of Thailand in welcoming the development of third-generation vaccines and the success in Japan in licensing those products. Kind donations from Canada, France, Germany, New Zealand and the United Kingdom of Great Britain and Northern Ireland had enabled continued efforts to stockpile first- and second-generation vaccines, of which 32.6 million doses were currently stored in Switzerland, with a further 27 million doses potentially available. The stockpiling system was controlled by a standardized operational procedure, which would be fully tested later that year. He assured the Committee that all research conducted under the supervision of the Advisory Committee had been outcome-oriented and time-limited, and that the results were available to Member States.

Following instructions given at the Sixtieth World Health Assembly in 2007 (resolution WHA60.1), full scientific reviews of all published and unpublished data in six key areas related to the

use of live variola virus had been completed. An independent expert group was being selected by the Director-General to analyse that data and the findings would be presented to the Advisory Committee and Executive Board in January 2011 in order to inform discussions on the further retention or destruction of existing stocks.

In response to the statements made by the delegates of the Russian Federation and the United States of America, he confirmed that inspections had been completed as planned. Both repositories had been found to operate at the highest levels of biosafety. The protocol for those inspections would continue to be developed.

The Secretariat was continuing to implement resolutions WHA52.10, WHA55.15 and WHA60.1. The Advisory Committee had received a copy of the Institute of Medicine's review of research, which would serve to inform further scientific reviews already under way.

He confirmed that efforts were being made to ensure greater geographical balance and a greater inclusion of public-health expertise on the Advisory Committee, whose current membership reflected those endeavours.

Work to convert all archive material into electronic format was near completion, and material would be made available to Member States in due course.

The Committee noted the report.

Availability, safety and quality of blood products: Item 11.17 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R14, and A63/20)

The CHAIRMAN, introducing the item, drew attention to the draft resolution contained in resolution EB126.R14.

Dr MULYONO (Indonesia) emphasized that blood and blood products saved lives, reduced morbidity and improved quality of life; however, they could also transmit life-threatening pathogens, as highlighted in both the draft resolution and the Secretariat's report. Because human populations differed in their susceptibility and resistance to diseases, a diagnostic reagent based on a strain from one geographical region might not be capable of detecting strains of the pathogen from other parts of the world. The actions set out in subparagraphs 1(2), 2(2) and 2(5) of the resolution would contribute to minimizing transfusion risks, including transmission of bloodborne pathogens, and they should be followed up with the use of highly sensitive and specific diagnostic devices, capable of detecting pathogens of different biological characteristics. Accordingly, he proposed that at the end of subparagraph 1(3) the phrase "including the use of diagnostic devices to prevent transfusion-transmissible diseases with highest sensitivity and specificity" be inserted.

In line with subparagraph 2(4), the Secretariat should provide Member States, and particularly developing countries, with support and access to WHO International Standards for the diagnosis of common transfusion-transmitted diseases, including HIV/AIDS, hepatitis B and hepatitis C.

Ensuring that women in childbirth had access to a safe supply of blood would contribute to meeting Target 5.A of Millennium Development Goal 5 (Reduce by three quarters the maternal mortality ratio).

Mr SUÁREZ IGLESIAS (Spain) speaking on behalf of the Member States of the European Union, said that the candidate countries Croatia, The former Yugoslav Republic of Macedonia, and Turkey, the countries of the Stabilisation and Association Process and potential candidates Albania, Bosnia and Herzegovina, Montenegro and Serbia, as well as Armenia, Georgia, Republic of Moldova, and Ukraine, aligned themselves with his statement. He recalled the original reasons for proposal of a resolution on availability, safety and quality of blood products: blood transfusion was indispensable in medical practice; plasma-derived medicinal products were included in the WHO Model List of Essential Medicines; and, on a global level, demand for blood products still exceeded available supply.

He supported the draft resolution as it would build the capacity of new and existing national blood service systems to supply, test, process, and ensure the administering and rational use of blood. National health programmes should place emphasis on those matters. Great efforts were needed at every stage of the process in order to ensure that local needs were met. Furthermore, the draft resolution should serve to encourage local plasma-collection efforts and, if possible, the building of local fractionation capacities, on the basis of new and existing blood service systems. The plasma collected through blood component separation should be available as a raw material for the manufacture of essential medicinal products, thus avoiding the current, unacceptable wastage of that precious resource. Good practices should be applied to the collection and testing of recovered plasma, as well as to the processing, labelling, storage and transportation of plasma for fractionation.

The draft resolution aimed to encourage Member States to modify their legislation, to strengthen regulatory supervision and to boost the capacity of their regulatory authorities. To that end the Secretariat should provide Member States with scientific, regulatory and technical advice and support to strengthen national regulatory authorities and thus ensure that blood products met internationally recognized standards of quality and safety. The Secretariat should also ensure the sustainable provision and appropriate use of international biological reference materials. WHO was to be commended for its leadership in those matters. Adoption of the draft resolution would encourage continued support to developing countries in establishing national blood and plasma programmes.

Dr JAYPAUL (Mauritius) said that equitable and timely access to safe blood was essential. The adequacy, safety and quality of blood products depended on the availability of voluntary, non-remunerated and regular blood donors; universal testing of donated blood; and a reduction in unnecessary transfusions.

Public health care was accessible to all citizens free of charge. The demand for blood was constantly rising, owing to the rapid expansion of the public and private health sectors and the introduction of high technology for medical interventions. The number of blood units collected had also increased steadily. Noncommunicable diseases accounted for the country's major disease burden and blood transfusion was needed to support cardiac and other types of surgery, oncology services and the renal dialysis programme. National guidelines on the appropriate use of blood were available and all blood collected was screened for HIV, hepatitis B, hepatitis C and syphilis. His Government was committed to provision of a good-quality blood service to its population; all public health care institutions, including the National Blood Transfusion Service, were being certified to the ISO 9001 standard for quality management. He fully supported the draft resolution.

Ms MATSAU (South Africa), speaking on behalf of the Member States of the African Region, said that the Regional Committee for Africa had adopted resolutions urging Member States to take action to enact blood policies and to mobilize the resources required to ensure that blood and blood products were available and safe. In 2001, a blood safety strategy for the African Region had been adopted. Its objectives had been realized to differing extents by different countries, but much still needed to be done.

In Africa, too many people were still dying because blood and blood products were not available or not safe. Supplies were insufficient to meet demand: some Member States did not have the legislative framework, equipment and resources to ensure a constant and safe supply of blood and blood products, nor the capacity for blood component separation and fractionation. Member States were acutely aware of the need for vigilance in the collection and supply of blood products, as there were more people in Africa carrying HIV and other pathogens than in any other WHO region. Any increased incidence of HIV through medical transmission of blood must be avoided at all costs. The safety of blood products was not negotiable. The Member States recognized that self-sufficiency in the supply of blood components based on voluntary, non-remunerated blood donation and secure supplies was essential to prevention of unnecessary mortality and provision of safe blood.

In regard to the draft resolution, she endorsed the need to establish, implement and support nationally coordinated, efficiently managed and sustainable blood and plasma programmes, adequate

regulatory frameworks and the building of human resources to meet international standards. Blood transfusion services in many Member States still depended on external donor funding, and health-care financing schemes should be explored. She welcomed the requests to the Director-General, notably the guidance for Member States to meet internationally recognized standards; and increased control and competence in the availability, safety and quality of blood products. However, support was also required to bridge the gap between policy and implementation.

Regional collaboration should play a much stronger role, with support from the Secretariat. The expertise and experience available in some Member States could be transferred to others through regional training and support for the development of national technologies. For example, sending all blood samples abroad for testing was neither sustainable nor cost-effective; the bulk purchasing of equipment and products would also save costs and increase the number of people able to benefit from blood transfusions and blood products. Changing people's perceptions of voluntary blood donation should be emphasized: that had been common practice in developed countries for many years but was little understood or practised in most of Africa. She supported the draft resolution but would have liked more emphasis placed on support for regional sustainability and collaboration between Member States and within regions.

Ms PATTERSON (Australia) supported the key theme of the draft resolution, namely: increased access to safe and good-quality blood and blood products through an integral approach that included donor assessment and deferral, universal testing of all donations, the adoption of quality systems and robust regulatory oversight. She strongly supported voluntary non-remunerated donation as the cornerstone of a safe and adequate blood supply, and the replacement of whole blood transfusions with component therapy where appropriate, in order to maximize the effective use of each unit of blood. She welcomed the initiatives mentioned in the draft resolution designed to increase transfusion safety and appropriateness and to reduce wastage resulting from inappropriate usage and lack of processing facilities.

Mr TAYLOR (United States of America) said that his Government had assisted the Secretariat in its effort to advance global regulatory capacity and effectiveness in assuring the quality of blood products through the WHO's Global Collaboration for Blood Safety, the Blood Regulators Network and other forums. He strongly supported the draft resolution, which reiterated the provisions of previous Health Assembly resolutions on national blood systems and introduced new elements, namely the establishment of regulatory controls and quality systems, designed to ensure the availability of safe blood in more than 70 countries and to address the current wastage of plasma. He encouraged Member States to add their full support and in that regard he recognized the leadership role taken by the United Arab Emirates in the Eastern Mediterranean Region.

The concept of oversight of the blood system by a national regulatory body might be new in some Member States and might meet with resistance from blood organizations that currently regulated themselves. Nevertheless, experience had shown that independent governmental regulation was essential in order to assure blood product quality and meet the goals of universal access to safe blood transfusion and adequacy of plasma-derived essential medicines. A quality system that embraced good manufacturing practices, good laboratory practices and reporting of adverse events associated with blood products was the necessary foundation for a sufficient and safe blood supply. Moreover, national legislation was required to ensure regulatory control in the implementation of quality systems and good manufacturing practices so that all blood products met internationally recognized standards and the wastage of plasma was prevented. The global needs for plasma-derived essential medicines could not be met without local collection of plasma that met international standards for fractionation. The establishment of a robust quality system was the key to achieving that goal.

Dr LIANG Wannian (China) said that, following legislation on blood donation in 1998, non-remunerated blood donation in China had increased significantly. By the end of 2009, all blood donation was non-remunerated. China had also established systematic regulations to govern the

collection, testing, storage, processing and distribution of blood products. The limitations of blood testing technology, however, had increased the risk of the spread of viral diseases. Additionally, with fewer people willing to donate blood there was often a shortage of Factor VIII and the needs of patients could not always be met. Many countries, especially developing countries, probably faced similar problems. He endorsed the report and supported the draft resolution.

Dr BAHAR (Brunei Darussalam) commended the leadership and commitment shown over many years by the Secretariat with regard to the availability, safety and quality of blood products. The issue was pivotal to health management, not least in the context of the health-related Millennium Development Goals. With the increasing demand for blood products worldwide, the challenges were daunting. She welcomed the draft resolution and called upon the Secretariat to continue its leadership role and its support to Member States.

Dr EVSEENKO (Russian Federation) endorsed the draft resolution. He paid tribute to WHO's leadership and the high priority given to the availability, safety and quality of blood and blood products and the importance of equitable access. In his country the main requirements were to increase the supply and to improve the management and rational use of blood and blood products. State coordination was based on a single policy of donation management. In 2008 the Ministry of Health and Social Development had launched a priority programme for blood donation that comprised technical restructuring of the blood transfusion services, the setting-up of a single database and the development of voluntary non-remunerated donations. Further positive developments would include the establishment of a federal programme of regional blood transfusion centres and a new factory for plasma fractionation.

Dr SHAUKAT (India), speaking on behalf of the Member States of the South-East Asia Region, observed that there was still no artificial substitute for human blood, in spite of the progress made in science and technology. Availability of blood was an important issue in the Region, where it was recognized that fear of and apathy towards donating blood had social and behavioural determinants. Those root causes were being tackled through community education and, with support from partners, voluntary blood donations were being encouraged. National blood programmes were being developed with community-based interventions. In the previous three years, all the Member States of the Region had celebrated World Blood Donor Day.

All donated units of blood in the Region were screened for HIV and hepatitis B markers. The focus had shifted from screening for transfusion-transmissible infections to ensuring that all units of blood would soon be screened to a high standard for pathogens of public health importance. The contribution of blood and blood products towards transmission of HIV and hepatitis B and C viruses had decreased substantially.

Notwithstanding the progress made, his Region had limited capacity to fractionate plasma. Support from WHO was required in order to obtain the technology and good manufacturing practices that were needed to build capacity; attain regional self-reliance; build human resources; establish services; strengthen regulatory mechanisms; and assure the quality of blood and blood products. The Secretariat should, as a matter of priority, develop and disseminate global standards for manufacturing plasma products. He supported the draft resolution.

Dr VIJJ KASEMSUP (Thailand) commended the report and welcomed the draft resolution. The national Red Cross Society coordinated blood donation and had collected more than 1.65 million packages of voluntary blood donations in 2009, most of which had been used separately as packed red cells and plasma. The excess plasma, around 500 000 packages, had been used to produce other important medical products such as human albumin, intravenous immunoglobulin, and Factors VIII and IX. The national Red Cross Society intended to preserve more plasma for that purpose. All blood and plasma packages were tested for syphilis, hepatitis B, hepatitis C and HIV. Nucleic acid amplification testing, a more refined and effective technique, was also applied to packages collected in

the capital, which accounted for one third of blood products collected. Questionnaires to all potential donors had further excluded high-risk groups from the pool of blood donors, and had contributed to the recorded falls in the numbers of infected packages.

He proposed that in subparagraph 1(2) of the draft resolution “national legislation” should be amended to read “national guidelines”.

Dr WERE (Kenya) welcomed the report and expressed his support for the draft resolution. In his country, blood policy guidelines had been issued in 2001, but the weak regulatory framework hindered effective implementation of the blood safety guidelines and shortages of appropriate technology led to wastage of blood and blood products.

World Blood Donor Day was celebrated in June each year. There were currently six regional and nine satellite centres in the country for blood donation. Blood screening for transfusion-transmissible infections was carried out routinely for markers of hepatitis B, hepatitis C, syphilis and infection with HIV-1 and HIV-2. Challenges remained, especially in mobilizing resources in order to sustain and scale up the gains achieved to date.

(For continuation of the discussion, see the summary record of the Committee at its eighth meeting, section 1.)

The meeting rose at 12:10.

FIFTH MEETING

Thursday, 20 May 2010, at 14:45

Chairman: Dr W. Jayantha (Sri Lanka)

STAFFING MATTERS: Item 17 of the Agenda (continued)

The election of the Director-General of the World Health Organization: Item 17.1 of the Agenda (Document A63/39) (continued from the third meeting)

The CHAIRMAN drew attention to a draft resolution on the subject proposed by a drafting group at the request of Committee B, which read:

The Sixty-third World Health Assembly,
Having considered the report by the Secretariat on the election of the Director-General of the World Health Organization,

AGREES IN PRINCIPLE that the Director-General should be appointed on the basis of rotation among the regions of the World Health Organization;

REAFFIRMS the criteria that the candidate nominated by the Executive Board for the post of Director-General should fulfil, adopted by the Executive Board in resolution EB97.R10;

REQUESTS the Executive Board to implement the agreement in principle referred to in paragraph 1 above and to amend its Rules of Procedure and to modify its current process for the nomination of the Director-General accordingly;

DECIDES that this resolution shall not apply to the incumbent Director-General;

REQUESTS the Executive Board to report on the actions taken to implement this resolution to the Sixty-fifth World Health Assembly.

Mr BURCI (Legal Counsel) explained that the draft resolution incorporated the elements discussed in informal consultations the previous day, in which several delegations had participated.

Mr BADR (Egypt) said that it was unacceptable that three WHO regions had never been represented in the highest office of WHO. The introduction of a system of regional rotation was a question of equity and followed the example of other United Nations bodies. He therefore urged all Member States to adopt the draft resolution by consensus.

Dr KUNBOUR (Ghana) suggested that paragraph 1 of the draft resolution be amended to read: "AGREES that the appointment of the WHO Director-General shall be by rotation among the Regions of the WHO". In paragraph 3 the words "in principle" should also be deleted since they left room for reservations or derogations. Consensus decision-making was emerging as a best practice and in that spirit his delegation and others had been prepared to retain paragraph 4. However, consensus required a semblance of equity: the regions concerned bore a greater share of the disease burden and that should be balanced by greater responsibility within WHO.

Mr OBAMA ASUE (Equatorial Guinea) expressed support for the statement by the delegate of Ghana. He would have preferred to amend paragraphs 4 and 5 to extend the principle of regional rotation to the incumbent Director-General.

Mr BLAIS (Canada) said that he would have preferred that informal consultations continued. However, since a draft resolution had been proposed, he suggested that some amendments might help to bridge the gap between the proponents of merit-based appointment and those of regional rotation. In his view, regional rotation was not necessarily more equitable than the present system, as it might rule out excellent candidates from other regions, including the African Region, when it was not their turn.

He therefore proposed that current paragraph 1 be reordered to follow current paragraph 2, in order to stress merit as the primary criterion, and that it be amended to read: "AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions". Paragraph 3 should be amended to read: "REQUESTS the 128th Executive Board to develop a proposal, with the support of the Secretariat, for consideration at the WHA64 to improve the election process for the position of Director-General with the view of strengthening the equitable consideration of qualified candidates for all regions".

Mr GWENIGALE (Liberia) said that the amendments proposed by the delegate of Canada simply returned the discussion to where it had ended at the Committee's third meeting. In that meeting, he had requested a roll-call vote, but it had been decided to wait until the Committee had a written text on which to vote. Since the draft resolution had been proposed, the Committee should vote on it.

Mr GARRIGUES (Spain), speaking on behalf of the Member States of the European Union, supported the amendments proposed by the delegate of Canada. The issue was complex and required further consideration. Personal and professional qualifications should be the prime consideration in the selection of the Director-General. He sympathized with the position of the African Region, but noted that the current Director-General had said that she would like to be judged on the Organization's work in Africa. He further noted that three international organizations were currently headed by Africans. Three regions had indeed yet to be represented in the post of WHO Director-General, but that did not mean that candidates should be excluded on the basis of their region. In any case, rotation and merit were not mutually exclusive. He suggested that the Executive Board should take up the issue at its 128th session in January 2011.

Ms LANTERI (Monaco) expressed support for the statement made by the delegate of Spain and endorsed the statement and amendments made by the delegate of Canada. The guiding principle for the selection of the Director-General must continue to be to ensure the highest level of technical expertise in the health field, irrespective of regional origin. She nevertheless understood the concerns of regions that had yet to be represented and would like to see the introduction of a mechanism that would enable more equitable representation of regions in elections to the post of Director-General.

Mr SEADAT (Islamic Republic of Iran) expressed support for the statements made by the delegates of Egypt and Ghana and for the draft resolution as amended by the delegate of Ghana. The criteria of regional rotation and qualifications were complementary, and could maximize both equity and efficiency. The amendments proposed by the delegate of Canada simply prolonged the decision-making process on the issue.

Mr SILBERSCHMIDT (Switzerland) expressed support for the statements made by the delegates of Canada and Spain. No other international organization had a strict rule of regional rotation, but that had not prevented two Africans from becoming Secretary-General of the United Nations. He asked the Legal Counsel to clarify whether paragraph 4 applied only to the current incumbent and what procedure would apply if the draft resolution was adopted, since the issue of

which region to start with could prove divisive. Furthermore, in the event of a separate vote on the amendments proposed to the resolution, he would like to put forward amendments of his own.

Mr BOJKOV (Bulgaria), expressing support for the statements made by the delegates of Canada and Monaco, said that the guiding principle in the election of the Director-General of WHO should be to ensure the professional qualifications and personal merits of the successful candidate. Geographical representation should not be a key factor.

Mr MCKERNAN (New Zealand), said that the rights of Member States to call a vote on agenda items at the Health Assembly should be respected; however, the current item should not be voted upon until all issues had been fully discussed. Steps should indeed be taken to ensure equity in the appointment of a Director-General, but the idea of regional rotation was complicated because regions varied in size, number and level of development of Member States, and in political alignment. Regional rotation would not therefore make the appointment process more equitable. In tackling significant and emerging global health challenges, the Director-General acted as the chief technical and administrative officer of the Organization, and as such needed the respect of all Member States and regions. He therefore supported the idea of equitable recruitment processes, but not through regional rotation. He agreed with the amendments proposed by the delegate of Canada.

Dr MÉSZÁROS (Hungary) said that the issue required further deliberation. He emphasized that the merit and the competency of the candidate were the most important criteria, and consequently automatic rotation was not the solution. It was important to improve the election process, with particular regard to equitable regional representation, and the proposals made by the delegate of Canada would form an appropriate basis for discussion.

Dr ALFAYEZ (Jordan), observed that in paragraph 1 of the draft resolution the translation into Arabic of “agrees in principle...” was incorrect. He emphasized the importance of geographical rotation. Since many competent people of various regions had in the past been ignored and earlier discussions on the issue disregarded, a vote had been requested.

Mr LINDGREN (Norway), expressed support for the statement made by the delegate of Switzerland. He noted that no other organization of the United Nations system required a resolution to govern the principle of equitable regional representation in the election of highest office. WHO should ensure equitable representation over time without the need to amend its basic statutes. He supported the draft resolution as amended by the delegate of Canada, as a basis for careful consideration.

Ms NYAGURA (Zimbabwe), agreeing with the comments made by the delegates of Egypt and Ghana, said that the professional skills required of a Director-General were not found only in regions with economic or political power. Therefore the African Region, supported by the Eastern Mediterranean Region, had put forward amendments to the draft resolution. The proposal by the delegate of Canada merely entrenched the current system. She supported the request for a vote on the draft resolution. The suggestion by the delegate of Spain to refer the matter to the Executive Board would further delay the issue.

Mr ADAM (Israel) said that the criteria for the election of a Director-General should relate only to the qualifications and merit of a candidate, and not to geographical distribution. WHO was one of the most complex and specialized organizations of the United Nations system; it should not be swayed by politics but should elect the best candidate for such a sensitive position. He therefore supported the proposal by the delegate of Canada and looked forward to consensus.

Dr RAMAPATLENG (Lesotho) expressed support for the statements calling for a vote. Three regions had been waiting for more than 50 years to elect a Director-General and possessed a considerable pool of personnel qualified for that role. She reiterated the need to vote on the issue.

Mr SCHARINGER (Germany) agreed with the proposal made by the delegate of Canada. The criteria of qualification and regional background were not mutually exclusive, but the issue was so important that time would be needed for adequate discussion of the draft resolution and the proposed amendments. He proposed that a drafting group should be established to produce a joint draft resolution for consideration at the seventh meeting.

Mr KAHUURE (Namibia) supported the draft resolution as amended by the delegate of Ghana, and agreed with the delegate of the Islamic Republic of Iran that further delay was unacceptable. He joined the call for a vote. That would clarify paragraph 1 of the draft resolution, and other related issues could be discussed at another time.

Mr HOHMAN (United States of America) agreed with other speakers that the most important criteria in the election of a Director-General should relate to the candidate's professional merit, and such a candidate could come from any region. He supported the proposal by the delegate of Canada, which would enable Member States fully to consider all aspects of the complex discussion.

Mr AL-GAHALI (Yemen) supported the comments made by the delegates of Egypt and Ghana, and said that, although the competency of the candidate must be ensured, geographical rotation was vital.

Mr JERE (Zambia) reiterated earlier calls for a vote on the principle of regional rotation.

Mr CASALS ALIS (Andorra), agreeing with the statements made by the delegates of Canada, Spain, Monaco and Switzerland, said that the position of Director-General should be open to all sufficiently qualified candidates. The proposal made by the delegate of Canada would enable further study of the issue by the Executive Board and the next Health Assembly.

Mrs GOY (Luxembourg), commended the work undertaken by current heads of organizations of the United Nations system who were from the African Region, and agreed with the principle of equal opportunities. However, concerns regarding geographical rotation had been adequately expressed by the delegate of Spain and others. Further consultations were required to reach consensus on a system to appoint a qualified Director-General. She therefore supported the proposals made by the delegates of Canada and Germany.

Dr GAYE (Gambia) expressed support for the comments of the delegates of Egypt and Ghana and emphasized the importance of geographical rotation. He asked what other criteria might determine eligibility for the post of Director-General.

Mr AL HIGAZI (Libyan Arab Jamahiriya), clarifying remarks that he had made at the previous meeting of the Committee, expressed appreciation of and respect for the positive role played by the current Director-General, who was making an excellent contribution to improving the health of all peoples worldwide. He wished to see the role of Director-General strengthened, and supported WHO in taking the global health agenda forward.

With regard to the election of the Director-General, he suggested that, in view of the significant difference of opinion between, on the one hand, the African, South-East Asia and Eastern Mediterranean regions and, on the other, the European Region, Canada, the United States of America and others, the two groups of Member States should take it in turns to nominate a candidate for the post from among themselves.

Mr PELLET (France) emphasized that the issue was of importance not only to WHO but all organizations in the United Nations system. Echoing the comments of the delegate of Spain, he emphasized the value of international diversity among high-ranking officials in international organizations. He understood the concerns of those that were in favour of a policy of geographical rotation in electing the Director-General and acknowledged that the electoral process could be improved, but said that such an important issue should not be hurried. The draft resolution should be the subject of constructive discussion, rather than rushed voting, and there was still time to work together to achieve consensus. To that end, he expressed support for the proposal by the delegate of Germany to establish a drafting group.

Dr AL-JALAHMA (Bahrain), expressing support for the position of the African, South-East Asia and Eastern Mediterranean regions, proposed that in paragraphs 1 and 3 the words “in principle” be deleted. The criteria of geographical rotation and professional competence were not incompatible, and she suggested that a vote should be taken to resolve the issue.

Mr BOUCHEDOUB (Algeria) expressed support for the comments of the delegates of Egypt and Ghana. Taking note of the draft resolution, he said that all regions should be represented equitably at the highest levels of the Organization through the application of the principle of geographical rotation, although due regard for competence must be maintained.

Mr PIRONEA (Romania), expressing support for the suggestion made by the delegate of Germany, emphasized the principles and practice of equity and diversity; nevertheless in the election of a Director-General, the prime consideration must remain the qualities and professional achievements of candidates. The widest possible pool of candidates should be sought in future elections in order to ensure the highest standards.

Mr SEILENTHAL (Estonia) said that the best candidate for the post of Director-General should not be rejected on the grounds of geographical origins. The Organization needed the most capable Director-General possible in order to confront the challenges of the global health agenda.

Ms TERSTAL (Netherlands) acknowledging the concerns of those calling for geographical rotation, said that WHO would be best served by having qualified candidates to lead the Organization and a fair system that ensured the best chance for candidates from all regions. However, a system based purely on the principle of rotation was not the solution and alternatives should be sought. She therefore supported the comments of the delegates of Canada and Spain and the proposal made by the delegates of Germany and France to establish a drafting group.

Dr SEAKGOSING (Botswana) supported the draft resolution, as amended by the delegate of Ghana. The principle of competence was important but should go hand in hand with equity and fairness, and the Director-General of WHO should therefore be elected in accordance with the principle of geographical rotation.

Ms KARAGULOVA (Kazakhstan) said that priority should be given to the professional and personal qualities of candidates for the post of Director-General. Every WHO region could field highly competent, professional candidates, and the best among them deserved to be elected, irrespective of origin. She supported the amendments proposed by the delegate of Canada.

Mr KHOKHER (Pakistan) said that the election of a competent Director-General did not contradict the principle of geographical rotation. The tenure of the current Director-General had clearly demonstrated that the developing world could provide excellent candidates to lead the Organization. He supported the draft resolution.

Professor LOUKOU (Côte d'Ivoire) said that due process had been observed with the submission of a draft resolution following the call for a roll-call vote made the previous day by the delegate of Liberia. If other Member States wished to call for a vote, they must follow the same procedure. The draft resolution should either be amended or voted upon forthwith.

Mr GWIAZDA (Poland) emphasized the pre-eminence of knowledge, skills and professional expertise in candidates for the post of Director-General, so that WHO could meet current and future health challenges effectively. He supported the amendments proposed by the delegate of Canada.

Dr KHADRA (Syrian Arab Republic) said that professional skills should not be the only criteria on which a Director-General was elected. It was also important that all WHO regions had the opportunity to be represented in that post. He called for a vote on the draft resolution, as amended by the delegate of Bahrain.

Dr KOMBA KONO (Sierra Leone) supported the draft resolution proposed by the delegates of Liberia and Cameroon, as amended by the delegate of Ghana, in the interests of ensuring equity in the election of the Organization's Director-General. He appealed to those that held other views to reconsider their stance and to enable consensus to be reached on the matter.

Mr HAZIM (Morocco) expressed support for the statements made by the delegates of Liberia, Egypt and the Libyan Arab Jamahiriya and called for a vote on the draft resolution.

Recognizing that many other important matters remained on the agenda, he maintained that the issue of the election of the Director-General deserved further discussion to a point where Member States could reach consensus. A candidate for the post of Director-General should have the appropriate professional competencies. However, suitable candidates were present in all regions and opportunities must be afforded to the three regions from which a Director-General had not been elected.

Dr SHONGWE (Swaziland), supporting the amendments proposed by the delegates of Bahrain, Egypt, Ghana and Liberia and other comments by Member States from the African and Eastern Mediterranean regions, called for a vote to be taken without further delay.

Dr STROHAL (Austria), noting that all Member States had agreed that the best possible candidate for the post of Director-General should be selected in an inclusive and equitable manner, said that the number of proposed amendments to the draft resolution made it clear that many questions remained. Those issues had been adequately addressed by the amendments proposed by the delegate of Canada and he expressed support for those. He also supported the proposal to suspend the debate and allow it to continue in another form that would facilitate the formulation of a text on which consensus could be reached.

He asked whether Rule 70 of the Rules of Procedure of the World Health Assembly would apply should a vote be called at that point. A decision of such importance should not be rushed.

Ms HANSSON (Finland) supported the amendments to the draft resolution proposed by the delegate of Canada. The Director-General must be able to lead countries through any unexpected public health emergencies and take responsibility for health security globally. She understood the concerns of regions yet to be represented at the level of Director-General, but maintained that candidates should always be elected on the basis of their qualifications and skills. Those skills were paramount and should remain the focus of the election process in future, despite any other improvements that might be made to that process and irrespective of the candidates' regions.

Dr TAKEI (Japan) agreed with the principles of fairness and equity and that consensus needed to be reached. To that end, he sought clarification on the future election system that was envisaged, particularly in respect of issues that included how often a region could expect to be eligible to

nominate a candidate; immigration; and changes in nationality. He supported the amendments to the draft resolution as proposed by the delegate of Canada.

Mr BURCI (Legal Counsel), responding to earlier questions by the delegate of Switzerland, explained that the language of paragraph 4 was intended to apply only to the current Director-General and not to any future incumbent.

In regard to the process adhered to when amendments were proposed to a draft resolution, the various WHO committees followed a range of practices. Amendments were sometimes discussed in drafting groups, whereas on other occasions they were decided upon on a case-by-case basis by the committee concerned. Where several amendments were proposed to the same draft resolution, Rule 65 of the Rules of Procedure of the World Health Assembly was applied. Attempts were often made to reconcile amendments, either on the floor or in a separate drafting group.

Mr SILBERSCHMIDT (Switzerland) asked what the position would be in the event of a conflict between a proposed amendment to the draft resolution and Rule 106 of the Rules of Procedure of the World Health Assembly.

Mr BURCI (Legal Counsel), replied that the intention of the draft resolution was to ensure that any decision by the Health Assembly would not apply to the current Director-General, particularly with respect to term of office. Should the text be found to conflict with Rule 106 in that regard, further discussion and consultation would take place.

Dr YOOSUF (Maldives) said that all implications of any decision made by Member States on the draft resolution could not yet be fully ascertained. He therefore was in favour of the draft resolution as amended by the delegate of Canada, which clarified the issues raised.

Mr VICENTI (Italy) echoed the support expressed by the delegate of Spain for the amendments proposed by the delegate of Canada. He emphasized that the focus on professional skills was not incompatible with regional rotation. With more time it would certainly be possible to reach consensus on an appropriate solution to the delicate and important issues raised.

Ms DAMIGOU (Greece) said that the election of the Director-General should be based on the qualifications and personal merits of candidates. She supported the suggestion put forward by the delegate of Germany to establish a drafting group to continue discussions and reach consensus on the draft resolution.

Dr ABAY (Eritrea) reiterated that the proposal for regional rotation could easily be incorporated in existing criteria on the skills and qualifications required for the position of Director-General, since all regions could put forward highly qualified candidates. The issue was how to ensure equity: election of candidates on the basis of personal and professional merit had not brought about the equity and fairness of regional representation that had been discussed at length. Regional rotation had therefore been proposed as a criterion.

The draft resolution had been formulated and Member States should discuss it, without proposing too many amendments, and then move to a vote. He urged Member States to avoid repetition of the discussions previously held on the matter and called for a vote without delay.

Dr GAYE (Gambia) said that the way to resolve contentious issues in any organization was to put the matter to the vote and called on Member States to do so.

Mr GALLAGHER (Ireland) said that, although he understood the concerns raised by many Member States on regional rotation, he attached great importance to the principles of professional

skills and merits in the election of a Director-General and the issue deserved further consideration. He supported the amendments proposed by the delegate of Canada.

Mr VALADAS DA SILVA (Portugal) supported the amendments to the draft resolution as proposed by the delegate of Canada. The election of the Director-General should be based on a candidate's qualifications and skills.

Dr AL-THANI (Qatar), noting that WHO had long adhered to the principle of fairness, particularly regarding regional representation, said that all regions should be given the opportunity to prove their competencies. The amendments proposed by the delegates of the African and Eastern Mediterranean regions further encouraged that principle of fairness. He called for a vote to be held.

Ms MICHAEL (Cyprus) supported the amendments proposed by the delegate of Canada and agreed with the proposal to establish a drafting group with the aim of producing a commonly agreed text for the draft resolution.

Dr DIAS VAN-DÚNEM (Angola) expressed support for the position of the delegates of Ghana and Egypt on regional rotation. Candidates for the post of Director-General must possess the requisite skills and competences, which were not exclusive to a particular region; three WHO regions had yet to be represented. He endorsed the suggestion by the delegate of Liberia to vote on the draft resolution.

Dr SUWIT WIBULPOLPRASERT (Thailand), agreeing in principle on the need for broader geographical representation, supported the proposal by the delegate of Canada to reverse the order of paragraphs 1 and 2 of the draft resolution so as to prioritize merit in the appointment of a new Director-General. He proposed that paragraph 1 be amended to read: "AGREES that each election of the Director-General will be first opened for candidates from those regions which have never had a Director-General before, or from three regions that have the lowest frequency of being a Director-General. If, through the first round of election, the Executive Board cannot select any candidate, then the current election processes would be applied. There will be no two consecutive Directors-General elected from the same region;".

Ms DENEFFE (Belgium), said that the concerns of Member States in the African Region about improved geographical representation could be met through further consideration of the amendments proposed by the delegate of Canada and others. She therefore endorsed the suggestion by the delegate of Germany to establish a drafting group and aim to secure a consensus the following day.

Mrs GIDLOW (Samoa), speaking on behalf of the Pacific island States, expressed support for maintaining the status quo, as noted in paragraph 8 of the report.

Dr MUSTAFA (Sudan), endorsing the comments by the delegate of Egypt, said that it would be fair to give every qualified candidate an equal opportunity to take up the post of Director-General, regardless of his or her region.

Mr LENNARTSSON (Sweden) said that the Director-General must be appointed on merit and competency in order to maintain the highest professional standards and preserve the legitimacy of the office and the Organization. The issue went to the heart of the governance of WHO and the entire United Nations system, and it must not be decided by a vote. Further consideration and consultation were needed; he supported the proposals by the delegates of Canada and Germany.

Dr MEMISH (Saudi Arabia) endorsed the comments by the delegates of Egypt, Ghana, the Libyan Arab Jamahiriya and Yemen, together with the amendment proposed by the delegate of

Bahrain. Candidates from every region should have a fair chance to be appointed Director-General, and the Committee should vote on the draft resolution.

Ms SOUŠKOVÁ (Czech Republic) said that she was in favour of diversity in the leadership of international organizations, and considered that merit and professional skills were the key criteria for election.

Dr KHOUILLA (Gabon) said that it was not too soon to proceed to a vote; that process was within WHO's rules and procedures and was the culmination of four years of effort. The democratic act of taking a vote, without undermining the original criteria, would provide the clarity required to allay the fears of delegates. The proposal by the delegate of Canada would remove the substance of the draft resolution.

Ms MATSAU (South Africa) said that the principle of regional rotation and the issue of the calibre and experience of candidates nominated to lead WHO were not mutually exclusive, and that suitable candidates could be drawn from all regions. That point was non-negotiable. She endorsed the amendments proposed by the delegate of Ghana and supported calls for moving to a vote. Those in favour of a vote had drafted the text and had come to the meeting prepared to move forward. Opponents were raising questions and prolonging the debate by what regrettably appeared to be delaying tactics. She requested clarification from the Legal Counsel in regard to the legal and procedural nature of the current process and where it would lead once all the speakers had taken the floor.

The CHAIRMAN said that five delegations remained on the list of speakers, which he closed with the agreement of the Committee.

Dr WIDYARTI (Indonesia) said that a candidate for the post of Director-General must have the personal and professional qualities to ensure that the Organization achieved its objectives and responded to global health challenges. WHO's legitimacy relied on geographical representation reflected not only in its membership but also in its leadership, and suitable candidates could be found in all the regions. Modernization should include the mechanism for election of the Director-General; the draft resolution, with the amendments by the delegate of Ghana, and emphasis on regional rotation, would provide strong, democratic and non-discriminatory foundations for that purpose.

Dr SALEHI (Afghanistan) strongly supported the call for a vote.

Dr BUSUTTIL (Malta) said that, although he agreed with the principle that the leadership of WHO should be open to candidates that represented every region, a Director-General must above all meet the criteria adopted by the Executive Board. Regional rotation might secure the choice of the best candidate from a particular region, but not necessarily the best candidate at the global level; and WHO was a global organization. Furthermore, the implications of that principle for the Organization had not been adequately examined. A quick decision might not be in WHO's best interests. He supported the amendments proposed by the delegate of Canada and the proposal to establish a drafting group.

Ms KITSELL (United Kingdom of Great Britain and Northern Ireland) said that everybody agreed on the need to nominate the best possible candidates to lead the Organization, regardless of their place of origin. Regional rotation, however, would not increase fairness; it would create divisions and politicize a technical agency whose Members were accustomed to working together until they reached agreement by consensus. She supported transparent, fair and merit-based recruitment for all posts at WHO, and would warmly welcome a Director-General from a region not previously represented in that post. But it was worrying that where the Director-General came from might make a difference, and the idea that they might give undue preference to the interests of their home region,

subregion or country was clearly unacceptable. The Director-General must serve the entire Organization, and confrontation on the matter was not the way forward. It would take far too long for the Committee to consider and vote on each of the many competing proposals, and would require considered legal advice. She therefore supported the compromise text proposed by the delegate of Canada, and agreed with the delegate of Luxembourg that the Committee should continue to work towards a consensus. She therefore supported the proposal to establish a drafting group.

Ms ESCOREL DE MORAES (Brazil) said that the draft resolution maintained the principal criterion of merit for the election of the Director-General. Regional rotation was under consideration, however, and flexibility would be required to ensure that the best-qualified candidate was elected, in keeping with the practice in other organizations in the United Nations system. Brazil had always supported candidates from the African countries who stood for election in different forums, including WHO, and would continue to do so. In the current situation, and since mandatory rotation was not a tradition in the multilateral system, a formula whereby the incoming Director-General should not be from the same region as the outgoing incumbent might be acceptable to the Committee. That would provide the diversity that the draft resolution was seeking without distancing the Organization from customary United Nations practice.

Mr BURCI (Legal Counsel) recalled that in its third meeting the Committee had agreed that a text on which the Committee could adopt a position would be preferable. That had led to the drafting of a text, which had then been considered by the Committee as a whole, and the delegates of Bahrain, Canada, Ghana and Thailand had submitted amendments. It was unclear whether the statement made by the delegate of Brazil constituted a proposed amendment or a statement of principle for further reflection.

A debate had ensued, during which Member States had expressed their positions. The situation facing the Committee was that the delegates of Bahrain, Canada, Ghana and Thailand had proposed amendments to the first operative paragraph of the draft resolution. The delegate of Canada had proposed that paragraph 2 should become paragraph 1, and both he and the delegate of Ghana had further proposed amendments to paragraph 3. The delegate of Germany had proposed postponement of further discussion of the item until the seventh meeting and that a drafting group should be set up to reconcile possible positions; that proposal was supported by several other delegates. The Committee could therefore decide either to take immediate action on the draft resolution or to postpone a decision until its next meeting. Should it decide on immediate action, a revised text of the draft resolution containing the proposed amendments could be prepared in accordance with standard practice. Alternatively, the Committee could decide to take an immediate vote on the matter, in which case the amendments would have to be voted on in a particular order beginning with that furthest removed in substance from the original proposal. A third option would be for delegates to withdraw some of their proposed amendments until only one was left for each paragraph.

Mr GWENIGALE (Liberia) recalled that following the tragic death of the Director-General, Dr Lee, it had been discovered that the late Director-General had appointed a successor who was not the best-qualified member of the Organization. That had convinced Member States of the need for action. The matter had been under discussion for four years, with debates in five out of the six regional committees. He suggested that the Committee should vote for the proposed amendments; no common position would be possible as some Member States would continue to use delaying tactics.

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that, despite the Legal Counsel's explanation, the situation remained unclear. The proposal by the delegate of Canada to change the order of paragraphs 1 and 2 was acceptable so long as the substance of paragraph 1 remained unchanged. Postponement of the discussion was not a viable option and consensus seemed improbable and therefore the only solution was to put the matter to the vote.

Mr BURCI (Legal Counsel) said that many Member States had spoken in favour of taking an immediate vote on the proposed amendments to the draft resolution. Once that had been completed, the Committee would then either have to vote on the original text should no amendments be agreed or on the draft resolution as amended.

Mr LORENZO DOMINGUEZ (Mexico), rising to a point of order, said that the Committee would need to see the latest proposed amendments in writing before deciding on a course of action. The suggestion made by the delegate of Germany, to postpone any further discussion until a text had been drafted on which the Committee could agree, should be considered. If that draft text failed to generate a consensus, the Committee could then proceed to a vote.

Mr HOHMAN (United States of America), rising to a point of order, noted that the delegate of Liberia had requested a recorded vote and asked whether each amendment would be voted on in the same way.

Mr BURCI (Legal Counsel) said that the delegate of Liberia had asked for a roll-call vote on the principle of geographical rotation. In his view, however, the draft resolution constituted a new proposal and would therefore be voted on by a show of hands, unless a roll-call vote was requested.

Replying to a point of order raised by Mr HOHMAN (United States of America) on whether a proposal that had been voted on by a show of hands could then be submitted to a roll-call vote, Mr BURCI (Legal Counsel) said that the same proposal could not be voted on twice. That would not, however, prevent the Committee from deciding on a different voting method for other amendments or a final vote on the proposal.

Dr KUNBOUR (Ghana), rising to a point of order, said that several assumptions were being made and the Committee was inventing differences where none existed. Nothing in the amendment proposed by the delegate of Canada contradicted the principle of rotation. It merely stated that any appointment should be based on competence. Therefore, in reality, there was no difference of substance between the two amendments. Nor were rotation and competence mutually exclusive.

However, there was a difference between a principle and mechanics. The Committee was debating the mechanics of appointing competent candidates, whereas the motion was asking for a principle to be accepted. Furthermore, questions had been raised about the threat posed by regional blocks to WHO's global position. However, the fact that consultations were conducted regionally was a direct result of the Organization's involvement with regional blocks. The opposing views expressed were, he suspected, the result of an imperfect understanding of what constituted a substantive amendment. Many of the differences could be eliminated following a clear ruling from the Legal Counsel.

The meeting rose at 17:05.

SIXTH MEETING

Thursday, 20 May 2010, at 18:00

Chairman: Dr W. JAYANTHA (Sri Lanka)

STAFFING MATTERS: Item 17 of the Agenda (continued)

The election of the Director-General of the World Health Organization: Item 17.1 of the Agenda (Document A63/39) (continued)

The CHAIRMAN asked whether consensus had been reached in informal discussions since the previous meeting.

Mr GWENIGALE (Liberia) replied that opinion among delegates was still divided. He therefore asked for a recorded vote.

Dr AL-JALAHMA (Bahrain) said that, following agreement reached among the Member States of the Eastern Mediterranean Region, she wished to withdraw the proposed amendment to paragraph 1. She supported the amendment to paragraph 3 proposed by the delegate of Ghana.

The CHAIRMAN said that, in the absence of a consensus, the Committee would proceed to a vote.

Mr GARRIGUES (Spain), rising on a point of order, asked whether he understood correctly the options before the Committee: to take immediate action, even though that would set a poor precedent, as ideally the Committee should seek a consensual solution; or to establish a drafting group that would try to reach such a conclusion. The Committee might wish to consider the second option.

Mr BURCI (Legal Counsel) recalled that the delegate of Germany, supported by other delegates, had proposed that the item should be suspended until the Committee's seventh meeting to allow a specially convened drafting group to produce a consensual text. According to the Rules of Procedure, the two proposals would be voted on in the order in which they had been made, namely, the draft resolution followed by the proposal to postpone debate and establish a drafting group.

Dr KUNBOUR (Ghana), rising on a point of order, said that it was not clear to which paragraphs the two amendments proposed by the delegate of Canada referred.

Mr HOHMAN (United States of America), seeking clarification, said that there appeared to be some confusion: as he understood it, if the Committee were to vote on each of the proposed amendments to the draft resolution, there would be eight consecutive votes. That process could take a considerable amount of time.

Dr MOHAMED (Oman), rising on a point of order, requested clarification on the order in which the draft resolution and proposed amendments would be voted on.

Mr BURCI (Legal Counsel) explained that when there were several amendments to a proposal, the rule was to vote first on the amendment furthest removed from the substance of the original

proposal. In the present case, amendments to paragraph 1 of the draft resolution were mutually exclusive, meaning that if one were adopted the others would be automatically eliminated. Hence, there could be a minimum of three votes: on the amendments to paragraph 1, on the amendments to paragraph 3, and on the proposal as a whole incorporating the relevant amendments.

Mr SILBERSCHMIDT (Switzerland) asked whether, in accordance with Rule 62(c) of the Rules of Procedure, the proposal of the delegate of Germany would take precedence over the other proposals, and, secondly, whether, in practice, there could be as many as eight votes as the delegate of the United States had suggested.

Mr BURCI (Legal Counsel) said that a motion to adjourn a meeting under Rule 59 of the Rules of Procedure had to be an unqualified motion. However, the delegate of Germany had proposed that consideration of the item should be postponed, a drafting group established and its findings considered by the Committee at its seventh meeting. Therefore, the proposal was not unqualified, and, in his view, constituted a separate proposal and should be voted on after the original proposal. In practice, there could be as many as eight votes if all the amendments were rejected.

Mr AL HIGAZI (Libyan Arab Jamahiriya), rising on a point of order, expressed concern that the matter was not being treated with the seriousness it deserved. Some of the proposed amendments were contradictory and it was hard to see how they could be reconciled in the manner suggested by the Legal Counsel. Therefore, the only satisfactory solution would be for the Committee to vote on the original text of the draft resolution without further delay.

The CHAIRMAN replied that the Legal Counsel's explanation had referred to the procedure to be followed when voting on amendments to a proposal. The Secretariat had followed that procedure with regard to the order in which the amendments proposed by the delegates of Canada, Ghana and Thailand should be taken.

Mr GWENIGALE (Liberia) asked whether it would be possible to have a preliminary vote on the individual amendments by means of a show of hands. Agreed amendments could then be incorporated into a final text on which a recorded vote could be taken.

Dr SUWIT WIBULPOLPRASERT (Thailand) asked what would happen if the Committee were to proceed to a vote under Rule 60 to adjourn the current discussion.

Mr BURCI (Legal Counsel) explained that a vote in favour of adjournment of the debate under Rule 60 would terminate further consideration of the item.

Mr GARRIGUES (Spain), rising on a point of order, said that, with regret, he did not agree with the Legal Counsel's interpretation of Rule 62 since there had been no intention on his part to terminate the debate, merely to suspend it in order to allow more time to reach consensus. If his concerns were to be ignored and the Committee were to decide to take immediate action, the European Union would be forced to request an adjournment in order to consider fully the amendments which had only just been made available in written form.

Mr SILBERSCHMIDT (Switzerland), rising on a point of order, said that he had understood that the intention of the delegate of Thailand was to invoke Rule 60 in order to allow the Committee to make use of the interpreters to discuss other issues. He wondered whether a vote under Rule 59 would allow the Committee temporarily to suspend the current discussion.

Mr BURCI (Legal Counsel) said that Rule 59 applied specifically to meetings and allowed for their suspension or adjournment. Suspension meant that a meeting would be resumed, whereas adjournment meant it would be terminated forthwith. Replying to the delegate of Spain, he explained

that a motion under Rule 59 to suspend or adjourn the meeting would take precedence over a vote on the proposal and would have to be put to the Committee immediately. In the absence of any opposition, it could be adopted without a vote. Otherwise it would have to be put to the vote.

In response to a request from the CHAIRMAN that the delegate of Spain should clarify his position, Mr GARRIGUES (Spain) moved that the meeting be suspended in order to allow his delegation time to consider the amendments and to decide on how it should vote.

Dr KUNBOUR (Ghana), rising on a point of order, questioned the value of suspending the meeting to allow further consideration of the amendments, which had already been carefully considered by the Committee.

The CHAIRMAN invited the Committee to vote on the motion to suspend the meeting for 30 minutes.

Mr GWENIGALE (Liberia) supported the motion.

Mr HOHMAN (United States of America), rising on a point of order, questioned the sense in the Committee spending 45 minutes voting on whether to suspend the meeting for 30 minutes.

Dr KUNBOUR (Ghana), rising on a point of order, asked whether, under the Rules of Procedure, it would be possible for a counter motion to be proposed while the original motion was still pending.

The CHAIRMAN having deemed such a course of action acceptable, Dr KUNBOUR (Ghana) moved that the meeting should not be suspended for 30 minutes.

Dr SUWIT WIBULPOLPRASERT (Thailand) pointed out that, in accordance with Rule 59 of the Rules of Procedure, when a delegate moved the suspension of the meeting, such a motion "shall not be debated but shall immediately be put to the vote". Therefore, the motion should be put to the vote without further debate.

The CHAIRMAN recalled that the delegate of Spain had moved that the meeting should be suspended for 30 minutes and invited the Committee to proceed to a vote by show of hands.

At the invitation of the CHAIRMAN, Mr BURCI (Legal Counsel) explained the modalities for voting by show of hands. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution were: Central African Republic, Comoros, Guinea-Bissau, Palau, Somalia, Tajikistan and Turkmenistan.

The proposal to suspend the meeting for 30 minutes was approved by 61 to 57, with 8 abstentions.

The meeting was suspended at 19:30 and resumed at 20:00.

The CHAIRMAN said that the Committee would vote on the amendments proposed to the draft resolution individually, and then on the draft resolution as a whole. He requested the Secretary to read the proposed amendments.

Dr ONDARI (Secretary) said that, in total, eight amendments had been proposed, of which one, proposed by the delegate of Bahrain to paragraph 1, had subsequently been withdrawn. One general textual proposal had been made.

In order of submission, the delegate of Canada had proposed that paragraph 1 should be amended to read: "REAFFIRMS the criteria that a candidate nominated by the Executive Board for the post of Director-General should fulfil, as adopted by the Executive Board in resolution EB97.R10"; the delegate of Ghana had proposed that paragraph 1 be altered to read: "AGREES that the appointment of the WHO Director-General shall be by rotation among the regions of the World Health Organization"; and the delegate of Thailand had proposed the following wording: "AGREES that each election of the Director-General will be first opened for candidates from those regions which have never had a Director-General before, or from three regions that have the lowest frequency of being a Director-General. If, through the first round of election, the Executive Board cannot select any candidate, then the current election processes would be applied. There will be no two consecutive Directors-General elected from the same region."

Two amendments had been proposed to paragraph 2. The delegate of Canada had proposed that it be amended to read: "AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions"; the delegate of Thailand had suggested that paragraph 2 should become paragraph 1.

Three amendments had been proposed to paragraph 3. The delegate of Canada had proposed that it be amended to read: "Requests the 128th Executive Board to develop a proposal, with the support of the Secretariat, for consideration at WHA64 to improve the election process for the position of Director-General, with the view of strengthening the equitable consideration of qualified candidates for all regions." The second proposed amendment reflected two separate proposals put forward by the delegates of Bahrain and Ghana, and the paragraph would be altered to read: "REQUESTS the Executive Board to implement the agreement referred to in paragraph 1 above and to amend its Rules of Procedure and to modify its current process for the nomination of the Director-General accordingly."

No amendments to paragraphs 4 or 5 had been proposed. The delegate of Brazil had proposed the following text for incorporation in the draft resolution where it was considered most appropriate: "The incoming Director-General should not be from the region of the outgoing Director-General."

Professor LOUKOU (Côte d'Ivoire) said that the amendment proposed to paragraph 1 by the delegate of Canada, which essentially sought to replace paragraph 1 with paragraph 2, should be considered as an amendment to paragraph 2. He requested the delegate of Thailand to withdraw his proposal to amend paragraph 1, as it dealt solely with procedural matters that should be examined at a later date by the Executive Board.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) declined to withdraw his proposed amendment.

Mr BLAIS (Canada) echoed the remarks of the delegate of Côte d'Ivoire regarding the order in which the proposed amendments should be considered. He wished paragraph 1 to be amended to read: "AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions." His proposals to amend the text and to change the order of paragraphs 1 and 2 should be considered as separate issues.

Mr ABOUBAKER (Djibouti) sought clarification from the Legal Counsel about the criteria for eligibility for amendments. The draft resolution concerned the acceptance of the principle of rotation in the election of the Director-General, not how principles should be applied. Any amendments relating to procedure should be withdrawn.

Dr KHOUILLA (Gabon) supported the statement by the delegate of Djibouti. He was surprised at the direction that the Committee's deliberations were taking and at the time being wasted on procedural matters. The Committee should focus instead on the fundamental principle of introducing rotation into the process of electing the Organization's Director-General. To that end, he suggested that a vote should be taken on the original text of the draft resolution.

Mr BURCI (Legal Counsel) clarified that three amendments had been proposed to the substance of paragraph 1. The delegate of Ghana had proposed that it be amended to read: "AGREES that the appointment of the WHO Director-General shall be by rotation among the regions of the World Health Organization." The delegate of Thailand had proposed that it should read: "AGREES that each election of the Director-General will be first opened for candidates from those regions which have never had a Director-General before, or from three regions that have the lowest frequency of being a Director-General. If, through the first round of election, the Executive Board cannot select any candidate, then the current election processes would be applied. There will be no two consecutive Directors-General elected from the same region." The delegate of Canada had proposed the following wording: "AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions." The proposal by the delegate of Canada to reorder paragraphs 1 and 2 did not affect their substance and could be dealt with after the substantial amendments had been considered.

In terms of voting procedure, the Chairman must rule on the order in which the amendments should be taken up. The amendment most removed from the substance of the original text should be considered first.

The CHAIRMAN ruled that the amendment proposed by the delegate of Canada should be taken up first, followed by the amendment by the delegate of Thailand and then the amendment by the delegate of Ghana.

Mr HAGE CARMO (Brazil) explained that the text he had suggested for inclusion in the draft resolution had been intended as a possible means of reaching consensus, rather than as a formal amendment.

Mr BOUCHEDOUB (Algeria) asked the Legal Counsel whether it would be possible to adopt the suggestion of the delegate of Gabon to vote on the draft resolution in its original form.

Mr BURCI (Legal Counsel) replied that to do so would constitute a breach of Rule 65 of the Rules of Procedure. Any amendments proposed must be voted on before the draft resolution as a whole could be considered. The Rules of Procedure should be followed in order to ensure the legitimacy and integrity of any decision taken.

The CHAIRMAN suggested that the three amendments to paragraphs should be voted on by a show of hands, in the order he had previously suggested.

Mr BURCI (Legal Counsel) clarified that, as the three amendments were mutually exclusive, the adoption of one would automatically preclude the need to vote on the others.

Mr HOHMAN (United States of America) requested further clarification regarding the various amendments proposed by the delegate of Canada, which included both textual amendments and proposals to change the order of certain paragraphs.

Dr ONDARI (Secretary), referring to the earlier statement by the delegate of Canada, said that the first amendment to be considered was to change paragraph 1 to read: "AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions." The issue of whether to change the order of the paragraphs 1 and 2 would be considered separately.

Mr GWENIGALE (Liberia) requested that, in order to avoid confusion, the text of each amendment should be read out before the vote.

The CHAIRMAN invited the Committee to vote by show of hands on the amendment to paragraph 1 proposed by the delegate of Canada, which read: “AGREES that the election of the Director-General needs to be conducted in a manner that is equitable and promotes candidacies from all regions.”

The proposal was rejected by 59 votes to 57, with 5 abstentions.

The CHAIRMAN invited the Committee to vote by show of hands on the amendment to paragraph 1 proposed by the delegate of Thailand, which read: “AGREES that each election of the Director-General will be first opened for candidates from those regions which have never had a Director-General before, or from three regions that have the lowest frequency of being a Director-General. If, through the first round of election, the Executive Board cannot select any candidate, then the current election processes would be applied. There will be no two consecutive Directors-General elected from the same region.”

The proposal was rejected by 93 votes to 3, with 14 abstentions.

The CHAIRMAN invited the Committee to vote by show of hands on the amendment to paragraph 1 proposed by the delegate of Ghana, which read: “AGREES that the appointment of the WHO Director-General shall be by rotation among the regions of the World Health Organization.”

The proposal was adopted by 58 votes to 56, with 5 abstentions.

Mr BURCI (Legal Counsel) confirmed that paragraph 1 would be replaced by the text proposed by the delegate of Ghana.

The CHAIRMAN invited the Committee to vote on the amendment proposed to paragraph 3 by the delegate of Canada, which read: “REQUESTS the 128th Executive Board to develop a proposal, with the support of the Secretariat, for consideration at WHA64 to improve the election process for the position of Director-General, with a view to strengthening the equitable consideration of qualified candidates for all regions.”

The proposal was adopted by 60 votes to 59, with 4 abstentions.

Mr BURCI (Legal Counsel) confirmed that paragraph 3 would be replaced by the text proposed by the delegate of Canada. The next step was to vote on the draft resolution as a whole, as amended.

Mr GWENIGALE (Liberia) said that he had tried to intervene to raise a point of order. The amendment to paragraph 3 was inconsistent with the amendment to paragraph 1 previously adopted: the former approved the principle of rotation, while the latter referred to “qualified candidates for all regions”. In view of that inconsistency, the amendment to paragraph 3 should not have been put to the vote. He asked the Legal Counsel how the two amendments adopted could be reconciled.

Mr HOHMAN (United States of America), rising to a point of order, requested that the vote on the draft resolution as a whole, as amended, be by secret ballot, in accordance with Rule 76 of the Rules of Procedure.

Dr KUNBOUR (Ghana), endorsing the statement by the delegate of Liberia, drew attention to the difference between substantive and procedural amendments. The amendment to paragraph 1, establishing the principle of rotation, was substantive. Any subsequent procedural amendments concerning the application of that principle should only be considered if they were compatible with the substantive provision they sought to implement. Treating the amendment to paragraph 3 as substantive

had resulted in the approval of two incompatible amendments, thereby creating a complex legal problem that would be difficult to solve.

Mr ABOUBAKER (Djibouti) supported the comments of the delegate of Liberia. Under Rule 65 of the Rules of Procedure, where the adoption of one amendment necessarily implied the rejection of another amendment, the latter amendment should not be put to the vote. The principle of rotation adopted by amending paragraph 1 implied the rejection of the amendment to paragraph 3. No vote should therefore have been taken on the amendment to paragraph 3 proposed by the delegate of Canada.

Mr BURCI (Legal Counsel) recalled that the approach suggested by the Chairman and accepted by the Committee had been to vote separately on the various amendments to each paragraph. It was for the Committee to decide whether the two amendments were incompatible, but any concern in that regard should have been raised before the voting procedure had been established. Once the Committee had accepted the voting sequence, it had to be followed.

Dr KUNBOUR (Ghana), rising to a point of order, expressed the view that the Committee was not responsible for inconsistencies in the positions of individual delegations. Once the principle of rotation had been adopted, any procedural provisions must conform to that principle. As the amendment by the delegate of Canada was not compatible with that principle, the Legal Counsel should have advised that it be set aside, and that the amendment reflecting the proposals of the delegates of Bahrain and Ghana, which was compatible with the principle of rotation, be taken up instead. Furthermore, before voting, several speakers had requested clarification from the Legal Counsel concerning exactly which amendments were to be put to the vote; the argument put forward that the issue should have been raised sooner was therefore not valid.

Mr OBAMA ASUE (Equatorial Guinea) said that, regardless of any legal arguments, logic dictated that the two amendments were incompatible. The fundamental principle of rotation had been adopted and could not be revoked by the proposal to amend paragraph 3.

Mr PINO ALVAREZ (Cuba) supported the views of the delegates of Ghana and other African Member States. The incompatibility between the two amended paragraphs must be resolved in order to ensure that the draft resolution, if adopted, could be implemented. Speaking on a point of order, he requested that the vote on the amendment to paragraph 3 be annulled, by virtue of Rule 65 of the Rules of Procedure.

Dr MALEFHO (Botswana) said that the Chairman appeared to have committed a procedural error, under the provision of Rule 65 cited by the delegate of Djibouti, and he requested that the mistake be rectified.

Professor LOUKOU (Cote d'Ivoire) associated himself with all those who had emphasized that the purpose of the vote had been to decide on the principle of rotation.

Mr GWENIGALE (Liberia) recalled that he had attempted to rise to a point of order – invoking the same provision of Rule 65 mentioned by the delegates of Djibouti, Botswana and Ghana – before the vote on paragraph 3 had been taken. Action then would have avoided the situation in which the Committee found itself.

Mr BLAIS (Canada) suggested that the Committee should vote by secret ballot on whether to revert to the original text of paragraph 3.

Dr KUNBOUR (Ghana), stressing the need to respect established rules, said that the fundamental issue before the Committee was whether a breach of Rule 65 had occurred, in which case

the adoption of the proposal to amend paragraph 3 should be rescinded. If breaches of procedural rules were allowed to occur, violations of substantive laws might become more likely. He asked the Legal Counsel whether Rule 65 had been breached.

Mr ABOUBAKER (Djibouti) recalled that he had attempted to intervene to ask for the vote on paragraph 3 to be halted, but without success. In the present case, there was a certain legal hierarchy to be preserved: in the event of a conflict between the Rules of Procedure and the question of consensus, then the Rules should take precedence.

Dr AL-THANI (Qatar) said that, in view of the confusion over whether the two amendments were compatible, the Legal Counsel should clarify how the Rules of Procedure should be applied and the vote should be taken again if necessary. It was to be hoped, however, that the two amendments would be ruled to be compatible, with the amendment to paragraph 3 being understood to give the Executive Board the opportunity to improve the election process. He requested the Legal Counsel to shed light on the issue and to suggest a course of action that would avoid a vote by secret ballot.

Mr BLAIS (Canada) observed that the procedure followed thus far had been irregular in several respects; for instance, proposals had been put to the vote before the two-day period stipulated in Rule 50 had elapsed. An important issue was being decided by fewer than one third of Member States. Despite the provision of Rule 68 that a proposal that had been accepted or rejected could not be reconsidered at the same session of the Health Assembly, he reiterated his suggestion to vote by secret ballot on whether to revert to the original text of paragraph 3, given that usual procedures seemed to be in abeyance.

Dr KUNBOUR (Ghana), rising to a point of order, expressed the view that it was inappropriate for the delegate of Canada to suggest reconsideration of a proposal on which he had not abstained from voting previously. Although Rule 68 stipulated that proposals adopted or rejected could not be reconsidered at the same session of the Health Assembly, exceptions could be made if procedural errors had occurred. It was essential to act in accordance with the basic tenets of legal procedure. The simplest and soundest way of resolving the complex legal problem that had arisen was to establish definitively whether there had been any breach of Rule 65. The issue of accommodating the aims of the amendment to paragraph 3 proposed by the delegate of Canada could be addressed once the legal position was clear.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), expressing concern at the situation, asked the Legal Counsel whether any other organization within the United Nations system used the principle of rotation in electing its leaders. Invoking Rule 59 of the Rules of Procedure, he moved to adjourn the meeting.

The CHAIRMAN asked the Committee whether it supported the motion to adjourn.

Mr GWENIGALE (Liberia) urged the Committee to continue its business. He requested the Legal Counsel to answer the outstanding questions put to him.

Mr BURCI (Legal Counsel), expressing regret at the procedural complications that had arisen, said that he would not knowingly have advised the Chairman to pursue a course of action that breached the Rules of Procedure. Whether Rule 65 had been breached by putting two incompatible amendments to the vote must finally be a decision for the Committee. Over the years, Rule 65 had been applied in various ways; in principle, as long as it was possible to reconcile the two amendments in question, there was no apparent breach of the Rule. The delegate of Ghana had made an important statement in this regard: the amendment to paragraph 3 would have to be applied in the light of the principle of rotation adopted in paragraph 1. It was certainly the case that no action could be taken under other provisions of the draft resolution that would contradict the principle of rotation.

Mr HOHMAN (United States of America) said that debate should have ceased immediately after the delegate of Thailand had moved to adjourn the meeting. The essence of the amendment to paragraph 3 was to request that the Executive Board should develop a proposal for consideration by the Health Assembly, rather than implementing the principle of rotation and amending its Rules of Procedure accordingly. The amendments to paragraphs 1 and 3 were not irreconcilable. Many speakers had taken the phrase “candidates for all regions” to be incompatible with the principle of rotation. If, however, one considered that the election process would apply to candidates for all regions sequentially, in a manner to be decided by the Board and the Health Assembly, then the two provisions could be reconciled.

The CHAIRMAN asked the delegate of Thailand whether he still wished to adjourn the meeting.

Dr GAD (Egypt), rising on a point of order, questioned why, given that the delegate of the United States had drawn attention to the similarity between the amendment to paragraph 3 proposed by the delegate of Canada and the original text, that amendment had been the first to be put to the vote. If the other proposed amendment had differed more substantially from the original formulation, it should have been considered first.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) confirmed his earlier motion to adjourn the meeting.

The CHAIRMAN asked whether the Committee agreed to adjourn the meeting.

Mr AL HIGAZI (Libyan Arab Jamahiriya) expressed support for the motion to adjourn the meeting, which would give the Legal Counsel time to reflect on the Rules of Procedure of the World Health Assembly. The Committee should not have been placed in its current position. When the debate resumed, full clarification on all issues should be provided.

Mr GWENIGALE (Liberia), expressing satisfaction at the progress made thus far, said that his delegation would continue to press its arguments in the Committee’s further deliberations of the issue.

Dr SEAKGOSING (Botswana) asked whether it was procedurally correct to adjourn a meeting in the middle of a vote. He asked whether the Committee could vote on a proposal by secret ballot, as had been suggested.

Mr BURCI (Legal Counsel) confirmed that voting by secret ballot was provided for under Rule 76 of the Rules of Procedure. With regard to adjourning the meeting during a vote, previous practice had been to consider such adjournments compatible with the Rules of Procedure if voting had reached a stage where it could be interrupted without disruption, as in the present instance. The final decision must rest with the Committee.

The CHAIRMAN took it that the Committee agreed to adjourn its meeting, in view of the fact that no further interpretation was available and in accordance with Rule 59 of the Rules of Procedure of the World Health Assembly.

It was so agreed.

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

The meeting rose at 22:15.

SEVENTH MEETING

Friday, 21 May 2010, at 10:00

Chairman: Dr W. JAYANTHA (Sri Lanka)

1. **FIRST REPORT OF COMMITTEE B:** (Document A63/62)

Dr SANNE (Norway), Rapporteur, read out the draft first report of Committee B.

Mr CHAUDHRY (India) drew attention to the draft resolution under agenda item 18.1 on partnerships. Since his delegation had not been afforded the opportunity to give its point of view on the resolution, he urged consideration of two suggestions: (1) to create a public registry of all partnerships and collaborative arrangements in which WHO was engaged, and (2), in addition to the reporting requirements currently in the resolution, the Director-General should further be requested to provide periodic updates to the Executive Board and the Health Assembly on the list of partnerships and collaborative arrangements, the financial impact on WHO of such partnerships and collaborative arrangements, and any specific and relevant conflict of interest issues.

He urged that the two points should be incorporated in the resolution, the policy guidelines being modified accordingly.

The CHAIRMAN informed the delegate of India that the item had been closed and could not be opened again for debate. However, the observations made would be attached to the report that would be submitted to the plenary.

The report was adopted.¹

2. **STAFFING MATTERS:** Item 17 of the Agenda (continued)

The election of the Director-General of the World Health Organization: Item 17.1 of the Agenda (Document A63/39) (continued from the sixth meeting)

The CHAIRMAN recalled that the proposed amendments to the draft resolution on the election of the Director-General of the World Health Organization had been voted on by a show of hands at the sixth meeting of Committee B. Noting that informal discussions had taken place since that meeting, he asked whether any progress had been made.

Mr BLAIS (Canada) said that the informal discussion had led him to propose a friendly amendment to amended paragraph 3 of the draft resolution. He proposed that in paragraph 3 the words “for all regions” be deleted and thus make the text more logical and provide a way forward.

The CHAIRMAN asked whether the proposal was acceptable and whether it was possible to proceed to a vote.

¹ See page 323.

Dr SUWIT WIBULPOLPRASERT (Thailand) asked the Legal Counsel what procedure should be followed in order to reconsider an issue that had been voted on, and which rule of the Rules of Procedure would be applied.

Mr AL HIGAZI (Libyan Arab Jamahiriya), speaking on behalf of the Member States of the Eastern Mediterranean and African regions and supported by Dr KUNBOUR (Ghana), said that he was in favour of the amendment proposed by the delegate of Canada.

Mr JAUHAR (Sri Lanka) regretted that the previous day's deliberations had failed to reach a successful conclusion. The situation could have been avoided if the Committee had been properly guided in a transparent manner by the Secretariat, including the Legal Counsel, during a complex and unprecedented working process. A spirit of compromise should guide the deliberations to a successful conclusion.

Dr AL-THANI (Qatar) agreed with the view expressed by the delegate of the Libyan Arab Jamahiriya. He thanked the delegate of Canada for the compromise solution and expressed the hope that all parties would be able to accept the amended proposal concerning rotation. The Executive Board should express its view and propose the best possible solution for rotation, affording all parties satisfaction.

Dr AL-JALAHMA (Bahrain) also thanked the delegate of Canada and endorsed the compromise amendment.

Mr BURCI (Legal Counsel), in reply to the delegate of Thailand, said that Rule 68 of the Rules of Procedure would apply to reconsideration by the Committee of a previous decision. If the Committee had no objection to deletion of the words "for all regions" from paragraph 3, as seemed to be the case, no problem would arise. Should there be any objection, he would guide the Committee on the procedural steps involved.

Dr SUWIT WIBULPOLPRASERT (Thailand) observed that, under Rule 68, once an amendment had been proposed, only two speakers opposing it should be given the floor. He therefore failed to understand why the Chairman was permitting so many delegates to speak in favour of it.

Professor LOUKOU (Côte d'Ivoire), welcoming the conciliatory attempts under way, asked for clarification on the amendment proposed by the delegate of Canada. The amendment to paragraph 1 proposed by the delegates of Ghana and Bahrain, which had already been voted on, clearly set out the principle of rotation and invited the Executive Board to amend the regulations thereon. He asked for reassurance that Canada's amendment would neither hinder the Executive Board's work nor affect the amendment proposed by the delegates of Ghana and Bahrain.

The CHAIRMAN invited the Secretary to read out the amended paragraph as proposed by the delegate of Canada.

Mr DAYRIT (Secretary) said that the amended text would read:

"REQUESTS the 128th Executive Board to develop a proposal with the support of the Secretariat for consideration at World Health Assembly 64 to improve the election process for the position of Director-General with a view of strengthening the equitable consideration of qualified candidates." The words "for all regions" had been deleted.

The CHAIRMAN asked whether there were any objections.

Professor LOUKOU (Côte d'Ivoire) requested an answer from the Legal Counsel to his previous query before he could decide whether he had any objections.

Ms MEBRAHETU (Ethiopia) asked for clarification on the exact nature of the proposal before the Committee. She was concerned that the wording of paragraph 3 might imply that qualified candidates had not been equitably considered in previous elections.

Dr KUNBOUR (Ghana), rising to a point of order, said that the concerns expressed by the delegates of Côte d'Ivoire and Ethiopia had been noted. The amendment did not affect the other parts of the resolution, and he urged all delegates to put the entire resolution to the vote.

In response to the request of the CHAIRMAN, Mr DAYRIT (Secretary) read out the amended resolution:

“The Sixty-third World Health Assembly,
Having considered the report by the Secretariat on the election of the Director-General of the World Health Organization,

1. AGREES that the appointment of the World Health Organization Director-General shall be by rotation among the regions of the World Health Organization;
2. REAFFIRMS the criteria that the candidate nominated by the Executive Board for the post of Director-General should fulfil, adopted by the Executive Board in resolution EB97.R10;
3. REQUESTS the 128th Executive Board to develop a proposal with the support of the Secretariat for consideration at World Health Assembly 64 to improve the election process for the position of Director-General with a view of strengthening the equitable consideration of qualified candidates.
4. DECIDES that this resolution shall not apply to the incumbent Director-General;
5. REQUESTS the Executive Board to report on the actions taken to implement this resolution to the Sixty-fourth World Health Assembly.”

The CHAIRMAN, observing that some Member States had requested a roll-call vote and others a secret ballot, asked which mode of voting would be preferred.

Mr AL HIGAZI (Libyan Arab Jamahiriya) said that a secret ballot would be unnecessary since there seemed to be a consensus on the wording. He suggested a show of hands.

Mr HOHMAN (United States of America) said that it had been his prerogative to request a secret ballot the previous day, in line with Rule 76 of the Rules of Procedure, and that he failed to understand why there was still debate over using that mode of voting.

Dr GOUYA (Islamic Republic of Iran) supported the idea of voting by roll-call on the amended draft resolution. He asked the Legal Counsel to clarify the procedure for deciding whether the vote might be taken by secret ballot. According to Rule 76 of the Rules of Procedure, the Health Assembly could only vote by secret ballot if it had previously been so decided by a majority of the Members present and voting, by show of hands.

Mr BURCI (Legal Counsel), in response to the delegate of the Islamic Republic of Iran, said that a show of hands was only necessary in the event of objection to taking the vote by secret ballot.

Dr GOUYA (Islamic Republic of Iran) said that, if he was not mistaken, the delegate of the Libyan Arab Jamahiriya had objected to holding a secret ballot.

Dr KUNBOUR (Ghana) said that he accepted that the delegate of the United States of America was entitled to request a secret ballot, but the Committee should put the amended draft resolution to the vote by another mode, in order to avoid losing momentum.

Dr AL-THANI (Qatar) agreed with the delegate of the Libyan Arab Jamahiriya that a secret ballot was not necessary, stating that it should only be used as a last resort. A show of hands would suffice.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, although he would prefer the Chairman simply to ask the Committee whether there were any objections to a secret ballot, the Rules of Procedure should be honoured. Since no objection to the proposal of a secret ballot had been raised the previous day, it could be considered that a decision had been made to adopt that mode of voting. Pursuant to Rule 76, therefore, no other mode could be requested or decided upon.

Mr AL HIGAZI (Libyan Arab Jamahiriya) recalled that there had indeed been objections to a secret ballot the previous day, with some Members favouring a show of hands. A decision had not been made either way. Thanks to the delegate of Canada and the representative of the European Union, the matter had since been resolved. A secret ballot was not necessary if all parties were in agreement; the usual show of hands would suffice.

The CHAIRMAN invited the Committee to vote by show of hands on the proposal by the United States of America to hold a secret ballot on the draft resolution, as amended.

A vote was taken by show of hands.

The proposal was rejected by 71 votes to 69, with 2 abstentions.

The CHAIRMAN therefore invited the Committee to vote by show of hands on the draft resolution, as amended.

A vote was taken by show of hands.

The CHAIRMAN requested the Legal Counsel to speak.

Mr BURCI (Legal Counsel) said that the Secretariat had been informed that countries whose voting rights had been suspended under Article 7 of the Constitution might have voted. Clarifying that the voting rights of the Central African Republic, Comoros, Guinea-Bissau, Palau, Somalia, Tajikistan and Turkmenistan had been suspended, he explained that if any of those delegations had voted, the vote would have to be repeated.

The CHAIRMAN requested the delegations of those seven countries to confirm whether or not they had voted.

The delegations of the Central African Republic, Comoros, Guinea-Bissau, Palau and Somalia indicated that they had not voted.

Ms JOBIROVA (Tajikistan) said that unfortunately she had voted, not having been aware that her country was not entitled to do so, and apologized.

Mr BURCI (Legal Counsel) said that the vote would therefore have to be repeated. The Central African Republic, Comoros, Guinea-Bissau, Palau, Somalia, Tajikistan and Turkmenistan should refrain from voting.

Mr AL HIGAZI (Libyan Arab Jamahiriya), rising to a point of order, said that those delegates who had mistakenly voted should be asked how they had voted, and the corresponding deductions made from the relevant vote counts. That would avoid repeating the whole voting process.

Mr HOHMAN (United States of America) said that he was perplexed at the apparent voting irregularities and that the validity of the vote was questionable. He therefore suggested that the whole procedure be repeated, including the first vote on whether the draft resolution should be voted on by secret ballot.

Mr RAMAPATLENG (Lesotho) said that the only proper way to vote on the draft resolution was by roll-call.

Dr GOUYA (Islamic Republic of Iran), rising to a point of order, said that any apparent irregularities in the most recent vote had nothing to do with the earlier vote on whether to hold a secret ballot, which was a matter that had already been voted on and decided.

Dr KHOULLA (Gabon) said that, failing a common-sense decision simply to deduct the vote of the delegation which had improperly voted, the only way forward was to take a roll-call vote.

The CHAIRMAN, noting the views expressed by the delegates of Lesotho and Gabon, asked whether there were any objections to the holding of a roll-call vote.

Mr AL HIGAZI (Libyan Arab Jamahiriya) recalled his suggestion that the delegate of Tajikistan should be asked which way she had voted, adding that he had become aware that Tajikistan had voted against the resolution. The sensible approach would therefore be to reduce that vote count by one. If, however, a new vote was to be held, it should be a roll-call vote, to ensure that those countries whose rights were suspended would not be able to vote again.

Mr LORENZO DOMÍNGUEZ (Mexico), noting that there had been two votes during the meeting, one or both of which might have been improper, asked for clarification of the subject of the new vote being proposed.

The CHAIRMAN replied that the new vote would be on the draft resolution, as amended.

Ms LANTERI (Monaco) expressed the view that, since it was unclear whether there had also been irregularities in the first vote, both votes should be repeated.

Dr GOUYA (Islamic Republic of Iran) observed that, although it was uncertain whether there had been any irregularity in the first vote, no objection had been raised at the time. Consequently, only the second round of voting should be repeated.

Dr GAD (Egypt), rising to a point of order, supported the view expressed by the delegate of Iran, adding that there could be no turning the clock back.

Mr BURCI (Legal Counsel) said that, when a vote had been concluded and no objection had been raised during the voting procedure, the vote was considered to have been regular. There had been no such objection in the first vote. Given, however, the allegations of irregularity in the second vote, he suggested that the Committee might wish to concentrate on that matter.

The CHAIRMAN asked whether the meeting wished to proceed in line with the suggestion from Lesotho, which had been seconded by Gabon.

Ms LANTERI (Monaco), rising to a point of order, said that there had been no allegations of irregularity in the first vote; however, both votes had been taken within the same time frame, and it was reasonable to doubt the propriety of the first one. She requested the Chairman to ask the delegations whose voting rights were suspended whether they had voted in the first round.

Dr KUNBOUR (Ghana), rising to a point of order, asked the Legal Counsel whether the allegation of irregularity in the second vote had been properly raised. He assumed that it should have been raised by a delegate from the floor, as a point of order, for everyone to hear.

Mr BURCI (Legal Counsel) replied that, according to Rule 74 of the Rules of Procedure, once a vote had been started it could not be interrupted except by a point of order having to do with the actual conduct of the voting itself.

Dr KUNBOUR (Ghana), rising to a point of order, asked whether it could be stated formally that a valid allegation of irregularity had been raised during the second vote.

The CHAIRMAN said that two delegations had come forward with a formal complaint that two Member States whose voting rights were suspended had in fact voted.

Dr KUNBOUR (Ghana), rising to a point of order, said that the responsibility for reminding delegations whose voting rights had been suspended that they could not vote rested entirely with the Secretariat. That had not been done before the second vote. Any suspicion of irregularity should have been raised by means of a point of order during the actual voting process. If “during the actual voting process” was taken to mean “until the announcement of the results”, then at the present moment the meeting was still in the voting process. The main issue, he repeated, was whether the allegation of irregularity had been validly raised.

The CHAIRMAN said that he had discussed the points raised by the delegate of Ghana with the Secretariat. A formal complaint of irregularity had been made by two delegates to himself and to the Legal Counsel; as a result, the Legal Counsel had read out the names of the countries whose voting rights were suspended, and the delegate of one of them had acknowledged having voted.

Dr AL-NAAMI (Yemen), rising to a point of order, asked whether a vote was going to be held on a vote, or whether the meeting was seeking a consensual mechanism by which to elect the Director-General. Since most countries had amicably agreed to the proposal by the delegate of Canada, he saw no need for a vote, whether secret or by roll-call, and considered that no more time should be spent on the matter.

Mr CHAUDHRY (India), rising to a point of order, emphasized that it was the responsibility of the Secretariat to point out, before the voting process began, that particular countries were ineligible to vote. That practice, followed in the United Nations General Assembly, should be followed in all specialized agencies, including WHO. Any delegate wishing to challenge the eligibility of certain countries to vote should have raised a point of order during the voting process in accordance with Rule 74 of the Rules of Procedure of the World Health Assembly. No delegate had done so and it was too late now. The voting process had been completed and it remained for the Chairman to declare the results.

Ms FARANI AZEVÊDO (Brazil), rising to a point of order, urged the Chairman to show leadership and take a decision.

Dr KUNBOUR (Ghana), rising to a point of order, said that the fact that the identity of the delegate who had raised the question of irregularity was not known was a further compelling reason for not vitiating the voting. In any case, the Legal Counsel, whose job it was to interpret the rules, should not become the lawyer for an unidentified delegate. The identity of a person mounting a challenge must be known.

Ms LANTERI (Monaco), rising to a point of order, said that since the countries ineligible to vote had not been so notified, all the votes that had taken place that morning should be held again.

The CHAIRMAN said that no formal complaint had been made during previous rounds of voting. According to the Rules of Procedure and in the view of the Legal Counsel and many delegates, the uncertainty about the validity of voting applied only to the current round.

Dr GOUYA (Islamic Republic of Iran), rising to a point of order, said that the uncertainty did not even apply to the current round for the reasons stated by the delegate of India. The action by the two unidentified delegates who had conducted consultations at the podium was tantamount to an interruption of the voting, which under Rule 74 was inadmissible.

Mr SUMEDHA EKANAYAKE (Sri Lanka) regretted having to say that the Committee had been misguided by the Legal Counsel that day and on the previous day. If any delegation was not qualified to vote, it was the responsibility of the Secretariat to notify the Committee accordingly. That had not been done. The Committee should proceed as proposed by the delegates of India and Brazil.

The CHAIRMAN said that, in a very difficult situation, he had endeavoured to remain impartial. A complaint about the voting process had been made to him and the Legal Counsel by two delegates, and it was a moot point whether that could be considered a formal complaint. But in the light of his consultations with the Secretariat, and in keeping with the role of leadership incumbent on the office of Chairman, he had decided to declare the results of the vote.

Mr PELLET (France), rising to a point of order, said, in defence of the Secretariat and the Chairman, that they had indeed announced the previous day, at the beginning of debate, who was entitled to vote and who was not. The Chairman had done his job. Rule 74 of the Rules of Procedure stated that after the President had announced the beginning of voting, no delegate should interrupt the voting except on a point of order in connection with the actual conduct of voting. In the current round, voting had begun but not ended. The Committee did not yet know the results. He was therefore raising a point of order, as authorized by Rule 74. The admission by one country that it had voted when ineligible to do so had introduced an element of suspicion. He supported the proposal by the delegate of Gabon to hold a roll-call vote.

The CHAIRMAN repeated his intention to declare the results of the vote.

Mr PELLET (France), rising to a point of order, reiterated his official complaint about the conduct of voting and his call for a roll-call vote. If he was not heard, he would not persist but considered that he had made his point very clearly.

Dr KUNBOUR (Ghana), rising to a point of order, called on the Chairman to break the deadlock by exercising leadership and going ahead with the declaration of results.

Mr SUMEDHA EKANAYAKE (Sri Lanka), rising to a point of order, said that he failed to understand how a delegate could call for a roll-call vote when the voting had already been concluded. He urged the Chairman to announce the outcome of the vote.

Dr SUWIT WIBULPOLPRASERT (Thailand) expressed his full confidence in the Legal Counsel. While the latter's interpretation of Rule 74 did not satisfy his own position, he was confident that it was unbiased. Like the delegate of France, he favoured a roll-call vote if an irregularity was found to have occurred, though only for the current round of voting, as the previous rounds had been completed, as the Legal Counsel had made clear.

Dr MOHAMED (Oman), rising to a point of order, requested clarification of the nature of a point of order, having observed in the previous three days that any country wishing to intervene had simply raised a point of order.

Mr CHAUDHRY (India), rising to a point of order, said that 15 minutes earlier the Chairman had ruled the election process to have been valid and no one had contested that. The election process had therefore been completed. He requested the Chairman, in order to expedite matters, to disregard any other advice he might receive and announce the outcome of the vote so that the Committee could proceed to the next item on its agenda.

The CHAIRMAN said that he would proceed to declare the results of the vote. Any delegate wishing to challenge his decision was free to do so.

Mr BLAIS (Canada), rising to a point of order, asked what criteria had been used to determine that the voting process had ended and at what point it had ended, adding that, even if the voting was deemed to have ended, the Committee should not proceed to the next agenda item without being informed of the result of the vote.

The CHAIRMAN announced the result of the vote.

The draft resolution was rejected by 73 votes to 71, with 4 abstentions.

The meeting rose at 11:55.

EIGHTH MEETING

Friday, 21 May 2010, at 14:55

Chairman: Dr G.J. KOMBA KONO (Sierra Leone)

later: Dr N. EL SAYED (Egypt)

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

Availability, safety and quality of blood products: Item 11.17 of the Agenda (Documents EB126/2010/REC/1, resolution EB126.R14, and A63/20) (continued from the fourth meeting)

Dr GOUYA (Islamic Republic of Iran) said that changing demographics and the use of more advanced surgical procedures had increased the need for blood transfusions. The availability, accessibility, safety and quality of blood products in developing countries were not yet comparable to those in developed countries. A risk of pathogen transmission through blood transfusions remained, and access to blood and plasma-derived products was limited for several reasons, including prohibitive costs. His country's goal was to ensure voluntary non-remunerated donation, but demand for blood products exceeded supply.

WHO must set further standards for the development of policies, strategies, quality management systems, and legislative and regulatory frameworks for the collection, testing, processing and supply of blood components. It was vital that expertise, experience and technology be shared with developing countries through collaborative research and courses on new technologies, with particular regard to inactivating pathogens; and thus enable self-sufficiency in the production of blood products and plasma derivatives and development of related human resources. More information should be provided on the Organization's global database on blood safety.

Mrs AL-RUBAIE (Iraq) noted the importance of blood availability and safety, with particular regard to emergency assistance. Her Government had carried out awareness campaigns in the workplace, in schools and in other institutions. It aimed to provide good-quality blood products through adequate testing and quality control, especially at donor banks in Baghdad and other cities; and was working with WHO to both further build capacity, using the latest scientific methods, and reach the most rural areas.

Dr KYEYUNE (Uganda) said that her country had a national blood service based on voluntarily non-remunerated donations of blood and blood products. The main challenge was to meet the increasing demand for safe blood, and strengthen the blood safety and quality control infrastructure. Research should be carried out to monitor known and emerging biological and epidemiological traits in the developing world; technology transfer to countries with a low Human Development Index should be encouraged to ensure standardization of blood product quality; national legislative and regulatory mechanisms should be established to define responsibilities and accountability along the vein-to-vein chain; and all Member States should ensure comprehensive monitoring and evaluation of the use of blood and blood products.

Ms BLACK (Canada), supporting the draft resolution contained in document EB126.R14, recognized the global shortage of blood products, and said that high-standard blood centres and fractionators were needed to ensure high-quality products. Regulatory controls for the production of

safe blood were lacking in many Member States, and the draft resolution encouraged the development of standards in the area of blood safety.

Dr Jaw-Jou KANG (Chinese Taipei) supported the current efforts to improve blood safety, including the establishment of the Global Steering Committee on Haemovigilance. It was essential to ensure equitable access to safe blood products, and as such Chinese Taipei had a voluntary donation programme with a 5% rate of donation each year. Policies encouraged citizens to use donated blood, which ensured the use of safe blood products for medical procedures. Nucleic acid testing was under way on a small scale, together with research to determine whether to expand nucleic acid testing to all blood, so as to further reduce transmission of HIV. In order to guarantee affordable and safe products, Chinese Taipei was ready to participate in international activities and cooperation.

Dr ETIENNE (Assistant Director-General) said that she had taken note of the comments and recommendations made. Worldwide, levels of quality and safety of blood were less than optimal, availability of plasma-derived products was limited and production of plasma low. Access to safe blood and blood products was essential for improving health outcomes and saving lives, including the reduction of maternal mortality. National standards, documentation, standard operating procedures, quality control systems, good manufacturing and laboratory practices and reporting of adverse events formed the basis of a safe blood supply. The Secretariat continued to work with partners, nongovernmental organizations and experts to define standards and norms, and to support national policy development, programme planning and implementation and capacity building. Guidelines had already been developed for blood donation, collection, screening and use as well as for viral inactivation. More guidelines were being drawn up for haemovigilance, good manufacturing practices and regulatory mechanisms. Work would continue at the national and regional levels to ensure self-sufficiency and safe products for all citizens.

The CHAIRMAN drew attention to the draft resolution contained in document EB126.R14.

Mr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. The delegate of Thailand had proposed that in subparagraph 1(2) the words “legislation” should be replaced with “guidelines”. The delegate of Indonesia had proposed that at the end of subparagraph 1(3) the words “including the use of diagnostic devices to prevent transfusion transmitted diseases with highest sensitivity and specificity” be added.

Mrs REITENBACH (Germany) asked whether the delegate of Thailand could accept the use of the word “regulations” instead of “guidelines” in order to give Member States greater regulatory flexibility.

Dr NARONG WONGBA (Thailand) agreed to that suggestion.

Dr MULYONO (Indonesia) said that his amendment should read “including the use of diagnostic devices to prevent transfusion-transmittable diseases with highest sensitivity and specificity”.

The draft resolution, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA63.12.

Progress reports: Item 11.24 of the Agenda (Document A63/27)

A. Poliomyelitis: mechanism for management of potential risks to eradication
(resolution WHA61.1)

Dr NAKORN PREMSRI (Thailand) commended current efforts to control poliomyelitis, in particular in security-compromised areas. The re-emergence of wild polioviruses in Senegal and Tajikistan, and the re-establishment of the disease in four African countries were very worrying. For that reason, poliomyelitis eradication activities must continue. Surveillance of acute flaccid paralysis must be increased, and a rapid response to the import of polioviruses ensured; and administration of oral poliovirus vaccine and other immunization initiatives must be extended. The International Health Regulations (2005) should be fully implemented in order to facilitate timely case reporting and the rapid containment of the disease. His Government remained fully committed to the eradication of poliomyelitis.

Professor ONDOBO ANZE (Cameroon), speaking on behalf of the Member States of the African Region, said that in spite of global progress made in interrupting indigenous transmission of wild polioviruses, the virus was still prevalent in Africa, with cases having been reported in 12 countries in 2009; Nigeria alone had experienced 236 cases between January and May. Vaccination campaigns in 2009 and 2010 had reduced the total number to 44, spread across Angola, Chad, Liberia, Mali, Mauritania, Niger, Nigeria, Senegal and Sierra Leone.

Among other measures to eradicate poliomyelitis, countries should increase routine oral third-dose poliovirus vaccination coverage to at least 90%, organize high-quality supplementary vaccination activities and additional campaigns within four weeks of the detection of wild poliovirus, and establish surveillance systems for acute flaccid paralysis. Where such strategies had been implemented, the results had been encouraging, but more remained to be done in several countries. In Cameroon, for instance, vaccination coverage had fallen and surveillance was inadequate; wild poliovirus had reappeared in 2009 after a gap of three years.

The Advisory Committee on Poliomyelitis Eradication had stated that the challenges faced by the Global Polio Eradication Initiative should not be allowed to overshadow significant achievements. He therefore expressed support for the Eradication Initiative's strategic plan for 2010–2012 to interrupt transmission. Coordinated campaigns and the use of bivalent oral poliovirus vaccine would be necessary. He expressed appreciation for the technical and financial support received; with continued support, success could be achieved in the African Region.

Dr LIU Xia (China) said that, since transmission had been interrupted in China in 2000, surveillance had been maintained and vaccination coverage increased, with a focus on reaching remote regions. A reporting system for wild poliovirus was in place and laboratories holding viruses were closely controlled. Routine and emergency vaccination capacity had been increased. She requested clarification on the use of inactivated rather than oral poliovirus vaccine in WHO's vaccination strategies and on specific vaccination strategies for developing countries. She called for more policy guidance from the Secretariat on the use of oral poliovirus vaccine, further research into such oral vaccines and the prevention of the circulation of vaccine-derived polioviruses and cases of vaccine-related poliomyelitis. Her country would continue to work closely with WHO to achieve poliomyelitis eradication worldwide.

Dr OBARA (Japan), emphasizing the importance of global eradication of poliomyelitis for public health, expressed support for the activities of the Global Polio Eradication Initiative and its strategic plan for 2010–2012. Attainment of the indicators in the strategic plan would need to be monitored in order to ensure progress.

It was important to strengthen surveillance and promote routine vaccination with trivalent oral poliovirus vaccine in countries where poliomyelitis was endemic and in neighbouring countries liable

to import poliovirus, in part because of the increased risk of poliomyelitis outbreaks expected in the course of introducing the new bivalent type 1 and type 3 oral poliovirus vaccines.

An appropriate balance was essential between expanded immunization programmes and vaccination campaigns. Both in disease-endemic areas and in countries where the disease had re-emerged, strategies were required that would genuinely promote routine vaccination. In its technical cooperation activities, the Japan International Cooperation Agency was careful to confirm the policy of recipient countries regarding expanded immunization programmes and poliomyelitis prevention within national health policies. In addition to transferring vaccine production technology, a clear understanding was required of the various issues surrounding poliomyelitis, such as logistics, information sharing, and data collection and analysis, and to respond to those appropriately.

Political commitment was needed to promote poliomyelitis prevention in disease-endemic areas, where WHO should pursue a strong, evidence-based approach to raising awareness of prevention strategies among politicians and religious leaders. Improved security and stability would also contribute to eradication efforts, particularly in Afghanistan and Pakistan.

The recent outbreak of poliomyelitis in Tajikistan highlighted the urgent need for vaccination, both throughout the country and in surrounding countries, and for improved surveillance. It was vital to maintain high vaccination coverage and build surveillance capacity even in areas previously certified free of the disease.

Dr BAGARIA (United Kingdom of Great Britain and Northern Ireland), welcoming the progress made, said that the recent outbreak of poliomyelitis in Tajikistan had provided a sober reminder of the fragile situation in Africa and Asia. The Eradication Initiative's strategic plan for 2010–2012 represented a major step, as it set realistic stages and prioritized activities. However, the shortfall in funding threatened to undermine the progress made to date. She asked how the Secretariat planned to address the problem, emphasizing that any strategy should combine expansion of the funding base with options to prioritize and protect core activities against any shortfall. India had invested domestic resources in eradication efforts and other Member States might follow that approach. Moreover, WHO could explore the possibility of active intervention by development banks.

Mrs TZIMAS (Germany) welcomed the considerable progress towards poliomyelitis eradication, but noted that the recent outbreak in the European Region, which had been declared free of the disease in 2002, demonstrated the importance of continued surveillance and strong collaborative measures to contain and halt the spread of infection from endemic areas to countries in their vicinity.

The Global Polio Eradication Initiative faced a substantial shortfall in funding of US\$ 1400 million. She urged all partners to donate additional funds, as her Government had, in order to ensure that vaccination programmes were carried out in all countries, including those where poliovirus transmission was considered to have been re-established. The final phase of the international eradication campaign must strengthen the efforts of Member States to interrupt transmission, support delivery of routine immunization, and expand surveillance and monitoring systems. With continued financial, political and technical commitment from governmental and nongovernmental bodies, poliomyelitis could be eradicated.

Dr MOHAMED (Oman), welcoming the new strategic plan for 2010–2012 of the Global Polio Eradication Initiative, observed that the situation differed markedly from one year previously. Much progress had been made in India and Nigeria, although the situation in Afghanistan and Pakistan still gave cause for concern, in large part because of continuing stability and security problems. Support was essential for all four countries.

The disease could re-emerge in Member States if prevention efforts were not redoubled, as the case of Tajikistan had shown. Member States that had been affected in recent years and had taken prevention measures could be asked to produce a report for consideration by the governing bodies, with a view to sharing the experience gained.

Dr BOUARÉ (Mali), welcoming WHO's support for efforts for eradication of poliomyelitis, said that the disease was not endemic in Mali but imported cases had been identified and surveillance for acute flaccid paralysis would continue to be strengthened. Vaccination and surveillance activities, including surveillance for acute flaccid paralysis, should be strengthened worldwide. Enormous efforts had also been made to overcome sociocultural barriers and address the security situation in the north of his country. Despite insufficient financial and material resources, his Government was fully committed to achieving eradication of poliomyelitis in the near future.

Dr TSESHKOVSKIY (Russian Federation) echoed concerns regarding the continued transmission of wild polioviruses in disease-endemic countries; the re-emergence of poliomyelitis in countries previously free of the disease; and notably the current outbreak in Tajikistan. In order to reduce the risk of cross-border spread, through traditional trade and migration links, measures had been taken to strengthen epidemiological surveillance and vaccinate children arriving from Tajikistan. Assistance had also been provided on the ground in Tajikistan, and clinical samples had been taken for laboratory analysis. His Government would continue to provide support for diagnosis and treatment of children, and to organize epidemiological and prevention measures. He expressed full support for the work of WHO and UNICEF to organize mass supplementary vaccination of children in Tajikistan and other countries in the region. It was vital to stop the virus spreading further into the European Region, which had previously been declared free of poliomyelitis. Having already donated significant sums to WHO's efforts, his Government would continue to give support.

Mr AL-TAAE (Iraq) said that his country would require support from WHO if it was to achieve its goal of eradication of poliomyelitis. The International Health Regulations (2005) must be applied by all Member States still affected by the disease and coordination between neighbouring countries was essential when cases were detected. He suggested that an annual world poliomyelitis day be established to raise awareness of the issue and he urged all Member States declared free of poliomyelitis to share their knowledge and experience with those still battling the disease. Further scientific research should also be encouraged.

Dr FALL (Senegal) said that the worsening epidemiological situation in West Africa had not spared Senegal, which had been free of the disease for 10 years prior to the emergence of new cases of poliomyelitis in January 2010. The Government was planning its fourth vaccination campaign with the aim of interrupting transmission of wild poliovirus by the end of June 2010, and he appealed for regional cooperation in order to achieve the target of coverage extended to around 95% of children and households. Vaccination programmes and epidemiological surveillance must be further strengthened.

Dr MULYONO (Indonesia), expressing support for the Global Polio Eradication Initiative, noted that among the core strategies to stop transmission in high-risk areas was the administration of supplementary doses of oral poliovirus vaccine to all children under five years of age as part of wider supplementary immunization activities. Reducing the risk of the international spread of poliovirus remained a challenge.

Recalling the recommendation by the Advisory Committee on Poliomyelitis Eradication that the Global Polio Eradication Initiative should establish a new three-year programme to stop wild poliovirus transmission globally, he urged that such a programme should not be limited to three years. Eradication efforts should continue until global transmission had been successfully interrupted; intensive surveillance, clinical evaluation and administration of oral poliovirus vaccine were of the utmost importance.

Mr CHAWDHRY (India) emphasized that his Government was committed to the eradication of poliomyelitis; for the period 2007–2012 it had allocated some US\$ 900 million to that end. That amount was greater than total funding for all other national disease programmes put together. India's routine immunization programme covered cohorts of about 27 million births every year.

Through intensified immunization activity and the use of bivalent and monovalent vaccines, poliovirus circulation had been confined to just two of India's 35 states. In 2009, two subnational immunization days had been organized in high-risk areas, using monovalent oral poliovirus vaccine types 1 and 3; two national immunization days had been held thus far in 2010, using bivalent oral poliovirus vaccine for the first time. Surveillance of acute flaccid paralysis was extremely sensitive, it enabled cases to be detected immediately and the efficiency of the system was monitored at state and district level.

Following a recent epidemiological review, the India Expert Advisory Group on poliomyelitis eradication had concluded that the country was still on target to eradicate wild poliovirus type 1. The national strategy would focus on ensuring interruption of transmission of wild poliovirus type 1 and maintaining control of type 3. The availability of bivalent oral poliovirus vaccine would greatly increase the efficiency and effectiveness of that strategy.

He called on WHO to conduct inspections of some private vaccine manufacturers to facilitate prequalification of bivalent oral poliovirus vaccines.

Mrs JOBIROVA (Tajikistan) expressed regret over the outbreak of imported wild poliovirus that had been reported in her country in March 2010, eight years after it had been certified poliomyelitis-free. Tajikistan had faced several difficulties since the outbreak, including weaknesses in the primary health-care system and its ability to detect cases of poliomyelitis. Joint coordinated work would need to be undertaken with certain countries, including holding simultaneous national and subnational immunization days, as Afghanistan, Tajikistan and Uzbekistan had done in May 2010. Routine immunization in Tajikistan would need to be strengthened as some children that had received all five doses of vaccine had still been infected with the disease. Monitoring of the quality of available vaccines would need to be improved.

Thanks to the quick response of both WHO and UNICEF following the outbreak, all children up to six years of age had been vaccinated. However, a much greater proportion of the population would need to be vaccinated as poliovirus had been detected in children and adults up to 30 years of age.

Dr CAMPBELL-FORRESTER (Jamaica) said that Jamaica's last case of poliomyelitis had been reported in 1982. Since then surveillance for acute flaccid paralysis had been established and strengthened and efforts aimed to achieve vaccination coverage of 95%, following a decline in recent years. Despite concerns over vaccine-associated paralytic poliomyelitis, Jamaica would continue to use trivalent oral poliovirus vaccine, in accordance with WHO recommendations.

She commended WHO's efforts towards eradication, but was concerned that the target date for transmission interruption had been pushed back several times, most recently to 2012. Challenges remained in eradication programmes in poliomyelitis-endemic countries, particularly in sub-Saharan Africa, where outbreaks continued to occur. Efforts should be strengthened to ensure both the increased vaccination coverage of children and the political will to continue routine and supplementary immunization activities.

She welcomed the introduction of the new bivalent vaccine, which had been shown to provide better protection than the trivalent vaccine. However, incomplete gut mucosal immunity to polioviruses in India had shown implications for herd immunity and the long-term protection of those vaccinated. The bivalent vaccine should be used as a matter of course, particularly in Nigeria. In Afghanistan and Pakistan, the relevant authorities should work with rebel forces to ensure that, even in conflict areas, the most vulnerable children were reached for vaccination.

WHO should continue to lobby for the additional funds needed and intensify eradication efforts globally.

Dr MALEFHO (Botswana) said that his country had been taking steps to achieve the goal of poliomyelitis eradication, including the incorporation of acute flaccid paralysis surveillance in its existing surveillance system. Supported by the Expanded Programme on Immunization, Botswana had been able to maintain its poliomyelitis-free status since 2005.

Oral poliovirus vaccine coverage had remained above 80% during the previous three years and surveillance had been strengthened through the training of community focal points under the “Reaching Every District” initiative. Other measures included: annual refresher training on disease surveillance for clinicians; active inspection for acute flaccid paralysis in priority areas for surveillance; annual training for laboratory technicians on handling stool specimens; harmonization of surveillance data between the Expanded Programme on Immunization and the national health laboratory; and quarterly feedback to districts on performance of acute flaccid paralysis surveillance.

Outstanding cross-border issues would need to be addressed if poliomyelitis was to be eradicated in the African Region.

Dr VILLENEUVE (United Nations Children’s Fund) welcomed the new strategic plan for 2010–2012 formulated by the Global Polio Eradication Initiative as a significant development in the global effort to eradicate the disease.

Much progress had been made over the past 20 years to reduce the burden of poliomyelitis, but challenges remained. Interrupting transmission once and for all in poliomyelitis-endemic countries would require new approaches, and partners must remain vigilant and flexible. Strategies should be tailored to local circumstances, especially as immunity thresholds in Asia were higher than in Africa. Special plans would be developed for underserved populations, as poliovirus could persist in smaller areas and subgroups. Immunization systems must be strengthened in line with the improved understanding of the routes of poliovirus transmission and outbreaks.

UNICEF supported the milestones and benchmarks established under the new strategic plan that would require all partners to renew their commitment to eradication; UNICEF would review its own efforts and resources in its focal areas of supply, communication and social mobilization.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, noted that 23 countries had reported outbreaks of wild poliovirus in 2009, the largest number in a decade. Concerned at the increase and the challenges it would create for the eradication initiative, her Federation had launched the Africa Polio Outbreak Emergency Appeal to assist 15 national societies in Africa, which had supported 27 national and subnational poliovirus vaccination rounds.

Poliomyelitis eradication was within the grasp of the international community but the shortfall in funding of US\$ 1400 million must be redressed immediately through innovative financing mechanisms. Poliovirus vaccination campaigns must be improved in areas where they were underperforming, support for routine immunization must be intensified with partners such as the GAVI Alliance and engagement must be stepped up with communities. Poliovirus vaccine should be accessible to the most remote and vulnerable groups. Volunteers from her Federation were present in many communities and prioritized social mobilization as the most effective way to reach all those in need.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, reiterated Rotary International’s commitment to eradication of poliomyelitis and welcomed the new strategic plan for 2010–2012. The continued commitment of leaders in Angola, Chad and West Africa was vital to ensuring that outbreaks were stopped by the end of 2010. The lack of funds for necessary activities was a matter of particular concern; essential campaigns earlier in the year had been made possible through extraordinary funding from Rotary International and the Bill & Melinda Gates Foundation. Sources of financial support had yet to be identified for about half the US\$ 2600 million needed by the end of 2012. He called on all countries, and particularly G8 and G20 members, to provide the resources necessary to achieve the goal of eradication.

Mr HERRINGTON (United States of America) welcomed the clear action guidelines offered by the new strategic plan for 2010–2012 and looked forward to working with the Secretariat and other Member States to maintain the momentum required to achieve the goal of poliomyelitis eradication.

Ms JAKAB (Regional Director for Europe) said, in response to the concerns raised by Member States regarding the recent outbreak of poliovirus in Tajikistan, that it had been the first importation of the disease since the European Region had been certified as poliomyelitis-free in 2002. A sharp increase in cases of acute flaccid paralysis in early April 2010 had prompted the Government of Tajikistan to request support from WHO for an investigation. WHO had deployed experts to the area bordering Afghanistan and Uzbekistan in the south-western part of the country, and the WHO regional reference laboratory in Moscow had confirmed poliovirus as the cause of the outbreak. The Secretariat had alerted all Member States and relevant international organizations to the new international public health risk and had provided regular updates on the epidemiological response actions and risk assessments.

She had asked all Member States of the European Region to strengthen their surveillance in order to detect any importation quickly, to be prepared for a rapid response and to review immediately their immunization status against poliomyelitis, particularly at the subnational level and in the case of population groups where immunization coverage might be low. The risk of cross-border spread of the disease was illustrated by the report of a child from Tajikistan who had travelled to the Russian Federation on 1 May 2010 where laboratory tests had confirmed infection with wild poliovirus type 1. In that context, WHO had recommended that all children under 15 years of age travelling from or to Tajikistan should be systematically vaccinated with a dose of type 1 oral poliovirus vaccine. As at 20 May 2010, 473 cases of flaccid acute paralysis had been reported in Tajikistan, in 129 of which wild poliovirus type 1 had been laboratory-confirmed. Most cases were among children under five years of age and all laboratory-confirmed cases were in the south-west of the country. On 8 May 2010, Tajikistan had completed its first round of nationwide immunization using monovalent type 1 oral poliovirus vaccine, having immunized more than 1.1 million children under six years of age. The second round was under way and a third round was planned for the beginning of June 2010. She had attended the launching event of the national immunization campaign in Tajikistan and the President and Prime Minister had evinced strong commitment to halting the outbreak.

The Secretariat was working closely with Member States, in particular with the neighbouring countries Uzbekistan, Kyrgyzstan, Turkmenistan and Kazakhstan, and partners in order to strengthen surveillance and initiate or plan immunization campaigns. International expert teams had been deployed to countries to provide on-site technical assistance. On 18 May 2010, Uzbekistan had begun the first round of a national poliomyelitis immunization campaign, which had already reached 2.7 million children under five years of age, representing more than 95% coverage. She thanked the Russian Federation for the invaluable support provided by the poliomyelitis reference laboratory in Moscow, and the Global Polio Eradication Initiative's partners for pledging funds for emergency response actions. WHO and UNICEF were seeking additional funding to support urgent vaccination campaigns in Tajikistan and other central Asian countries.

The European Member States and the Regional Office for Europe were fully committed to poliomyelitis eradication and to maintaining the Region's poliomyelitis-free status.

Dr AYLWARD (Polio Eradication Initiative) concurred with previous speakers that 2009 had been a watershed for the eradication programme. In accordance with resolution WHA61.1, an evidence base was being compiled and additional research carried out in order to develop a new three-year strategic plan for interrupting the remaining chains of poliovirus transmission. The Organization appreciated the guidance provided by Member States, particularly those that had served on the independent evaluation team. The strategic plan included a new vaccine and robust approaches that were reaching children who had consistently been missed. Although the plan was in its infancy, there was already clear evidence that it was making a difference. For example, in the two key reservoir areas of northern Nigeria and northern India, case numbers had plummeted, with Nigeria recording only three cases in 2010 compared to more than 300 in May 2009. In northern India the most devastating virus type had not been seen for six months.

Risks to the implementation and success of the plan had been highlighted. With regard to international spread, a key element of the plan was the strengthening of immunization systems,

ensuring rapid response activities, and synchronizing mass campaigns across countries. Potential new initiatives that might help to shorten outbreaks were being examined. Guidance on immunization of travellers was available on WHO's web site under international travel and health documents. Another key element of the plan was ensuring that coverage was extended to all children regardless of culture, geography or religion. Where security was a problem, WHO had wide experience of working in areas affected by conflict. Although situations might differ and strategies had to be individually tailored, the programme had eradicated poliomyelitis from all but two conflict-affected areas. The strategies deployed included the use of local "access negotiators"; new partnerships with local nongovernmental organizations; rapid campaigns during windows of opportunity; and negotiation of local days of tranquillity. New partnerships had also been formed, including with the International Federation of Red Cross and Red Crescent Societies, which had played a vital role in facilitating access in insecure areas.

Another major challenge that had been highlighted concerned supply of bivalent oral poliovirus vaccine. After some initial doubt about whether the vaccine would play a role in the eradication initiative, it was proving hard to satisfy the demand. He assured Member States that the inspections for prequalification of new bivalent vaccines had been expedited and four products had been prequalified between late 2009 and 2010; another two or three were in the pipeline.

The new strategic plan would indeed require additional and continued international financing, although nearly one third of the eradication budget was funded by the countries affected themselves. Innovative financing mechanisms were also being used to provide vaccines in some countries. WHO was supporting the private-sector initiatives of organizations such as the International Federation of Red Cross and Red Crescent Societies, and, in particular, Rotary International, which had pledged a further US\$ 200 million. In addition to the World Bank, WHO was working with the Islamic Development Bank and the Asian Development Bank. Moreover, the Director-General was spearheading a major effort to secure and expand the donor base and had already succeeded in engaging the support of the leaders of the G8 and G20 countries.

Concerning the risks associated with vaccine-derived polioviruses, and the need for aggressive strategies to deal with them and guidance for Member States on using oral rather than inactivated poliovirus vaccines, he said that a policy document on those matters would be published in the Weekly epidemiological record in June 2010. WHO was also expediting its research agenda to develop affordable inactivated poliovirus vaccine strategies for low-income settings in the long term and would be issuing a call for expressions of interest for technology transfers of new inactivated poliovirus vaccine technologies.

He thanked Member States for the patience they had shown during the development of the new three-year strategic plan.

The DIRECTOR-GENERAL acknowledged the efforts and political commitment of countries in which poliomyelitis was endemic, countries in which the disease was re-emerging and countries into which polioviruses were being imported, as well as their allocation of domestic financial resources to eradicating the disease. Responding to the delegate of Japan, she said that, although efficiencies could generate substantial benefits, efficiency savings should not be taken to extremes that compromised the quality of surveillance and campaigns. It was a question of finding the right balance and she gave her assurance that resources were being put to good use. It was her practice to hold regular teleconferences with all Regional Directors and WHO Representatives in countries with cases of poliomyelitis in order to receive updates on the progress made and the challenges and difficulties faced, so that she could assist them to achieve total eradication and prevent any recurrence of events such as the recent outbreak in Tajikistan. Ultimately, the most cost-effective solution, particularly in terms of human suffering and disease burden, was to eradicate poliomyelitis. She therefore called on Member States and WHO's partners to redouble their efforts in that regard. The year 2010 had already seen the thirtieth anniversary of smallpox eradication. It was to be hoped that the world would soon be able to celebrate the eradication of poliomyelitis.

B. Control of human African trypanosomiasis (resolution WHA57.2)

Mrs MOHAMMED (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that Sudan was the only country in the Region in which human African trypanosomiasis remained endemic. Between 2007 and 2009 about 1000 cases had been detected, all of which had been treated. People who had previously been infected had also been treated. She thanked the Secretariat for providing medicines and human resources, particularly in the south of the country, and requested continued support. Nevertheless, a pressing need remained for access to diagnostic tools. A report on the progress that had been made since 2009 would be submitted to the Secretariat.

Mr SURAPOCH SUWANPANICH (Thailand) said that the re-emergence of human African trypanosomiasis demonstrated the importance both of maintaining surveillance systems and awareness among health personnel, and of the prompt implementation of control measures. Control of the disease relied on case detection and treatment, although advances in vector control were also feasible. Hence, research on new affordable and effective diagnostic tools, safer medicines and vector-control measures needed to be expanded, for which long-term funding would be required.

Dr BASTOS (Angola) suggested that the Secretariat should convene a second expert meeting on human African trypanosomiasis in order to stimulate efforts to combat the disease more effectively in the affected countries.

Ms KONYINAN (Central African Republic), speaking on behalf of the Member States of the African Region, thanked all the stakeholders involved in efforts to control human African trypanosomiasis and WHO for: providing support to national programmes; promoting the use of eflornithine; mapping the spread of the disease; supplying diagnostic tools and free medicines; and mobilizing funds. Although the progress report described a decline in the number of reported cases, inadequate detection in some Member States might cause underreporting. The disease remained a major threat to public health in 35 Member States in the African Region and Sudan, and there was a danger that the situation could deteriorate to the level prevailing in the 1980s. The commitment of the African Union, vital to finding new ways of combating the scourge, needed to be harmonized with the activities of other partners, as well as those of WHO, in affected countries. The African Union recognized that human African trypanosomiasis was a barrier to socioeconomic development in Africa and called on WHO to secure the necessary means in terms of funding, diagnostic tools, treatment and vector-control measures, to combat the disease.

Dr NAKATANI (Assistant Director-General) said that WHO always tried to take its lead from affected countries and communities. The African Union had played an active role in obtaining life-saving donations of medicines from the pharmaceutical industry and the Secretariat was providing technical advice to Member States. As a result, there had been a reduction in the number of new cases of the disease; for example, in Sudan the number had fallen from nearly 80% from 1998 to fewer than 400 cases in 2010.

WHO was working with research development partners, such as the Foundation for Innovative New Diagnostics and the Drugs for Neglected Diseases initiative to develop new diagnostics and new medicines.

The Secretariat had already organized an expert meeting on leishmaniasis and one on leprosy was being planned. The request for such a meeting to be held on human African trypanosomiasis would be duly considered.

C. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)

Dr NIPUNPORN VORAMONGKOL (Thailand) said that the number of teenage pregnancies in her country had risen over the previous 13 years, especially among the uneducated rural poor, and led in many cases to unsafe abortion and adverse maternal and child health outcomes. The education, health and social sectors should work together, in conjunction with civil society, in order to empower adolescents with respect to their reproductive health; improve counselling and family planning services; reform sex education; and promote development of life skills.

Ms NIGUSSIE (Ethiopia), speaking on behalf of the Member States of the African Region, said that maternal and child mortality in Africa remained alarmingly high owing mainly to poor access to sexual and reproductive health care; low levels of contraceptive use and unmet family planning needs; unsafe abortion; and inadequate skilled attendance at birth. Despite the grim picture, the situation had improved, in part through high-level advocacy and initiatives such as the African Union's Campaign on Accelerated Reduction of Maternal Mortality in Africa. Launched at the fourth session of the African Union Conference of Ministers of Health in Addis Ababa in May 2009, the campaign had generated considerable regional and international interest and support since coming into effect at the national level in 11 Member States.

She was gratified by the progress reported by the Secretariat and the Region remained committed to full implementation of the strategy. She requested that the Secretariat continue to provide technical guidance on the key issues involved in sexual and reproductive health, which was vital for Africa's rapid progress towards the achievement of the Millennium Development Goals.

Mr LENNARTSSON (Sweden), speaking on behalf of the Nordic countries, Estonia, the Netherlands and Switzerland, said that the progress report confirmed many of the findings in WHO's report, *Women and health: today's evidence tomorrow's agenda*. Despite improved access to antenatal care and assisted delivery, the overall situation remained unacceptable. Too few young people in developing countries knew how to avoid sexually transmitted infections, which reflected an acute need to expand gender-sensitive sex education and information. Furthermore, action must be taken to put an end to genital mutilation and violence against women, whose physical integrity and control over their sexuality and fertility depended on their general status in society. Sexual and reproductive health and rights were crucial to the achievement of Millennium Development Goals 3 (Promote gender equality and empower women), 4 (Reduce child mortality), 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases), and he requested WHO to show stronger leadership in that area.

Mrs APA (New Zealand) welcomed the emphasis placed in the progress report on family planning, male involvement in reproductive health, access to care during pregnancy and delivery, and the Organization's partnership with UNFPA to meet sexual and reproductive health needs in developing countries. However, the tabular information in the report, on deliveries attended by a skilled health worker, was disaggregated according to WHO region and failed to take account of intraregional variations. Future progress reports should therefore discuss such variations in order to indicate where efforts could best be targeted. Furthermore, the current report drew on an assessment of questionnaires completed by less than one third of Member States. She therefore asked the Secretariat to comment on how representative the results were; on whether the report provided an accurate assessment of the progress made; and on how the response rate could be improved to render future reports more comprehensive.

Dr BAGARIA (United Kingdom of Great Britain and Northern Ireland) welcomed the Secretariat's continued focus on sexual and reproductive health. Adolescents, who formed a large part of the population in many developing countries, must have access to the relevant health services to

enable progress to be accelerated towards Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), especially Target 5.B (Achieve, by 2015, universal access to reproductive health). It was crucial to strengthen health systems and to expand access to family planning, and she urged the Secretariat to ensure that core voluntary contributions were channelled into support for that complex and sensitive area.

Dr HUSSEIN (Syrian Arab Republic), speaking on behalf of the Member States of the Eastern Mediterranean Region, described efforts in the Region to make progress towards achieving Millennium Development Goals 4 and 5 through the improvement of maternal and child health. The Regional Committee had adopted two resolutions on the subject: resolution EM/RC51/R.4, which urged those Member States to strengthen national surveillance mechanisms, identify mortality and morbidity trends, and establish maternal mortality committees; and resolution EM/RC54/R.2, which called for universal coverage of existing cost-effective interventions, together with enhanced registration and monitoring of progress.

Furthermore, the Regional Office had conducted an assessment of national mechanisms for monitoring of maternal mortality in the Islamic Republic of Iran and Tunisia in 2008, and had introduced national monitoring systems in Lebanon, Morocco, the Syrian Arab Republic and Tunisia. A WHO Collaborating Centre for Training and Research in Reproductive Health had been designated in Tunis, and the designation process would continue. Many Member States in the Region devoted a large share of their budgets to sexual and reproductive health, and yet still lacked the resources to tackle high rates of maternal and child mortality and a high prevalence of HIV/AIDS. He therefore appealed for additional funding and called on the Regional Office to continue working with other stakeholders at the regional and subregional levels.

Mr AL-TAAE (Iraq) said that improved reproductive health was crucial to the achievement of the Millennium Development Goals. Iraq was working with WHO on a national workplan to foster such efforts, which was underpinned by baseline data obtained through cluster surveys and other surveys. He urged WHO to support capacity building in every area of reproductive health; promote mother-friendly and baby-friendly hospital initiatives; encourage research; and strengthen partnerships with relevant organizations.

Dr MHLANGA (South Africa) said that rates for skilled attendance at birth had declined in his country as fear of HIV infection had prompted many health workers to move abroad or to other occupations, and thus had increased the burden on those that remained. The overall proportion of deliveries attended by health workers was high but the quality of the attendance was variable. Records of maternal mortality, retained since 1997, had shown an increase in HIV/AIDS-related mortality, confirmed by the committee that examined causes of perinatal deaths. HIV treatment and care must be incorporated into reproductive health-care services, and surveillance should be combined with remedial action.

Ms WITTENBERG (United Nations Population Fund) said that saving the lives and protecting the health of women and adolescents called for an integrated, women-centred, package of reproductive health services delivered by a well-functioning health system. It must include family planning; maternity care that included emergency obstetric care; skilled attendance at delivery; the prevention, diagnosis and treatment of sexually transmitted infections; and sexuality education for adolescents that would promote respect for gender equality and zero tolerance for violence against women. Millennium Development Goal Target 5.B (Achieve, by 2015, universal access to reproductive health) was far from being met and the work of WHO in that area was more crucial than ever.

Mrs SACKSTEIN (International Alliance of Women), speaking at the invitation of the CHAIRMAN, said that reproductive health was a key component in efforts to combat maternal mortality and morbidity, which had been deemed a pressing human rights concern by the United

Nations Human Rights Council in resolution 11/8. Family planning and contraception were crucial to the success of those efforts and to progress towards the achievement of all eight Millennium Development Goals: Goal 3 (Promote gender equality and empower women) must be considered in the implementation of strategies to achieve Goal 5 (Improve maternal health), and both had a positive impact on progress towards Goal 4 (Reduce child mortality). Family planning remained a thorny problem and urgent action and donor support was required at the national and international levels. The Alliance stood ready to assist in an advocacy role.

Ms MAFUBELU (Assistant Director-General) commended Member States' efforts in the area of sexual and reproductive health, but noted that progress was uneven and especially slow with respect to meeting Target 5.A (Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio), Target 5.B (Achieve, by 2015, universal access to reproductive health) and Target 4.A (Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate). Unmet need for family planning, the poor availability of sexual and reproductive health services, and the lack of financial resources were indeed serious problems that needed to be tackled urgently. She assured the delegate of Sweden that WHO would continue to show strong leadership in the area of sexual and reproductive health and rights.

Responding to the delegate of New Zealand, she said that the questionnaire forming the basis of the report had not been a global survey designed to provide representative data. It had focused on key qualitative issues in high-burden countries, and had been sent out to 80 developing countries only. Accordingly, the fact that 57 countries had responded meant that the response rate was quite high. The Secretariat would nevertheless work to secure a higher response rate in the future and would take into account the suggestion to discuss intraregional variations in future progress reports.

Responding to the delegate of South Africa, she said that the leading cause of death among women of childbearing age in low- and middle-income countries was HIV infection, with maternal mortality coming second. Accordingly, in order to reduce maternal mortality, HIV programmes, maternal, newborn and child health programmes and sexual and reproductive health programmes had to be integrated. WHO would continue working with its partners, including UNFPA and other organizations in the United Nations system, to help Member States to achieve the Millennium Development Goals by 2015 and to ensure universal access to sexual and reproductive health beyond that date.

D. Rapid scaling up of health workforce production (resolution WHA59.23)

Dr KRISADA SAWAENGDEE (Thailand) commended the progress made in rapid scaling up of health workforce production, notably in sub-Saharan Africa. Support from global health initiatives must be aligned with national policies, context and needs. Rural recruitment, local training and hometown placement were the best strategies for retention of staff in rural areas. She invited Member States to nominate outstanding national health care workers for recognition at the Second Global Forum on Human Resources for Health to be held in Bangkok in January 2011.

Mr JERE (Zambia), speaking on behalf of the Member States of the African Region, said that, since the adoption of resolution WHA59.23, more than 30 Member States had developed strategic plans as a basis for the production, recruitment and retention of health workers. He acknowledged partnership initiatives led by WHO to expand training capacity in the Region and support Member States to retain core health workers. Since 2008, 11 Member States had begun adapting the global recommendations and guidelines on task shifting.

Challenges remained as a result of macroeconomic and fiscal realities, as well as weak leadership and management capacities in the area of human resources for health. Therefore, health workforce production must be given priority in national budgets and supported by partners in order to build capacities for health management and leadership; strengthen the role of trained community health workers for delivery of health care to disadvantaged populations; and increase investment in the

production of trained health workers by encouraging partnerships between high- and low-income countries. Task-shifting strategies required leadership from national governments to ensure the establishment of a regulatory framework. He urged Member States to adopt the code of practice and the Secretariat to continue advocacy for more support from partners to alleviate the human resources crisis.

Mrs MOHAMMED (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that accelerated training of health-care personnel was essential. Member States in the Region were collaborating to ensure that the health workforce was well trained and were working with WHO and the Global Health Workforce Alliance to make the training more effective. Through its new scientific and medical academy and other institutions, her country would be able to train 14 000 health workers; Djibouti had established a training programme and was appointing university professors to train trainers and health-care personnel. Her country was cooperating with others to develop a national strategy for improving the effectiveness of health workforce training.

Mr EL QABLI (Morocco) said that his Government had expanded the trained health workforce from 1600 to more than 2600 over the preceding two years, and had established a programme for the training of 3300 doctors per year by 2020. Specific data on the migration of health-care personnel in the Region were lacking and he therefore suggested that a global observatory be established in order to monitor the detrimental impact of health workforce migration on the health-care situation, especially in developing countries.

His Government intended to establish a quality system that included a centre for the accreditation of health-care personnel, but that would require technical and other support. He requested that WHO and its partners provide support to broaden the training of health-care personnel and instructors, and thus expand access to a good level of health workforce training.

Dr BAGARIA (United Kingdom of Great Britain and Northern Ireland) welcomed the progress report, but expressed concern at the lack of detail or discussion concerning the impact of resolution WHA59.23, particularly with regard to the impact of WHO's advocacy on the level of financial support provided by global health partners to accredited health-training institutions in developing countries; the number of countries facing health-worker shortages that had formulated comprehensive, costed national workforce strategies; and whether there had been a net increase in the number of health-care workers in the 57 countries identified in *The world health report 2006*.

Mr RAKUOM (Kenya) noted that health training infrastructure such as schools remained inadequate, especially in sub-Saharan Africa, and that there was still a shortage of trainers. He urged all the parties concerned to direct more efforts and resources to those problems.

Dr DAYRIT (Human Resources for Health) commended the progress made by Member States, working with partners such as WHO, since the adoption of resolution WHA59.23. Huge gains had been made. Scaling up health workforce production was linked with the other aspects of human resource development, including migration, retention and the monitoring of countries' progress. That was a challenge, as many health workforce interventions might take years to show results: it took six years to train a doctor, for instance. In the meantime, shortages could be addressed by interventions such as task shifting and the training of mid-level cadres, but any training or policy must be tailored to the specific context.

Responding to the delegate of the United Kingdom, he said that he could not quantify the investments being made in health workforce development, but observed that, of the 57 crisis countries identified in *The world health report 2006*, 24 had developed investment plans, for which six had obtained funding; 45 had also set up national health workforce development plans. The only country

known to have achieved a net increase in health workers was Uganda, but the WHO Global Code of Practice on the International Recruitment of Health Personnel approved by Committee A¹ would provide the platform for more systematic development of international and national health workforce databases to permit better health workforce planning.

The complete lack of awareness about the issue of human resources for health development in 2006 had been replaced by widespread awareness. Several partnerships had been developed, including the Global Health Workforce Alliance and similar alliances in Asia and Africa, which should make it easier to measure Member States' progress in the future.

E. Strengthening nursing and midwifery (resolution WHA59.27)

Dr SUCHITTRA LUANGAMORNERT (Thailand) thanked the Secretariat for supporting the development of nursing and midwifery at all levels – an area where significant progress had been made. Her Government was implementing its second national nursing and midwifery development plan aimed at improving nursing education, research, services, policy, laws and regulations. The nursing and midwifery database had been upgraded but shortages of nurses remained and her Government planned to increase the number of nurses trained each year from 6000 to 8000 by 2016.

Her Government would continue to support the WHO mandate on strengthening nursing and midwifery. She requested the Director-General to continue her efforts to remedy the shortage of health and nursing staff; to provide technical support and encourage Member States to develop a healthy and safe workplace, and to implement the WHO Global Code of Practice as a means of retaining nurses; to further the development and use of a nursing database; and to promote the sharing of experience in the development of nursing regulations and legislation in order to protect public safety, provide affordable health services and build the policy-making capacities of nurse leaders and administrators.

Mrs AHMAD (Malaysia) said that advanced and specialized training of nurses in her country was needed. Retired nurses were currently being recruited back into the workforce, particularly those with specializations. National legislation and regulatory processes were being reviewed by the nursing and midwifery boards to ensure optimum quality of care and the welfare of the workforce. Continuous professional development was a requirement for annual re-certification, and some nurses now held professional and management positions.

Ms TUNICLIFF (New Zealand) acknowledged the international shortage of employed nurses and midwives, important members of the workforce, who made a significant contribution to positive health outcomes such as achieving the Millennium Development Goals. Nurses and midwives should contribute to service planning, decision-making and the development of good-quality health services for their communities, and for that reason her delegation included two nurses. Under the Lead Maternity Carer approach in her country, professionally trained midwives worked alongside general practitioners and obstetricians to manage pregnancy and childbirth. The national primary health care strategy sought to ensure that equitable and accessible services were delivered by a skilled workforce, and to improve indigenous health provider services. There had been an increase in the number of nurse practitioners with prescribing rights; postgraduate education was available to registered nurses and midwives and training to enrolled nurses. Measures were being taken to improve the quality of nursing care.

Mrs CHOTA (Uganda) said that nursing and midwifery made a significant contribution to public health despite the shortage of nurses owing to migration, sickness and poor working environments. The national policy for human resources for health emphasized the need for skilled workers in health planning, development, management, monitoring and evaluation. A national health

¹ Adopted by the Health Assembly as resolution WHA63.16.

workforce database had been established, and the Ministry of Health was being restructured. It was important to attract and retain health workers in difficult sectors, and improve career advancement in nursing and midwifery. The number of institutions and universities that offered training for nurses and midwives had resulted in a greater need for tutors and mentors. Given the current development of nursing and midwifery in many countries, further progress should be reported in both 2011 and 2012.

Dr HWENGA (Zimbabwe), recognizing the role of nurses and midwives in the public health-care delivery system and in meeting the Millennium Development Goals, urged WHO to continue working to strengthen those professions and take into account statements made by nursing and midwifery officers at the recent nurse regulators forum and triad meeting. Further developments in strengthening nursing and midwifery should be reported in 2011, and a new draft resolution should be tabled to ensure that those disciplines continued to contribute to good-quality comprehensive health services, regardless of the place of recruitment.

Mr RAKUOM (Kenya), speaking also on behalf of Swaziland, noted that the progress report was the final report required by resolution WHA59.27 on strengthening nursing and midwifery. Substantial efforts had been made across the regions to implement that resolution, and he commended Member States, development partners and the Secretariat for their commitment.

He had intended to table a draft resolution on strengthening nursing and midwifery, but, given the heavy workload of the Health Assembly, he proposed instead that a report and a resolution on the subject should be prepared by the Secretariat for consideration by the Executive Board.

For eight years, Kenya had been operating a comprehensive nursing workforce database which was being extended to include other health workforce cadres, and the country was collaborating with Member States in the Region to establish similar databases.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) supported the proposal made by the delegate of Kenya, but asked that any new resolution on the subject should take into account other related resolutions, including those on the WHO Global Code of Practice on the International Recruitment of Health Personnel and on primary care.

Ms KOIVISTO (Finland) said that maternal and child health, nursing and midwifery were facing new challenges, particularly noncommunicable diseases and emerging health threats. By implementing advanced nursing and midwifery roles, the full potential of the workforce would be reached and the increasing needs would be met. She supported the proposal made by the delegate of Kenya for the preparation of a new resolution and progress report on the subject.

Mr KYEREMEH (Ghana), recognizing the critical role played by nurses and midwives in the achievement of Millennium Development Goals 4 (Reduce child mortality) and 5 (Improve maternal health), also supported the proposal made by the delegate of Kenya. In response to resolution WHA59.27, his Government had developed community-based health planning services and reintroduced midwifery certification for experienced community health nurses in order to improve access to delivery by trained birth attendants. In addition, a degree-level programme and a diploma in midwifery had been established. He called on WHO and the International Council of Nurses to support initiatives that enabled trained nurses and midwives to work more closely with patients in communities or patients' homes.

Dr CAMPBELL-FORRESTER (Jamaica) said that her country continued to struggle with the shortage of nurses and midwives, which had a negative impact on health-care providers and delivery. The crisis must be addressed at national level. A coordinated, integrated, collaborative approach to health-care planning and delivery was essential in order to strengthen nursing and midwifery services in the member countries of the Caribbean Community and the Secretariat should continue to support regional efforts in those countries. She welcomed the adoption of the WHO Global Code of Practice

on the International Recruitment of Health Personnel, and supported the proposal made by the delegate of Kenya.

Mr SUÁREZ IGLESIAS (Spain), welcoming the progress report, supported the proposal by the delegate of Kenya for the preparation of a new resolution.

Mr AL-TAAE (Iraq) recognized that the problems that affected nursing and midwifery globally required enhanced health-care systems to reduce maternal and child mortality. Improved training for midwives, strengthened national nursing and midwifery capacities, internationally standardized qualifications and partnerships between Member States would ensure better staffing and a more qualified workforce; universities and other training centres should cooperate to provide specialist training. In Iraq, the health and education ministries, with civil society, were cooperating to provide effective training programmes.

Ms BRYANT (Australia), recognizing the central role played by nurses and midwives in provision of health services, in particular in primary health care, said that additional funding was available in Australia for nurse practitioners and midwives through pharmaceutical benefits schemes. In addition, funding had recently been approved under the national budget for an increase in the number of nurses at primary-health care centres, and for the provision of more higher education places, nursing scholarships and clinical placements in indigenous health services. She supported the proposal made by the delegate of Kenya for the preparation of a new resolution on nursing and midwifery.

Dr MHLANGA (South Africa) supported the proposal made by the delegate of Kenya for the preparation of a new resolution. His country would host the 2011 Triennial Congress of the International Confederation of Midwives, and he encouraged Member States to attend and submit plans to increase the number and quality of midwives worldwide. Nurses and midwives should be treated with greater respect as they were the hope for the future; the attainment of Millennium Development Goal 5 (Improve maternal health) depended upon them.

Dr MTASIWA (United Republic of Tanzania) said that his country had reduced its health workforce deficit from 68% to 65% by implementing a human resources strategic plan for the health sector, and was increasing the number of nurses and other graduate health professionals each year. Staff motivation and retention schemes were in place, including the recognition of graduate nursing training; with support from partners, improvements had been made to the infrastructure of public and private training institutions, most of which were nursing schools. Welcoming the continuing support of WHO, he supported the proposal by the delegate of Kenya.

Ms WEBBER (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the efforts to optimize the contribution of nurses and midwives to the attainment of the health-related Millennium Development Goals, but noted that much remained to be done. The Secretariat and Member States should continue to work to resolve the workforce crisis through initiatives such as flexible work approaches and positive practice environments. Greater investment was required in education, and regulatory mechanisms should be updated to improve access to health care and primary health services and encourage the optimum contribution of nurses. Nurses had continually proven their ability to address significant health needs, and her organization called on WHO to remove restrictive regulations that inhibited nurses' ability to make an optimum contribution. Although resolution WHA59.27 had stimulated significant progress, she supported the call for a draft resolution to be submitted to the Sixty-fourth World Health Assembly so as to ensure long-term human resources development related to health. She expressed concern that replacing the Secretariat's Chief Nursing Scientist with a general coordinator would significantly reduce the ability to develop

nursing and midwifery policy and activities. She asked the Director-General to reconsider that change, and thus ensure further coordination of expert advice from the profession.

Dr DAYRIT (Human Resources for Health) noted with satisfaction the progress that had been made in various countries. In the broadest context, nurses and midwives were one category among the wider group of health professionals, all of whom were part of a skills mix. However, WHO recognized that they played a specific role, particularly in primary health care and in the attainment of Millennium Development Goal 5 (Improve maternal health). He noted that the situation of nurses and midwives varied from country to country; overproduction, underproduction and the training of faculty members were some of the problems faced. In 20 countries in the Region of the Americas, nursing regulations were already being updated to improve the effectiveness of personnel. Nurses were being given more tasks, including infection control, acute respiratory disease management and hepatitis B control, which strengthened nursing capacity overall. Some countries, such as Kenya, had such an efficient nursing database that national policy-making for nursing had become more precise, and vacancies and unemployed nurses could be easily matched. Broad national policies in countries like the United Kingdom of Great Britain and Northern Ireland had led to new regulations and many unemployed nurses were returning to work. The Secretariat had a role to play in supporting Member States to tackle the challenges they faced. The Global Advisory Group on Nursing and Midwifery Development met annually to provide policy advice, thereby supporting regional and national activities; and Triad meetings, attended by chief nursing and midwifery officers, provided a framework for improved coordination. With regard to the proposal by the delegate of Kenya, he said that it was the responsibility of Member States to prepare a resolution, but the Secretariat could assist in its preparation. He had taken note of a concern raised about changing the title of the Chief Nursing Scientist to Coordinator, but said that the terms of reference for that position remained unchanged. The move towards more generic titles within the Organization would not detract from the emphasis placed on nursing and midwifery.

Ms RASHEED (Maldives) said that nursing training in her country had evolved from a diploma programme in the 1990s to a full degree programme, and that the Maldives Nursing Council had been established to standardize regulatory processes. Nurses and midwives played a major role in enhancing public health, and the adoption of resolution WHA59.27 had given a clear future direction for strengthening nursing and midwifery.

Dr El Sayed took the Chair.

F. Sustaining the elimination of iodine deficiency disorders (resolution WHA60.21)

Dr ALMARZOOQI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, noted that in 2008, the Regional Committee for the Eastern Mediterranean had adopted a declaration on a salt iodization campaign launched in partnership with salt producers and a campaign for the rapid elimination of iodine deficiency disorders. Her Government had established a strategic plan with the International Council for the Control of Iodine Deficiency that gave high priority to the elimination of such disorders and a partnership to analyse the iodine content of food staples in order to set healthy levels and meet WHO targets. That analysis had revealed a reduction in iodine deficiency from 20% to 8% in just a few years. Many Member States still faced significant problems because of lack of access to iodized salt, but partnerships with salt producers and monitoring programmes could help reduce iodine deficiency disorders. The plan adopted by her Government could therefore serve as a model. She urged WHO to continue its efforts in that regard.

Dr MALEFHO (Botswana) said that his Government had conducted a micronutrient study in 1994 that had also involved physical assessments of goitre and the measurement of iodine excretion in school-age children. The study had found a total goitre rate of 16% in children. Efforts to control iodine deficiency disorders through universal salt iodization had begun in 1992, when local salt producers had been asked to iodize salt for human consumption voluntarily; however, the 2007 family health survey had found that only 66% of households were using appropriately iodized salt. Public education on the importance of iodine and the storage of iodized salt was therefore continuing. Apart from salt, cereal-based foods for governmental supplementary feeding programmes were fortified with vitamins and minerals, including iodine. The challenge for Botswana was to monitor the impact of governmental interventions and he therefore requested WHO's support in that and other relevant research.

Dr KYEYUNE (Uganda), speaking on behalf of the Member States of the African Region, said that iodine deficiency continued to be a major cause of preventable disease and disability among children and adults in many Member States. The proportion of households that consumed adequately iodized salt varied considerably, but more than 50% of school-age children suffered from iodine deficiency in more than 14 Member States. Ghana and Nigeria had successfully established salt iodization programmes, and in Uganda more than 95% of households consumed adequately iodized salt. Universal salt iodization remained the cornerstone of control efforts.

To scale up iodization programmes, the Regional Committee for Africa at its fifty-eighth session had adopted document AFR/RC58/7, which contained a situational analysis of iodine deficiency disorders in the Region and recommendations for national plans to enforce salt iodization regulations, update policies, mobilize political support and strengthen national and international advocacy. In order for countries to achieve certification of freedom from iodine deficiency disorders, African governments should enforce policies and legislation for compulsory salt iodization and the inspection of all salt imported for human and animal consumption, and should prohibit salt that did not meet WHO standards. Standards for salt iodization also needed to be harmonized within the various African trading blocs. Capacity building of customs and food standards agencies must be sustained and there should be public education campaigns on iodine deficiency disorders, especially for those communities at highest risk of consuming locally produced non-iodized salt.

Mr AL-TAAE (Iraq) said that his Government had been monitoring the production and importation of salt. Around 28% of families in Iraq used iodized salt. Partnerships had been strengthened in order to increase access to iodized salt and standards were being developed. WHO had an important role to play in creating a reliable database on the issue and should also consider the various alternatives for combating iodine deficiency disorders.

Ms KIANIAN-FIROUZGAR (UNICEF) said that WHO and UNICEF had been working closely to eliminate iodine deficiency and universal salt iodization had been the preferred strategy for control of iodine deficiency since 1994. Although the proportion of people that consumed iodized salt had increased dramatically, around 41 million children were born each year into households that did not have access to iodized salt and were thus at risk of life-long brain damage. UNICEF would support all national and international efforts to monitor and accelerate progress in the sustainable elimination of iodine deficiency.

Dr BRANCA (Nutrition for Health and Development) said that elimination of iodine deficiency disorders could be achieved with affordable and cost-effective measures. Despite considerable progress, several countries still had a high prevalence of low iodine status and one third of households worldwide did not have access to iodized salt. More than 40 million children were exposed to the risk of brain damage resulting from iodine deficiency. WHO was currently reviewing guidelines on the use of salt as a vehicle for fortification and aimed to develop recommendations for the adjustment of iodine concentration in fortified salt according to both the iodine and the salt intake of populations.

Impact assessment required the evaluation of iodine status in women and children and of salt consumption and the monitoring of the quality of iodized salt. The Secretariat would continue to work with Member States on improving access to iodized salt and assessing the impact of fortification strategies.

G. Multilingualism: implementation of action plan (resolution WHA61.12)

Ms BRANCHI (France) said that respect for multilingualism and use of the official and working languages of WHO were essential for the effectiveness of the Organization's work and the success of all its activities, from policy design to implementation in the field. That meant not only the timely translation of publications but also the interpretation of statements and communications. She commended the efforts made at the current Health Assembly to provide interpretation in working groups, technical meetings and informal consultations, a practice that must be made systematic in order to ensure the participation of all delegations and regional groups and permit mutual understanding. For its own credibility, the Organization needed to fulfil the principle of universality that underpinned the work of the United Nations. If draft resolutions were published in only one language, some delegations might be excluded from the discussions, which would then less than fully reflect the diversity of delegations' views.

She welcomed the involvement of Member States in the setting of translation priorities. She looked forward to the extension of the pilot survey of staff language competencies to the entire Organization and supported staff language training activities. However, she would have liked more information on the activities of, and the resources allocated to, the special coordinator for the promotion of multilingualism. She recommended that WHO strengthen its ties with the International Organisation of La Francophonie and thanked the Director-General for her sensitivity to the issue of multilingualism and her efforts to develop it within WHO. She paid tribute to the interpreters for their work throughout the current Health Assembly proceedings.

Mr BOUCHEDOUB (Algeria) said that multilingualism was essential to ensure the participation of all Member States in negotiations, debates and decision-making. He thanked WHO for its efforts to provide interpretation and translation services to all meetings and groups at the current Health Assembly, but noted that there had been some shortcomings, particularly with regard to informal meetings, where some draft resolutions had not been translated. He therefore urged WHO to implement multilingualism fully both at headquarters and in the regional offices, which would in turn enable the latter to contribute to translation work, especially for important documents. He welcomed the availability of staff language training activities in WHO, which should facilitate communication between WHO bodies and Member States. He particularly favoured increasing multilingual technical content on the WHO web site.

Mr PARDO (Monaco) said that the progress report seemed to depart from the spirit of resolution WHA61.12. For instance, only two regions appeared to have been consulted about translation priorities. With regard to publications and the content of the WHO web site, there was no mechanism for measuring changes in the volume of pages that could be consulted in the official languages, especially French. The information provided was quantitative, but not qualitative. The role of the special coordinator for the promotion of multilingualism was crucial, but he asked what work was actually done by that person in terms of consultations.

WHO staff must learn to think and express themselves multilingually. Multilingualism was a reflection of true diversity and must be allowed to develop and thrive. It could not simply be decreed and quantified, it must be lived.

Ms TRENOU (Togo) welcomed the progress made in promoting multilingualism, particularly the increase in the number of documents published in different official languages. Multilingualism gave Member States a greater role in the Organization's work and decision-making and thus a better

understanding of its activities. She suggested that the Secretariat should help Member States to build their capacity to introduce the teaching of the official languages into their education systems.

Mrs MOHAMMED (Sudan) expressed frustration at the marginalization of Arabic, particularly in some informal meetings at WHO. The principle of multilingualism must be strengthened in all WHO meetings, publications and documents. She thanked the interpreters for having contributed to the success of the Health Assembly's work.

Dr AL SHORBAJI (Knowledge Management and Sharing) said that one function of the special coordinator for the promotion of multilingualism was to liaise with the different technical and administrative bodies that produced their own information and documents in the six official languages. With regard to non-official languages, his role was to contact Member States and to decide which documents were to be translated into their different languages. The pilot survey of staff language competencies would be distributed to all WHO offices and the staff language training programme was ongoing.

Translation priorities were set in cooperation with all regional offices, some of which had not yet provided all necessary information in that regard. All Member States had been invited to indicate the languages into which they would like WHO documents to be translated and it was to be hoped that more Member States would identify those needs. WHO was prepared to introduce other languages and provide training in them at the level of individual Member States.

H. Health of migrants (resolution WHA61.17)

Ms PATCHAREEWAN PHUNGNIL (Thailand) commended the progress made in implementing resolution WHA61.17 and thanked WHO and other international organizations for their cooperation in that regard.

Thailand was host to more than two million irregular migrants and their dependants. Employers provided full health coverage for registered migrants, and the Ministry of Public Health defrayed part of the cost of health services for non-registered migrants on humanitarian grounds. Universal coverage had recently been introduced for half a million stateless people in Thailand. Budget subsidies for non-registered migrants and their dependants imposed a huge and increasing burden on the Government. Emerging diseases were also a growing problem and the Government had launched a policy for integrating disease surveillance among migrants into national disease surveillance systems.

Mr AL-TAAE (Iraq) said that the health of returning migrants, and their security, human rights and decent living conditions must be ensured. Community-based initiatives and sustainable development must also be encouraged. In addition, WHO should work with other international organizations, and in partnership with the Member States concerned, to support and monitor the health conditions of migrants while they were abroad and exchange expertise on the impact of national workplans for the implementation of both the Millennium Development Goals and public health-care activities.

Dr MACHATINE (Mozambique), speaking on behalf of the Member States of the African Region, said that they were making efforts to eliminate disparities in health status and access to health services between migrants and host populations. All national strategic HIV/AIDS plans included statements that emphasized the vulnerabilities and needs of migrants and mobile populations. The Southern African Development Community's Policy Framework for Population Mobility and Communicable Diseases (2009) provided guidance on the protection of cross-border migrants from communicable diseases and on the control of diseases in cross-border movement.

However, overstretched health infrastructures restricted effective response to the service delivery needs of migrants. For instance, HIV programmes that were centred in the workplace, in sectors such as mining and commercial agriculture, tended to target permanent employees only, and

failed to cover their families; nor did they cover casual workers or surrounding communities. Member States should therefore step up the implementation of national laws and practices in order to comply with international standards, which included respect for health-related rights.

Dr MOSCA (International Organization for Migration), commended the progress made in implementing resolution WHA61.17. He thanked the Governments of Portugal and Spain for having hosted a side event to present the results of the Global Consultation on Migrant Health (Madrid, 3-5 March 2010) which had identified priorities and established a framework for implementation of the migrant health agenda at the global, regional and country levels.

Leadership at country level was essential to establish migrant health units or focal points within national ministries of health in order to ensure effective programming and establish partnerships with other ministries. That would enable a coherent response to country-specific challenges. His Organization promoted comprehensive access to health care and prevention services for migrants, and the adoption of globally accepted minimum standards of access to health care for migrants. Those standards should be rooted in the public health concepts of equity and safety, irrespective of the migrant's status.

The reporting on progress had helped to maintain the momentum on the implementation of the resolution; that periodic reporting should be continued and thus maintain a spotlight on an issue of public health and equity that was highly relevant in a globalized world.

Dr LAROCHE (Assistant Director-General) thanked the Governments of Portugal and Spain for organizing the side event during the Madrid Consultation. He also thanked those Governments and the International Organization for Migration for having defined the strategic frameworks and networks that needed to be put in place. The Secretariat was ready to accept the suggestions made and to help Member States to define their migrant health strategies.

I. Climate change and health (resolution WHA61.19)

Mr AL-TAAE (Iraq) recognized the particular importance of the work conducted in the area of climate change. Further studies and research were necessary as Member States faced the challenges of deforestation, desertification and other climate-related phenomena. He urged the further promotion of the World Day to Combat Desertification and increased efforts to combat both desertification and environmental degradation.

Mr SEARL (United Kingdom of Great Britain and Northern Ireland) said that there was a growing body of evidence on the adverse effects of climate change on health. The health community had a special role to play on the issue and the work of WHO and its regional offices was vital to helping communities to manage the risks of climate change and strengthen health systems. He urged health ministers and professionals to continue to raise awareness on climate change and health, which were closely interconnected issues.

He considered that, given the importance of the agenda item, progress reports should be provided annually rather than every two years.

Dr KHYYAM (Bangladesh), speaking on behalf of the Member States of the South-East Asia Region, expressed appreciation for the progress report on climate change and health. In view of time constraints, he said that he would submit the full text of his statement to the Secretariat for information.

Dr KOUYATE (Burkina Faso), speaking on behalf of the Member States of the African Region, said that natural disasters had led to huge loss of life and material damage in many Member States. Support to those had been underlined in the progress report, alongside the development of a framework for protecting health against climate-related risks.

Member States had begun to analyse the situation and assess needs in regard of the implementation of the Libreville Declaration on Health and Environment in Africa and the provisions for achieving the Millennium Development Goals set by the Fifteenth Conference of the Parties to the United Nations Framework Convention on Climate Change. Obstacles that hampered progress included: a lack of long-term financing for capacity building and for inter-country support teams; poor coordination of policy formulation and implementation; and a lack of data on seasonal variations in climate available to the health sector.

The progress report could have been enhanced if Member States had been called upon to develop road maps on implementation of frameworks for protecting health against climate-related risks in Africa and encouraged to increase coordination in policy formulation in all sectors and not only social sectors.

Mrs TZIMAS (Germany) fully supported WHO's activities aimed at achieving the objectives of the workplan for climate change and health. Her Government supported national and regional health programmes in more than 50 countries. Discussions were being pursued on how to ensure that such cooperation programmes responded to the current and anticipated human health-related threats posed by climate change, and how to increase the capacity of people and systems to adapt to climate change at the local level.

Dr NERLANDER (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the humanitarian consequences of climate change were central to much of the Federation's work, as was emphasized in its Strategy 2020. By the end of 2010 many Red Cross and Red Crescent national societies would have completed the preparedness for climate change programme, under which they would liaise with WHO and health ministries as well as with meteorological services. The Federation was undertaking activities in relation to the WHO's workplan for climate change and health, in areas such as advocacy, awareness raising, and partnerships. It was integrating climate change considerations into its regular work and using climate information on all time scales to better plan for extreme events.

Pursuant to the Declaration "Together for humanity" adopted at the 30th International Conference of the Red Cross and Red Crescent in 2007, the Federation was committed to important work on climate change and health.

Mr DOEBLER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, called on WHO to continue its efforts to promote consideration of the health impacts of climate change and asked the Director-General to ensure WHO's active involvement in forthcoming meetings on the issue in Bonn, Germany, and Cancún, Mexico.

He encouraged the Secretariat and Member States to ensure the protection of the most vulnerable from the adverse effects of climate change on health. The obligation to cooperate was incumbent upon all Member States under United Nations legal instruments and WHO's Constitution.

Dr NEIRA (Protection of the Human Environment) said that the Secretariat would continue its efforts to gather scientific evidence that health was adversely affected by global warming. It would continue to support countries in establishing national plans, assessing vulnerability and establishing mechanisms for funding and adaptation, and would continue with its advocacy efforts to demonstrate that not only did climate change have a negative impact on health, but also that health improved when policies were introduced to reduce greenhouse gas emissions. She welcomed the opportunity for WHO to participate in the forthcoming meetings in Bonn and Cancún and to share that message.

The Secretariat was grateful to all countries that had participated constructively in climate-change policy formulation and that were making a financial contribution to project implementation.

J. Primary health care, including health system strengthening (resolution WHA62.12)

Mr SUÁREZ IGLESIAS (Spain), speaking on behalf of the European Union, expressed appreciation for the progress report and said that comprehensive health systems that provided universal coverage and equal access to basic quality care were a high priority for the European Union.

The European Union welcomed WHO's efforts to streamline its primary health-care activities, as strong health systems were essential to the integration of disease-specific initiatives into comprehensive health care. It looked forward to a greater focus on results in the next progress report in the four areas of implementation to which resolution WHA62.12 referred.

Dr WACHARA RIEWPAIBOON (Thailand) emphasized: the link between national planning and strategy building processes within each health system; the formulation of plans to bolster WHO's support to policy; investment in health-care infrastructure; and technical advisory committees.

He requested the Secretariat to include information in its next progress report on the collation and analysis of the experiences of Member States in the implementation of primary health care and on facilitating exchange of information in that regard.

Mrs YAHAYA (Nigeria), speaking on behalf of the Member States of the African Region, commended the Secretariat's efforts to support Member States in the elaboration of national strategies, the strengthening of capacity and the mobilization of additional resources. However, the priorities outlined by the Secretariat were not sufficient in themselves to achieve the desired improvements in health outcomes.

Accelerated progress in the Region would require: support to governments to enhance their stewardship role, particularly in regard to regulation of private-sector participation in primary health-care delivery; innovative approaches to address the human resources situation; the use of vertical funding mechanisms to facilitate progress on decentralization and integration; the use of new technologies to improve information management and efficiency, including the use of mobile telephony to expand access; and domestication of the health reform agenda in the African Region, as many Member States had traditional institutions that could play a positive role in identifying demand for primary health-care services.

Mr AL-TAAE (Iraq) emphasized the importance of strengthening primary health care and of constantly renewing efforts in that domain.

Ms TUPUIMATAGI TOELUPE (Samoa), welcoming the increased linkages made in programmes and country cooperation strategies in regard to primary health care, said that WHO should make every effort to ensure that those linkages were built on existing national health plans and systems. She urged the Secretariat to ensure that the practical implementation of the Paris Declaration on Aid Effectiveness did not cause the Organization to lose its technical role in health.

Mrs MOHAMMED (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, recalled the Qatar Declaration on Health and Well-being through Health Systems based on Primary Health Care, to which Member States had reaffirmed their support.

The Regional Office had developed a six-year strategic plan that would provide technical support to Member States in the promotion of primary health care. However, challenges remained: health systems in low- and middle-income countries were considerably underfunded; there was an imbalance in the health workforce; health infrastructure was inadequate; and essential technologies were unavailable. Under those circumstances some Member States would struggle to achieve the health-related Millennium Development Goals.

She urged the Director-General to allocate more resources to primary health care.

Ms CHASOKELA (Zimbabwe) said that the spirit of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa had kept her country on track and the implementation tools developed by WHO had proved to be highly useful.

She requested the support of the Director-General in adopting and adapting the tools needed to ensure provision of quality and comprehensive services in communities, and to promote participation in decision-making. She acknowledged the role of communities and stakeholders in policy decisions, health-care services planning, implementation, monitoring and evaluation. She encouraged the creation of a technical advisory committee on primary and health systems strengthening that was representative of all regions and subregions.

Dr MTASIWA (United Republic of Tanzania) thanked WHO for the technical support that had enabled his country to develop a primary health-care programme for the next ten years. Continued support was needed from WHO and all partners to achieve national goals in strengthened health systems.

Mr TAAL (Gambia) emphasized that renewal of the primary health-care approach would be fundamental to reducing burden of disease and inequalities in health-service delivery in African countries. The Regional Committee for Africa had endorsed, through its resolution AFR/RC56/R6, the revitalization of health services using the primary health-care approach to accelerate achievement of the Millennium Development Goals.

In Gambia, challenges to the health system concerned: human resources for health; strengthening health information systems; health financing; and community ownership and participation. The Government looked forward to partner support to implement its new five-year strategic health plan.

Ms EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the references in the progress report to civil society participation and recommended that such participation be extended to the technical advisory committee on primary care and health systems strengthening. Primary health-care plans should be linked to national expenditure frameworks and time-bound budgets. In that way, plans would be linked to poverty reduction strategies, which would ensure with their full financing. The progress report could have given more attention to donor strategies and efforts to support primary health care. She awaited *The world health report 2010*, which might identify ways in which Member States could protect citizens from falling into poverty through provision of primary health-care funding.

Dr ETIENNE (Assistant Director-General) praised Member States' commitment to the renewal of primary health care and reaffirmed the Secretariat's support for their efforts to achieve the goal of health for all.

The CHAIRMAN said he took it that the Committee wished to note the progress reports contained in document A63/27.

The Committee noted the reports.

2. SECOND REPORT OF COMMITTEE B

Mr SANNE (Rapporteur) read out the draft second report of Committee B.

The report was adopted.¹

3. CLOSURE

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

The meeting rose at 19:55.

¹ See page 324.

PART II
REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly has been replaced by the serial number (in square brackets) under which they appear in document WHA63/2010/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA63/2010/REC/2.

COMMITTEE ON CREDENTIALS

Report¹

[A63/60 – 19 May 2010]

The Committee on Credentials met on 18 May 2010. Delegates of the following Member States were present: Angola, Austria, Bangladesh, Eritrea, Israel, Nicaragua, Oman, Singapore, The former Yugoslav Republic of Macedonia, Trinidad and Tobago, Zambia.

The Committee noted that the delegate of Nauru was absent.

The Committee elected the following officers: Dr B. Blaha, (Austria) – Chairman, and Mr S.A. Ali (Bangladesh) – Vice-Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials, and the Committee therefore proposed that the Health Assembly should recognize their validity.

The Committee examined notifications from the following Member States, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommended to the Health Assembly that the delegates of these Member States be provisionally seated with all rights in the Health Assembly pending the arrival of their formal credentials: Saint Kitts and Nevis, The former Yugoslav Republic of Macedonia, and United Arab Emirates.

States whose credentials it was considered should be recognized as valid (see fifth paragraph above)

Afghanistan, Albania, Algeria, Andorra, Angola, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Azerbaijan, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Benin, Bhutan, Bolivia (Plurinational State of), Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Colombia, Comoros, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea,

¹ Approved by the Health Assembly at its sixth plenary meeting.

Democratic Republic of the Congo, Denmark, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, Finland, France, Gabon, Gambia, Georgia, Germany, Ghana, Greece, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Honduras, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malawi, Malaysia, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Micronesia (Federated States of), Monaco, Mongolia, Montenegro, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Nigeria, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Romania, Russian Federation, Rwanda, Samoa, Saint Lucia, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, Solomon Islands, Somalia, South Africa, Spain, Sri Lanka, Sudan, Suriname, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Tajikistan, Thailand, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tunisia, Turkey, Turkmenistan, Tuvalu, Uganda, Ukraine, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, Uzbekistan, Vanuatu, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia, Zimbabwe.

GENERAL COMMITTEE

Report¹

[A63/61 – 20 May 2010]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 19 May 2010, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Armenia, Barbados, China, Ecuador, Mongolia, Morocco, Mozambique, Norway, Seychelles, Timor-Leste, United States of America, and Yemen.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

¹ See document WHA63/2010/REC/2, verbatim record of the seventh meeting of the Health Assembly.

COMMITTEE A**First report¹**

[A63/58 – 18 May 2010]

Committee A held its first meeting on 17 May 2010 under the chairmanship of Dr M. Mugitani, Japan.

It was decided to recommend to the Sixty-third World Health Assembly the adoption of one resolution relating to the following agenda item:

11. Technical and health matters
 - 11.1 Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits [WHA63.1].

Second report²

[A63/59 – 19 May 2010]

Committee A held its third meeting on 18 May 2010 under the chairmanship of Dr M. Mugitani, Japan.

It was decided to recommend to the Sixty-third World Health Assembly the adoption of one resolution relating to the following agenda item:

13. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA63.2].

Third report²

[A63/63 – 20 May 2010]

Committee A held its seventh meeting on 19 May 2010 under the chairmanship of Dr M. Mugitani, Japan.

It was decided to recommend to the Sixty-third World Health Assembly the adoption of one resolution relating to the following agenda item:

11. Technical and health matters
 - 11.8 Food safety [WHA63.3].

¹ Approved by the Health Assembly at its sixth plenary meeting.

² Approved by the Health Assembly at its seventh plenary meeting.

Fourth report¹

[A63/64 – 21 May 2010]

Committee A held its eighth and ninth meetings on 20 May 2010. The eighth meeting was held under the chairmanship of Dr U. Scholten (Germany) and the ninth meeting under the chairmanship of Dr M. Mugitani (Japan).

It was decided to recommend to the Sixty-third World Health Assembly the adoption of four resolutions relating to the following agenda items:

11. Technical and health matters
 - 11.4 Monitoring of the achievement of the health-related Millennium Development Goals [WHA63.15]
 - 11.5 WHO Global Code of Practice on the International Recruitment of Health Personnel [WHA63.16]
 - 11.9 Prevention and control of noncommunicable diseases: implementation of the global strategy
 - Marketing of food and non-alcoholic beverages to children [WHA63.14]
 - 11.10 Strategies to reduce the harmful use of alcohol [WHA63.13].

Fifth report¹

[A63/66 – 21 May 2010]

Committee A held its eleventh and twelfth meetings on 21 May 2010 under the chairmanship of Dr M. Mugitani, Japan.

It was decided to recommend to the Sixty-third World Health Assembly the adoption of 12 resolutions and one decision relating to the following agenda items:

11. Technical and health matters
 - 11.3 Public health, innovation and intellectual property: global strategy and plan of action
 - Establishment of a consultative expert working group on research and development: financing and coordination [WHA63.28]
 - 11.4 Monitoring of the achievement of the health-related Millennium Development Goals
 - WHO HIV/AIDS strategy for 2011–2015 [WHA63.19]
 - 11.6 Infant and young child nutrition [WHA63.23]
 - 11.7 Birth defects [WHA63.17]
 - 11.12 Viral hepatitis [WHA63.18]
 - 11.14 Chagas disease: control and elimination [WHA63.20]

¹ Approved by the Health Assembly at its eighth plenary meeting.

- 11.18 Strategic Approach to International Chemicals Management
 - Improvement of health through safe and environmentally sound waste management [WHA63.25]
 - Improvement of health through sound management of obsolete pesticides and other obsolete chemicals [WHA63.26]
- 11.19 WHO's roles and responsibilities in health research [WHA63.21]
- 11.20 Counterfeit medical products
 - Substandard/spurious/falsely-labelled/falsified/counterfeit medical products [WHA63(10)]
- 11.21 Human organ and tissue transplantation [WHA63.22]
- 11.22 Strengthening the capacity of governments to constructively engage the private sector in providing essential health-care services [WHA63.27]
- 11.23 Treatment and prevention of pneumonia
 - Accelerating progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia [WHA63.24].

COMMITTEE B

First report¹

[A63/62 – 20 May 2010]

Committee B held its first, second and third meetings on 19 May 2010 under the chairmanship of Dr W. Jayantha (Sri Lanka).

It was decided to recommend to the Sixty-third World Health Assembly the adoption of eight resolutions and one decision relating to the following agenda items:

- 15. Financial matters
 - 15.1 Financial report and audited financial statements for the period 1 January 2008 – 31 December 2009 [WHA63.4]
 - 15.4 Scale of assessments 2010–2011 [WHA63.5]
 - 15.7 Safety and security of staff and premises and the Capital Master Plan
 - Safety and security of staff and premises [WHA63.6]
 - The Capital Master Plan [WHA63.7]
- 16. Audit and oversight matters
 - 16.1 Report of the External Auditor [WHA63.8]
- 17. Staffing matters
 - 17.4 Amendments to the Staff Regulations and Staff Rules
 - Salaries of staff in ungraded posts and of the Director-General [WHA63.9]
 - 17.6 Appointment of representatives to the WHO Staff Pension Committee
 - United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA63(8)]
- 18. Management and legal matters
 - 18.1 Partnerships [WHA63.10]
 - 18.3 Agreements with intergovernmental organizations [WHA63.11].

¹ Approved by the Health Assembly at its eighth plenary meeting.

Second report¹

[A63/65 – 18 June 2010]

Committee B held its fourth, fifth and sixth meetings on 20 May 2010 and its seventh meeting on 21 May 2010 under the chairmanship of Dr W. Jayantha (Sri Lanka). Its eighth meeting, on 21 May 2010, was held under the chairmanship of Dr G.J. Komba Kono (Sierra Leone) and Dr N. El Sayed (Egypt).

It was decided to recommend to the Sixty-third World Health Assembly the adoption of one resolution relating to the following agenda item:

11. Technical and health matters
 - 11.17 Availability, safety and quality of blood products [WHA63.12].
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¹ Approved by the Health Assembly at its eighth plenary meeting.