TENTH MEETING

Saturday, 21 May 2011, at 09:30

Chairman: Dr W. AMMAR (Lebanon)

1. FOURTH REPORT OF COMMITTEE A (Document A64/59 (Draft))

Dr KULZHANOV (Kazakhstan), Rapporteur, read out the draft fourth report of Committee A.

The report was adopted.

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

Prevention and control of noncommunicable diseases: WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases (September 2011): Item 13.12 of the Agenda (Documents A64/21 and A64/21 Add.1) (continued from the fourth meeting, section 3)

The CHAIRMAN drew attention to the following draft resolution on preparations for the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, following the Moscow Conference, proposed by Argentina, Australia, Bahrain, Barbados, Bolivarian Republic of Venezuela, Brazil, Canada, Chile, China, Colombia, Côte d'Ivoire, Ecuador, Ghana, Hungary on behalf of the Member States of the European Union, Iraq, Kuwait, Mexico, Monaco, Norway, Oman, Paraguay, Peru, Plurinational State of Bolivia, Qatar, Republic of Moldova, Russian Federation, Saudi Arabia, Switzerland, Trinidad and Tobago, Uganda, United Arab Emirates, United Republic of Tanzania, United States of America, Uruguay, and Yemen:

> The Sixty-fourth World Health Assembly,
>
> PP1 Having considered the report on WHO's role in the preparation, implementation and follow-up to the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases[1] (high-level meeting);
>
> PP2 Deeply concerned that the global burden and threat of noncommunicable diseases continues to grow, in particular in developing countries, and convinced that global action is necessary and urgent response is needed, including by effectively addressing the key risk factors for noncommunicable diseases;
>
> PP3 Reaffirming its commitment to the aim of the global strategy for the prevention and control of noncommunicable diseases to reduce premature mortality and improve quality of life (resolution WHA53.17);
>
> PP4 Further recalling United Nations General Assembly resolution 64/265 in which the General Assembly decided to convene a high-level meeting of the General Assembly in September 2011, with the participation of Heads of State and Government, on the prevention

[1] Resolution 64/265 – Prevention and control of noncommunicable diseases.

and control of noncommunicable diseases, as well as resolution 65/238 on the scope, modalities, format and organization of the high-level meeting;

PP5 Recognizing the leading role of the World Health Organization as the primary specialized agency for health, and reaffirming the leadership role of WHO in promoting global action against noncommunicable diseases;

PP6 Noting with appreciation the first *WHO Global status report on noncommunicable diseases* launched on 27 April 2011, which may serve as an input into the preparatory process for the high-level meeting;

PP7 Noting the outcomes of the regional consultations which were held by WHO in collaboration with Member States, with the support of relevant United Nations agencies and entities, which will serve to provide inputs to the preparations for the high-level meeting, as well as to the meeting itself;

PP8 Welcoming the outcome of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, which was organized by the Russian Federation and WHO from 28 to 29 April 2011 in Moscow,

1. ENDORSES the Moscow Declaration, annexed to the present resolution, including as a key input for the preparations leading to the High-level Meeting;

2. URGES Member States:[1]

(1) to continue to support the preparations at national, regional and international levels for the high-level meeting, including, where feasible and relevant, situation analysis of noncommunicable diseases and their risk factors, as well as an assessment of national capacity and health system response to address noncommunicable diseases;

(2) to be represented at the level of Heads of State and Government at the high-level meeting and to call for action through a concise action-oriented outcome document;

(3) to consider, as appropriate and where relevant, including in their national delegations to the high-level meeting parliamentarians, representatives of civil society, including nongovernmental organizations, academia and networks working on the control and prevention of noncommunicable diseases;

3. REQUESTS the Director-General:

(1) to continue exercising the leading role of WHO as the primary specialized agency for health working together in a coordinated way with the United Nations, its specialized agencies, funds and programmes, and other relevant intergovernmental organizations and international financial institutions, in supporting Member States, including:

(i) in undertaking concerted action and a coordinated response in order to promptly and appropriately address the challenges posed by noncommunicable diseases, including further building on available situation analyses on noncommunicable diseases and risk factors; and

(ii) in highlighting the social and economic impact of noncommunicable diseases, including financial challenges, in particular in developing countries;

(2) to take into account the outcomes from the Moscow Conference into the preparations for the high-level meeting;

(3) to ensure adequate financial and human resources within the WHO to prepare for the high-level meeting and to respond swiftly to its recommendations;

(4) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on the outcomes of the first Global Ministerial Conference on Healthy Lifestyles and

[1] And, where applicable, regional economic integration organizations.

Noncommunicable Disease Control and the high-level meeting, and to develop, together with relevant United Nations agencies and entities, an implementation and follow-up plan for the outcomes, including its financial implications, for submission to the Sixty-sixth World Health Assembly, through the Executive Board.

ANNEX

First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control Moscow, 28–29 April 2011

MOSCOW DECLARATION
PREAMBLE

We, the participants in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease (NCDs) Control, gathered in Moscow on 28–29 April 2011.

I.

Express appreciation for the leading role of the World Health Organization and the Government of the Russian Federation in the preparation and holding of the Ministerial Conference.

II.

Recognize that the right of everyone to the enjoyment of the highest attainable standards of physical and mental health cannot be achieved without greater measures at global and national levels to prevent and control NCDs.

III.

Acknowledge the existence of significant inequities in the burden of NCDs and in access to NCD prevention and control, both between countries, as well as within countries.

IV.

Note that policies that address the behavioural, social, economic and environmental factors associated with NCDs should be rapidly and fully implemented to ensure the most effective responses to these diseases, while increasing the quality of life and health equity.

V.

Emphasize that prevention and control of NCDs requires leadership at all levels, and a wide range of multi-level, multi-sectoral measures aimed at the full spectrum of NCD determinants (from individual-level to structural) to create the necessary conditions for leading healthy lives. This includes promoting and supporting healthy lifestyles and choices, relevant legislation and policies; preventing and detecting disease at the earliest possible moment to minimize suffering and reduce costs; and providing patients with the best possible integrated health care throughout the life cycle including empowerment, rehabilitation and palliation.

VI.

Recognize that a paradigm shift is imperative in dealing with NCD challenges, as NCDs are caused not only by biomedical factors, but also caused or strongly influenced by behavioural, environmental, social and economic factors.

VII.

Affirm our commitment to addressing the challenges posed by NCDs, including, as appropriate, strengthened and reoriented policies and programmes that emphasize multi-sectoral action on the behavioural, environmental, social and economic factors.

VIII.

Express our belief that NCDs should be considered in partnerships for health; that they should be integrated into health and other sectors' planning and programming in a coordinated manner, particularly in low- and middle income countries; that they should be part of the global research agenda and that the impact and sustainability of approaches to prevent and control NCDs will be enhanced through health systems strengthening and strategic coordination with existing global health programs.

RATIONALE FOR ACTION

1. NCDs, principally cardiovascular diseases, diabetes, cancers and chronic respiratory diseases, are the leading causes of preventable morbidity and disability, and currently cause over 60% of global deaths, 80% of which occur in developing countries. By 2030, NCDs are estimated to contribute to 75% of global deaths.

2. In addition, other NCDs such as mental disorders also significantly contribute to the global disease burden.

3. NCDs have substantial negative impacts on human development and may impede progress towards the Millennium Development Goals (MDGs).

4. NCDs now impact significantly on all levels of health services, health care costs, and the health workforce, as well as national productivity in both emerging and established economies.

5. Worldwide, NCDs are important causes of premature death, striking hard among the most vulnerable and poorest populations. Globally they impact on the lives of billions of people and can have devastating financial impacts that impoverish individuals and their families, especially in low- and middle-income countries.

6. NCDs can affect women and men differently, hence prevention and control of NCDs should take gender into account.

7. Many countries are now facing extraordinary challenges from the double burden of disease: communicable diseases and noncommunicable diseases. This requires adapting health systems and health policies, and a shift from disease-centred to people-centred approaches and population health measures. Vertical initiatives are insufficient to meet complex population needs, so integrated solutions that engage a range of disciplines and

sectors are needed. Strengthening health systems in this way results in improved capacity to respond to a range of diseases and conditions.

8. Evidence-based and cost-effective interventions exist to prevent and control NCDs at global, regional, national and local levels. These interventions could have profound health, social, and economic benefits throughout the world.

9. Examples of cost-effective interventions to reduce the risk of NCDs, which are affordable in low-income countries and could prevent millions of premature deaths every year, include measures to control tobacco use, reduce salt intake and reduce the harmful use of alcohol.

10. Particular attention should be paid to the promotion of healthy diets (low consumption of saturated fats, trans fats, salt and sugar, and high consumption of fruits and vegetables) physical activity in all aspects of daily living.

11. Effective NCD prevention and control require leadership and concerted "whole of government" action at all levels (national, sub-national and local) and across a number of sectors, such as health, education, energy, agriculture, sports, transport and urban planning, environment, labour, industry and trade, finance and economic development.

12. Effective NCD prevention and control require the active and informed participation and leadership of individuals, families and communities, civil society organizations, private sector where appropriate, employers, health care providers and the international community.

COMMITMENT TO ACTION

We, therefore, commit to act by:

At the Whole of Government level:

1. Developing multi-sectoral public policies that create equitable health promoting environments that enable individuals, families and communities to make healthy choices and lead healthy lives;

2. Strengthening policy coherence to maximize positive and minimize negative impacts on NCD risk factors and the burden resulting from policies of other sectors;

3. Giving priority to NCD prevention and control according to need, ensuring complementarity with other health objectives and mainstreaming multi-sectoral policies to strengthen the engagement of other sectors;

4. Engaging civil society to harness its particular capacities for NCD prevention and control;

5. Engaging the private sector in order to strengthen its contribution to NCD prevention and control according to international and national NCD priorities;

6. Developing and strengthening the ability of health systems to coordinate, implement, monitor and evaluate national and sub-national strategies and programmes on NCDs;

7. Implementing population-wide health promotion and disease prevention strategies, complemented by individual interventions, according to national priorities. These should be equitable and sustainable and take into account gender, cultural and community perspectives in order to reduce health inequities;

8. Implementing cost-effective policies, such as fiscal policies, regulations and other measures to reduce common risk factors such as tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol;

9. Accelerating implementation by States Parties of the provisions of the WHO Framework Convention on Tobacco Control (WHO FCTC) and encouraging other countries to ratify the Convention;

10. Implementing effective policies for NCD prevention and control at national and global levels, including those relevant to achieving the goals of the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol and the Global Strategy on Diet, Physical Activity and Health;

11. Promoting recognition of the rising incidence and burden of NCDs on national as well as international development agendas, and encouraging countries and international development partners to consider the level of priority accorded to NCDs.

At Ministry of Health level:

1. Strengthening health information systems to monitor the evolving burden of NCDs, their risk factors, their determinants and the impact and effectiveness of health promotion, prevention and control policies and other interventions;

2. According to national priorities, strengthening public health systems at the country level to scale up evidence-based health promotion and NCD prevention strategies and actions;

3. Integrating NCD-related services into primary health care services through health systems strengthening, according to capacities and priorities;

4. Promoting access to comprehensive and cost-effective prevention, treatment and care for integrated management of NCDs, including access to affordable, safe, effective and high quality medicines based on needs and resource assessments;

5. According to country-led prioritization, ensuring the scaling-up of effective, evidence-based and cost-effective interventions that demonstrate the potential to treat individuals with NCDs, protect those at high risk of developing them and reduce risk across populations.

6. Promoting, translating and disseminating research to identify the causes of NCDs, effective approaches for NCD prevention and control, and strategies appropriate to distinct cultural and health care settings.

At the International level:

1. Calling upon the World Health Organization, as the lead UN specialized agency for health, and all other relevant UN system agencies, development banks, and other key international organizations to work together in a coordinated manner to address NCDs;

2. Working through WHO in consultation with other multilateral organizations, international nongovernmental organizations, the private sector and civil society stakeholders to strengthen normative guidance, pool technical expertise, coordinate policy to achieve the best possible results and capitalize on synergies among existing global health initiatives.

3. Strengthening international support for the full and effective implementation of the WHO FCTC, the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, the WHO Global Strategy to Reduce the Harmful Use of Alcohol, the Global Strategy on Diet, Physical Activity and Health and other relevant international strategies to address NCDs.

4. Investigating all possible means to identify and mobilize the necessary financial, human and technical resources in ways that do not undermine other health objectives.

5. Supporting the WHO in developing a comprehensive global monitoring framework on NCDs.

6. Examining possible means to continue facilitating the access of low- and middle income countries to affordable, safe, effective and high quality medicines in this area consistent with the WHO Model Lists of Essential Medicines, based on needs and resource assessments, including by implementing the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

WAY FORWARD

With a view to securing an ambitious and sustainable outcome, we commit to actively engaging with all relevant sectors of Government, on the basis of this Moscow Declaration, in the preparation of and the follow-up to the United Nations General Assembly High-level Meeting on the Prevention and Control of noncommunicable diseases in September 2011 in New York.

The CHAIRMAN also drew attention to the financial and administrative implications for the Secretariat of the adoption of the resolution, which were as follows:

1. Resolution Preparations for the High-level Meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases, following the Moscow Conference[1]

2. Linkage to programme budget

Strategic objective:	Organization-wide expected result:
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	3.1 Advocacy and support provided to increase political, financial and technical commitment in Member States in order to tackle chronic noncommunicable diseases, mental and behavioural disorders, violence, injuries and disabilities together with visual impairment, including blindness.
	3.2 Guidance and support provided to Member States for the development and implementation of policies, strategies and regulations in respect of chronic noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.
	3.3 Improvements made in Member States' capacity to collect, analyse, disseminate and use data on the magnitude, causes and consequences of noncommunicable diseases, mental and neurological disorders, violence, injuries and disabilities together with visual impairment, including blindness.
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.	6.2 Guidance and support provided in order to strengthen national systems for surveillance of major risk factors through development and validation of frameworks, tools and operating procedures and their dissemination to Member States where a high or increasing burden of death and disability is attributable to these risk factors.

(Briefly indicate the linkage with expected results, indicators, targets, baseline)

It is envisaged that there will be an increase in the number of Member States: (i) with a unit in the ministry of health or equivalent national health authority, with dedicated staff and budget, for the prevention and control of noncommunicable diseases (indicator 3.1.4); (ii) that have adopted a multisectoral national policy on chronic noncommunicable diseases (indicator 3.2.3); (iii) with a national health reporting system and annual reports that include indicators on the four major noncommunicable diseases (indicator 3.3.4); (iv) with a functioning national surveillance system for monitoring major risk factors to health among adults based on the WHO STEPwise approach to surveillance (indicator 6.2.1).

[1] First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control (Moscow, Russian Federation, 28-29 April 2011).

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$ 4.5 million over a period of three years.

(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$ 1.0 million at all levels of the Organization.

(c) Is the estimated cost noted in (b), included within the existing approved Programme budget for the biennium 2010–2011?

Yes.

4. Financial implications

How will the estimated cost noted in 3(b) be financed (indicate potential sources of funds)?

Costs will be met through income from voluntary contributions from Member States and contributions from international partners.

5. Administrative implications

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

All levels of the Organization.

(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).

Every effort will be made to make full use of secondments from Member States, as well as employing short-term staff.

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

Three years for all actions (the Secretariat is drawing up an implementation plan accordingly).

Mr KÖKÉNY (representative of the Executive Board), introducing the item, said that the Executive Board at its 128th session had considered both a report on the role of WHO in the preparation, implementation and follow-up of the high-level meeting of the United Nations General Assembly on the prevention and control of noncommunicable diseases and a draft resolution on prevention and control of noncommunicable diseases. Many members had expressed strong support for WHO's efforts to increase activities in the area of noncommunicable diseases and its leadership in the preparations for the high-level meeting and committed themselves to both the preparations and the concept of the summit. Recognizing that the high-level meeting would provide a unique opportunity to draw global political attention to the new epidemic of noncommunicable diseases, the Board had considered that WHO had a responsibility to offer evidence-based solutions to reduce the burden of disease and should coordinate implementation of the outcomes of the meeting. Despite formal and informal deliberations Board members had been unable to reach consensus on the draft resolution and had agreed to defer consideration of the draft resolution, following further Member State consultation, to the current Health Assembly.

Dr GOPEE (Mauritius) welcomed the priority the Health Assembly was giving to noncommunicable diseases. The epidemiological transition to those diseases had occurred in Mauritius some 25 years earlier and their prevalence had progressed significantly, with a survey in 2009 revealing rates of 21% for diabetes (the third highest in the world) and 38% for hypertension. Although the population of the country was only 1.2 million, noncommunicable diseases accounted for 80% of the disease burden. The measures that had been implemented following the survey included the establishment of a dedicated noncommunicable diseases unit and a national screening programme; initiatives had included regulation of the palm oil content of blended oils and the imposition of a tax on tobacco. Physical activity programmes had been introduced in schools and for the general population, with extensive media coverage of the major risk factors and recommended activities. Mauritius had scaled up its interventions in line with the various resolutions and conventions adopted by the Health Assembly and WHO's strategies and action plans to combat noncommunicable diseases. Those for nutrition, cancer control and tobacco were being implemented, while initiatives relating to alcohol, respiratory diseases and mental health were being prepared. Regulations prohibiting the advertisement, promotion and sponsorship of alcoholic beverages and tobacco had been adopted, and the sale of soft drinks and unhealthy foods with high salt and sugar content had been banned in all educational institutions. Officials from the Health Inspectorate conducted regular visits to monitor compliance with the regulations. A special diabetic foot-care programme was being prepared in view of the unacceptably high amputation rate. Other initiatives included a national service framework for diabetes, cancer screening services and a master plan to strengthen the primary health-care system focusing on the essential role of primary health-care professionals in the control of noncommunicable diseases.

Notwithstanding the chronic disease burden, life expectancy at birth in Mauritius had risen to 73 years, annual mortality due to noncommunicable diseases was declining, cigarette imports had been reduced and the rates of complications from noncommunicable diseases were stabilizing. In cooperation with WHO and the International Diabetes Federation, his country had hosted the International Conference on Diabetes and Associated Diseases in 2009, which had resulted in the Mauritius Call for Action, targeting the African Region. His country had obtained first prize at the 2011 All Africa Public Sector Innovation Awards, in recognition of its mobile clinic service, which gave the population access to health education and screening, in addition to other sources of primary health care.

The major challenge at global, regional and national levels was controlling the vectors of noncommunicable diseases, by engaging with the fast-food, alcohol and tobacco industries so as to limit the harmful effects of their products on people's health. WHO's guidance in that regard, including preparation of a national salt-reduction strategy, and its technical expertise in bringing about the adoption of healthier lifestyles, especially among young people, would be welcome. Given the magnitude of the disease burden and the possible shortfall in future budgetary allocations, he suggested that WHO should take the opportunity of the forthcoming United Nations General Assembly high-level meeting to call for the establishment of a global fund for noncommunicable diseases.

Dr FEISUL MUSTAPHA (Malaysia) said that the announcement of the high-level meeting had been useful for advocating further work on noncommunicable diseases in Malaysia, particularly in operationalizing a "whole-of-government" approach, although securing the support of ministries and agencies outside the health sector remained a challenge. His Government was committed to reducing the burden of noncommunicable diseases and their risk factors and thanked the Secretariat and particularly the Regional Office for the Western Pacific for technical support, expertise, guidelines and supporting documents, which had proved invaluable for policy and programme development. He supported the draft resolution.

Dr ALI (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that preventing noncommunicable diseases was a priority for the Region in view of the epidemiological transition it was experiencing. Intersectoral cooperation had been established, and every effort was made to prevent and combat such diseases. Morbidity and mortality from noncommunicable diseases in the Region continued to rise and rates were among the highest in the world. Prevention and control had been integrated into national development programmes and into primary health care; emphasis was being placed on capacity-building for health-care professionals, and national strategies were being strengthened to promote healthier lifestyles. The social determinants of noncommunicable disease were also being addressed multisectorally. The countries of the Region, which had participated in preparation of the global strategy for the prevention and control of noncommunicable diseases, were fully committed to its implementation. Calling for ongoing support from the Secretariat in that regard, she endorsed the draft resolution.

Dr AL HAJERI (Bahrain) said that her country had devised a plan to combat chronic diseases, which were a national priority; its implementation involved cooperation at the various levels of Government and with civil society. A national committee responsible for drafting a strategy to strengthen health care had been established with the participation of municipalities and other stakeholders. Her country had prohibited the advertisement of tobacco, whose use had been banned in the workplace. It was implementing the Global strategy on diet, physical activity and health in schools. In cooperation with the Secretariat, her Government had developed primary health care services and had opened health centres for people with chronic mental conditions, with early screening facilities. Bahrain had participated in the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and had signed the resulting Moscow Declaration. Recognizing the growing threat posed by noncommunicable diseases and stressing the importance of WHO's role in the context of the United Nations General Assembly high-level meeting, she reaffirmed her Government's commitment to implementing the global strategy for the prevention and control of noncommunicable diseases. She endorsed the draft resolution.

Dr KIMANI (Kenya), noting with concern that noncommunicable diseases caused almost four times more deaths than HIV/AIDS, malaria and tuberculosis combined, added that people with the former were more susceptible to infectious diseases. Noncommunicable diseases resulted not only in chronic disabling and life-threatening conditions but had a significant social and economic impact in all countries. Their prevention should therefore be integral to the global development agenda.

Confident that WHO, as the primary specialized agency for public health, would pave the way for a successful high-level meeting in September 2011, he drew attention to his Government's expected outcomes: recognition of noncommunicable diseases as a major global public health and developmental challenge; establishment of global mechanisms to help developing countries to integrate primary prevention programmes for noncommunicable diseases into their health systems; establishment of a global funding mechanism to support developing countries in implementing programmes for the prevention and control of noncommunicable diseases, without jeopardizing support for communicable diseases; elaboration of global mechanisms for monitoring and reporting trends in noncommunicable diseases and countries' interventions for prevention and control; improving access to health care for people with noncommunicable diseases, particularly to affordable high-quality screening services and medical supplies; and helping civil society to support and implement noncommunicable disease initiatives. Kenya further expected that the high-level meeting would commit governments to implement noncommunicable disease policies by integrating the targets into the development goals that would succeed the Millennium Development Goals. He supported the draft resolution.

Mr FOURAR (Algeria) said that, for emerging countries such as Algeria, the control of noncommunicable diseases was a priority in view of their growing prevalence and impact on national

health systems. The challenges were the high cost of lifelong treatment and care and ensuring equal access to health care, particularly for poor people. Adequate investment would be required for decades to come to control noncommunicable diseases and to improve the quality of life for current and future generations. Most developing countries were experiencing demographic and epidemiological transitions to noncommunicable diseases. Their rising incidence in Algeria had led to an integrated control strategy based on a multisectoral approach in 2003. The Government had made the control of noncommunicable diseases central to its health development plan and had quadrupled its budget allocation for health in the past 10 years. It had set up an innovative, sustainable cancer fund and had launched an investment programme to reinforce the health system infrastructure, improve equipment and enhance primary health care. Algeria had endorsed the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the African Region and considered that innovative measures should be found to ensure access to medicines for noncommunicable diseases in developing countries.

Algeria advocated an integrated, evidence-based approach to promoting healthy lifestyles, in which international initiatives were coordinated so as to ensure compliance with commitments to foster development in developing countries. That approach would strengthen the global strategy for the prevention and control of noncommunicable diseases and mitigate the health and socioeconomic impact with a view to achieving sustainable development and reducing inequalities. Mobilization of the international community under the auspices of WHO was essential for determining the appropriate strategies, including an information system on the burden of morbidity, risk factors and major determinants; introduction of a multisectoral approach to the control of noncommunicable diseases and its integration into primary health-care; access to essential medicines; and the mobilization of the necessary financial resources.

Professor ADITAMA (Indonesia) noted that his country had contributed to noncommunicable disease prevention and control at national, regional and global levels. It had recently hosted the WHO South-East Asia Regional meeting on health and development challenges of noncommunicable diseases (Jakarta, 1-4 March 2011); the ensuing Jakarta Call for Action on Noncommunicable Diseases urged global leaders, donor partners and organizations in the United Nations system to include noncommunicable disease in internationally agreed development goals; assist countries in integrating management of those diseases in public health centres; enhance capacity-building and technical and financial support for sustainable prevention and control programmes; and support research into the prevention and control of noncommunicable diseases. In June 2011, his Government would hold a meeting, with WHO's support, to build consensus on the roles of various sectors in the prevention and control of noncommunicable diseases in Indonesia. The issue was a priority in the national health strategic plan for 2010–2014, and the Ministry of Health had prepared a comprehensive noncommunicable disease strategic plan for 2010–2015.

Dr PÁVA (Hungary), speaking on behalf of the European Union and stating that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro and Iceland, the countries of the Stabilisation and Association Process and potential candidates Bosnia and Herzegovina, Serbia and Ukraine, aligned themselves with her statement, said that the European Union supported the draft resolution and wished to cosponsor it. The global burden of noncommunicable diseases demanded attention in all countries, at all levels of governance, and WHO should provide leadership in normative work, coordination, technical support and monitoring in that regard.

Four main issues needed attention. The control of noncommunicable diseases must be based on health promotion and prevention, at both population and individual levels, as they could largely be prevented and cost-effective public policies and interventions were available. A “health in all policies” approach, for example through the creation of health-conducive environments and improvements in health literacy, was needed to deal with the socioeconomic and environmental determinants, which

often increased health inequities. The approach should be systematic and comprehensive rather than disease-specific and vertical, expanding the current focus on cardiovascular and respiratory diseases, diabetes and cancer, to cover other noncommunicable diseases that contributed to the global disease burden, such as mental disorders. A well-functioning health system was a prerequisite for implementing appropriate health policies and ensuring effective disease management; the prevention and control of noncommunicable diseases must be integrated into health system structures and functions, particularly at the primary health-care level, and health systems must monitor such diseases and the underlying risk factors for informed decision-making.

Because many developing countries faced the double burden of communicable and noncommunicable diseases, the European Union would support them in tackling the latter and their risk factors in accordance with national priorities and commitments, through, for instance, the strengthening of health systems and involvement of patient associations and other civil society organizations. She expressed appreciation to the Russian Federation for its contribution to the issue and welcomed the Moscow Declaration.

Dr KASSEM (Jordan) drew attention to the significant burden placed on health systems by noncommunicable diseases, including the high treatment costs. His Government's Ministry of Health had launched a health awareness campaign, with emphasis on diabetes, a condition that affected more than one third of the country's population. The treatment of noncommunicable diseases had been integrated into primary health care, and national legislation was being reviewed to ensure compliance with the WHO Framework Convention on Tobacco Control. Initiatives for the prevention of breast and colon cancer were also under way. Financial resources had been allocated to the prevention and control of noncommunicable diseases, particularly through awareness-raising and research. Every effort was made to provide adequate health care for people suffering from those diseases.

Dr VOUMBO MATOUMONA (Congo), speaking on behalf of the Member States of the African Region, underlined the increasing morbidity and mortality due to noncommunicable diseases in the Region, and warned that they jeopardized achievement of the Millennium Development Goals and threatened to increase social inequalities. A multisectoral control strategy was essential in order to tackle the social, behavioural, environmental and economic determinants. Numerous declarations, strategies and action plans had been or were being implemented in many countries of the Region, with technical support from WHO. Civil society and the private sector were also becoming involved.

The growing burden of noncommunicable diseases, in particular for low-income countries, demanded stronger partnerships should be strengthened, and WHO's leadership was more necessary than ever. Countries of the Region had adopted the Brazzaville Declaration on Noncommunicable Diseases Prevention and Control in the African Region and participated in the Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in Moscow. The priorities were: to include the prevention and management of noncommunicable diseases in future Millennium Development Goals; to enhance national health systems as part of a global approach to promoting healthy lifestyles, improving access to primary health care, information-sharing, retaining health-care staff, increasing funding for health care, expanding access to medicines and equipment, and improving infrastructure; to draw up national action plans and build institutional capacity for the prevention and control of noncommunicable diseases; for WHO to act as lead agency and the Secretariat to provide technical support to Member States in the preparation, implementation, follow-up and evaluation of their national plans and sharing of experience; to strengthen the participatory and multisectoral role of partnerships and networks; and to mobilize funding from development partners.

She urged the Secretariat to encourage African countries to participate in the high-level meeting in New York and to help them to draw up national strategic plans. She called for the establishment of a funding mechanism similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria in order to control noncommunicable diseases, without diminishing the funding for communicable diseases. She called for action and supported the draft resolution.

Dr DAULAIRE (United States of America) welcomed the report. Highlighting the leadership provided by PAHO in the preparations for the forthcoming high-level meeting and commending the successful outcomes of the WHO Global Forum: Addressing the Challenge of Noncommunicable Diseases, and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, both hosted by the Russian Federation, he said that his Government was strongly committed to raising the profile of noncommunicable diseases as a major health concern globally and its Department of Health and Human Services was active in the areas of their prevention, control and research. Recent activities included a new initiative focused on people with multiple chronic health conditions; introduction of regulations to further restrict the promotion of tobacco use by young people; and a national campaign, launched by the First Lady, to encourage exercise and diet among children and young people. Mental health was recognized as an essential component of a comprehensive strategy to address noncommunicable diseases.

WHO had a central role to play in raising awareness and increasing prevention, early detection and control of noncommunicable diseases, building on existing activities and frameworks, sharing best practices and lessons learnt and fostering global collaboration. As the lead agency in the health sector, WHO had the authority and expertise to fulfil that role and to serve as a focal point for a "health in all policies" approach.

Mr TUITAMA LEAO TUITAMA (Samoa) said that 2011, and the Sixty-fourth World Health Assembly in particular, would be seen as the turning-point, when global calls for action were translated into instruments for reversing the epidemic of noncommunicable diseases. He urged the Secretariat and Member States not to waste the opportunity. The effect of noncommunicable diseases on the people and economy of Samoa and other Pacific islands had reached a crisis point, threatening to overwhelm their meagre resources and adversely affect social development, economic aspirations and already-fragile health systems. The islands were especially vulnerable because of their small populations, geographical isolation and vulnerability to climate change and globalization.

He urged the Health Assembly to adopt a resolution that called for political commitment to primary health-care principles and their maintenance as part of the global health and development agenda, and that would ensure that the needs of the vulnerable and most affected were adequately met. The prevention and control of noncommunicable diseases, their risk factors and health determinants should be placed high on national, regional and global development agendas. The Health Assembly's decisions would affect the priority that country leaders accorded to noncommunicable diseases during their discussions in the United Nations General Assembly in September 2011. Health promotion and prevention at all levels was the best long-term solution for Samoa, given its limited resources and financial capacity.

He supported a research agenda that gave priority to best practice and better access to affordable, safe diagnosis and treatment for noncommunicable diseases. He further supported calls for a monitoring framework to assist progress, including the elaboration and adoption of standardized indicators.

Referring to the second preambular paragraph of the draft resolution, he proposed that the words "including small island States," be inserted after the words "in developing countries".

Dr DOUA (Côte d'Ivoire) said that, in discussions on drafting the resolution, his country had suggested that WHO should seize the historic occasion of the high-level meeting to advocate the establishment of a special fund to help to combat noncommunicable diseases in developing countries. He therefore proposed amending subparagraph 3(1)(ii) of the draft resolution by adding the words "related to combating these diseases" after "financial challenges".

Dr RODIN (Canada) commented that the draft resolution advocated a multisectoral approach to the prevention and control of noncommunicable diseases. The Moscow Declaration highlighted the need for policies and practices at all levels to tackle the social, environmental, economic and

behavioural determinants of noncommunicable diseases in order to foster the creation of the necessary conditions for healthy living. She congratulated the Secretariat on facilitating discussions in preparation for the high-level meeting, which had elicited various views and experiences. She urged WHO to reach beyond the usual channels in order to harness the efforts of other international parties. Canada fully supported WHO's role as the lead United Nations agency on noncommunicable diseases. The high-level meeting presented a good opportunity for the international community to address the challenges and to strengthen political commitment to collective action.

Dr VENEGAS (Uruguay), speaking on behalf of the Union of South American Nations (UNASUR), observed that noncommunicable diseases were the main cause of death and disability worldwide and accounted for high percentages of cases of ill health and premature death in UNASUR. The main risk factors, smoking, a sedentary lifestyle and alcohol consumption, were avoidable and preventable. Most deaths caused by noncommunicable diseases occurred in developing countries, thus increasing social inequities and poverty.

Public policies to prevent and control noncommunicable diseases should be strengthened among institutions and in all sectors. Commitment to the Millennium Development Goals showed that it was easier to contribute to alliances and the development of appropriate frameworks to achieve specific health outcomes when clear objectives were set. He therefore urged WHO to take action on the social determinants of health and strengthen political commitment to promoting prevention, providing access to treatment and monitoring systems to ensure comprehensive management of noncommunicable diseases, including access to safe, effective, high-quality medicines. Specific goals for reducing noncommunicable diseases, especially with regard to the social determinants of health, should be included in the Millennium Development Goal. He supported the draft resolution and asked WHO to continue its leadership in coordinating the prevention and control of noncommunicable diseases.

Dr CAÑETE (Paraguay) supported the development of intersectoral public policies to reduce risk factors in cooperation with the private sector and civil society, including non-health sectors, which played essential roles in prevention. As there was a strong link between noncommunicable diseases and community development models and environment, with consequent social inequity, prevention and control programmes should include actions on the social determinants of health, such as poverty reduction, regulating the private sector, gender and intercultural approaches and community participation. Priority should be given to improving access to health care and guaranteeing the availability of safe, effective, high-quality medicines. Paraguay had established 500 family and community health units, which emphasized noncommunicable diseases and provided essential medicines as part of a free, high-quality health-care service. It was also conducting a national survey among the general population and the indigenous peoples on risk factors for noncommunicable diseases, whose results would assist it in formulating public policies. It was vital to have commitment at governmental level, in addition to an international policy, with respect to the financing of programmes for the prevention and control of noncommunicable diseases.

Dr SOLÍS VÁSQUEZ (Peru) concurred with the comments of previous speakers and said that her country had been monitoring noncommunicable disease since 1998, including studies of risk factors within families in seven of the country's regions between 1998 and 2001, whose findings had provided the basis for prevention measures. Cancer trends had been monitored in hospitals since 2006, and every region was required to set up a cancer registry and have at least one cancer hospital. Moreover, monitoring systems were being established in each region for risk factors such as alcohol consumption, smoking, weight, obesity, hypertension and diabetes; healthy lifestyles were being promoted. Her Government would continue to improve measures to prevent and control noncommunicable diseases, including legal and normative instruments, to ensure that people had access to good health care and treatment, subject to available financing. She urged the Director-

General to continue taking the lead in addressing noncommunicable diseases in order to guarantee the health of future generations.

Dr KONG Lingzhi (China) said that her country would continue to combat noncommunicable diseases and agreed with previous speakers that WHO should take full advantage of the opportunity provided by the high-level meeting to call for noncommunicable diseases to be given high priority. WHO should also formulate an action plan for implementing the global strategy and prepare guidelines for simple indicators. It should advocate inclusion of the objectives relating to noncommunicable diseases in development agendas and in the Millennium Development Goals. The Secretariat should urge Member States to take up the challenge of the prevention and control of noncommunicable diseases.

Ms ESCOREL DE MORAES (Brazil) said that the fight against noncommunicable diseases was top of the global health agenda for 2011. Their prevention and control was of increasing importance, particularly in developing countries. Noncommunicable diseases were a serious health problem in Brazil, hitting the poorest and most vulnerable groups hardest. Nevertheless, with the expansion of primary health care and reduced tobacco consumption following the introduction of dissuasive measures, mortality associated with cardiovascular and respiratory diseases had fallen by 20%. Brazil was taking measures to promote physical activity, and food companies had agreed to reduce salt in some products. It was also taking steps to improve access to medication, including distributing free medicines through a network of well-known pharmacies under a new Government scheme.

Poor social conditions were closely linked to the prevalence of noncommunicable diseases, and many of the world's most underprivileged people remained trapped in a circle of poverty and disease. In order to ensure that all people attained the highest possible level of health, the root causes of ill health must be addressed. With that in mind, Brazil was hosting the World Conference on Social Determinants of Health (Rio de Janeiro, 19–21 October 2011) in order to allow exchange of views and experiences on strategies, policies and plans. She urged Member States to attend and work together to address social determinants and reduce inequity by developing specific measures to tackle noncommunicable diseases.

Ms BENNETT (Australia) reaffirmed her Government's commitment to further collaboration before the high-level meeting. Australia was refocusing its health system towards prevention, including establishing a new national preventive health agency to tackle noncommunicable diseases. Tobacco control measures were a key priority; recent Government initiatives included a 25% increase in excise duty on tobacco products and the introduction of the world's first plain-packaging laws. She urged all Member States to adopt the draft resolution.

Mr NACEUR (Tunisia) welcomed the report and its useful information. Tunisia had established a programme on the prevention of noncommunicable diseases, which had been integrated into its national health policies, in line with WHO guidelines. In 2010, it had adopted a comprehensive plan for noncommunicable diseases, which incorporated the six objectives set by WHO in its action plan for the global strategy for the prevention and control of noncommunicable diseases. Tunisia was also seeking to strengthen its partnerships with other countries and parties to mitigate the impact of noncommunicable diseases. He supported the draft resolution, as it reflected the needs of WHO's different regions, and particularly welcomed the call for steps to assist countries in implementing national noncommunicable disease control strategies.

Dr KHAMIS (United Arab Emirates) said that noncommunicable diseases threatened to reach epidemic proportions in developing countries. His Government had recently reviewed its national strategies to combat those diseases, having successfully reduced the incidence of communicable diseases, particularly those targeted by its national vaccination campaign. Noncommunicable diseases,

especially diabetes and cardiovascular disease, caused more than half of the country's registered deaths and were being tackled by means of science-based health policies in the light of findings from a global health survey, which had shown noticeably higher levels of obesity, inactivity, unhealthy eating and smoking among schoolchildren. Given the link between noncommunicable diseases and lifestyle, risk awareness and prevention from an early age were the first-line measures used against those diseases. Strategies for tackling noncommunicable diseases fell under the rubric of primary health care and family medicine, in conformity with WHO's guidelines on the monitoring of diabetes and cardiovascular disease at health-care centres, which were accessible throughout the country.

Ms KOIVISTO (Finland) identified 2011 as a landmark year in terms of events, strategies and action plans for tackling the important global health issue of noncommunicable diseases, starting with the Ministerial Conference in Moscow. The process, of which the current discussion formed a part, would pave the way to a successful outcome of the high-level meeting of the United Nations General Assembly. Against that background and with its own experience in the area of noncommunicable diseases, Finland was pleased to be bringing the issue of health promotion back to the European Region — the origin of the Ottawa Charter for Health Promotion — by hosting the Eighth Global Conference on Health Promotion in Helsinki in June 2013; its focus would be implementation, the role of health systems and social determinants. Her country looked forward to collaborating closely with the Secretariat, other Member States and stakeholders in preparing for the Conference.

Dr BAYUGO (Philippines) said that the prevention and control of noncommunicable diseases formed part of an initiative launched by his Government in support of global efforts to end decades of neglect and unjustified omission of chronic diseases from the global development agenda. A six-year action plan aimed to reduce mortality due to noncommunicable diseases, and a campaign to promote healthy lifestyles had been launched. The Philippines continued to participate in international research and to generate relevant data on the prevalence of risk factors in such areas as tobacco consumption, nutrition, diabetes and cardiovascular diseases. In response to the strong presence of the tobacco industry in Asia, existing tobacco laws were strictly implemented, and efforts were under way to reform the tobacco tax system and introduce legislation requiring tobacco products to carry graphic health warnings. A nationwide physical activity programme had been introduced the previous week, with senior members of Government, including the President, sending a strong message to the public about the health benefits of physical activity by participating in a cycling demonstration.

Mr CONSTANT (Trinidad and Tobago) said that the prevention and control of noncommunicable diseases required leadership at all levels, as well as a wide range of measures to address, inter alia, social determinants and equity. Such diseases posed multifaceted, complex challenges, consequently demanding heightened attention from the international community. He therefore urged continuous cooperation to promote intersectoral policy changes in order to build on the gains achieved by Member States in the context of their national programmes to combat chronic diseases. He supported without reservation the call for WHO to develop a comprehensive monitoring framework on noncommunicable diseases and to take the lead in assisting country implementation of the resolution expected from the high-level meeting.

Mr DAKPALLAH (Ghana) said that noncommunicable diseases threatened to erode the health gains achieved over the years. In developing countries, their burden had been such as to undermine capacity-building for their detection, management and control. Failure to respond to that need would result in costly changes in the use of health services and have a negative impact on health financing mechanisms. Ghana had therefore advocated new thinking about health-care delivery, with emphasis on its Regenerative Health and Nutrition Programme, on which its national health policy of promoting a healthy lifestyle was based so as to deal holistically with the problem of noncommunicable diseases.

Noncommunicable diseases were a developmental issue to be approached from a multisectoral perspective, with advocacy for the adoption of appropriate legislation, social mobilization and health promotion forming the central strategy. Early detection capacity, improved quality of care and more effective disease management structures should be developed at country level. Proven strategies should be used to detect and raise public awareness of noncommunicable diseases, which were best addressed in the longer term through strong leadership and governance systems working in appropriate partnership with the private sector and social support systems, among others.

Dr TSESHKOVSKIY (Russian Federation) said that measures to promote healthy lifestyles, minimize risk factors and ensure access to high-quality health care were vital elements of the strategy for the prevention and control of noncommunicable diseases, as was the need for scientific research and a multisectoral approach. WHO's activities relating to those diseases could be usefully expanded to include the provision of technical assistance for the development of national health systems and prevention and control programmes, including training in modern diagnostic and treatment methods. Given its experience in dealing with noncommunicable diseases, the Russian Federation was well placed to participate in the relevant work of WHO and other international bodies. Its national health programme encompassed a raft of measures to encourage healthier lifestyles, including hundreds of fully-equipped health centres open to all citizens. As emphasized in the Moscow Declaration, comprehensive measures for the detection and prevention of noncommunicable diseases were an essential part of the international health agenda, requiring cooperation at both global level and in countries.

Mr WAHABI (Morocco) said that noncommunicable diseases constituted a major public health burden worldwide and a socioeconomic threat. The exorbitant cost of treatment posed difficulties of access for patients, and the diseases themselves were an obstacle to progress in developing countries. Action to address the problem was a priority for Morocco, which had accordingly formulated a comprehensive integrated national plan for tackling noncommunicable diseases. He commended WHO's efforts to combat those diseases and expressed support for the draft resolution.

Dr MUKONKA (Zambia) said that his country had developed a draft strategic plan to counter the growing epidemic of noncommunicable diseases, and work was under way to establish preventive measures, enact relevant legislation and strengthen routine data collection, which had thus far been inadequate and inaccurate. Underlying weaknesses in such areas as financing, governance and medical technology nonetheless impeded the potential for delivery of the health services needed to respond to noncommunicable diseases. In that connection, emphasis must be placed on improving the quality of primary care and addressing the constraints that prevented universal coverage with those services. Special attention should also be devoted to mental health and issues affecting young people, such as alcohol and drug abuse. Existing resources earmarked for maternal and child health and communicable diseases must remain intact, however. It would therefore be necessary to seek additional resources and mechanisms for funding activities to combat noncommunicable diseases.

Dr GOUYA (Islamic Republic of Iran) said that developing countries were experiencing a growing burden of noncommunicable diseases, in addition to the substantial burden of communicable diseases that they continued to carry. The prevention and control of noncommunicable diseases required planning throughout a patient's life and demanded political and popular will. Matters to be taken into account in such planning included ongoing studies of risk factors, continuous education for all age groups, respect for cultural norms, preventive interventions and patient care and rehabilitation. His country had established a risk surveillance system that provided valuable information for decision-making on appropriate measures. Important aspects in the prevention and control of noncommunicable diseases included governance resting fully with WHO, global political commitment, promotion of knowledge and skills, and financial and technical support. He expressed the hope that the outcome of

the Health Assembly would be reflected in September's high-level meeting on the subject at the United Nations.

Dr VALENZUELA (Chile) said that efforts and action should be guided by proven scientific evidence so that the risk factors could be identified and noncommunicable diseases detected as early as possible. Joint policies should be formulated with the food industry, agriculture, trade, transport, urban development, education and finance. Formulating an integrated response at country level was complex, requiring capacity building, refocusing on primary health care and reinforcing policies on healthy lifestyles and the social, economic and environmental causes of noncommunicable diseases, monitoring and evaluating the noncommunicable disease burden, and assuring quality. In developing countries, issues related to health inequity should also be addressed.

Among a range of activities undertaken in Chile, the national health surveys had provided valuable information on the prevalence of risk factors. The multisectoral programme *Elige vivir sano* (Choose a healthy lifestyle), covering both physical and mental health, had been launched with the support and participation of the private sector.

Dr JAMEED (Afghanistan) said that his country, which had unfortunately been in conflict for more than three decades, had concentrated mainly on reducing the high rates of maternal and child mortality. It depended on limited external resources, and funds had not been available to gather information on the prevalence of noncommunicable diseases. Given the lack of priority afforded to those diseases in Afghanistan, WHO's support was requested for establishing an evidence base and a health management information system, training, monitoring and evaluation. The country also sought a commitment by donors to integrate the prevention and control of noncommunicable diseases into WHO's Basic Package of Health Services and the Essential Package of Hospital Services for Afghanistan. He thanked WHO for putting noncommunicable diseases high on the international agenda.

Dr YAHYA (Brunei Darussalam) said that specific tools such as the action plan for the global strategy for the prevention and control of noncommunicable diseases provided invaluable guidance for Member States. Effective implementation of the strategy was a major challenge, however, involving as it did policies, commitments and resources across all sectors. Inclusion of noncommunicable diseases on the agenda of the forthcoming United Nations General Assembly therefore marked a significant achievement with respect to raising their profile and highlighting their linkage with the socioeconomic and development agenda. It was consequently essential to capitalize on the opportunities thus provided to accelerate and secure the involvement and collaboration of all sectors in a concerted effort to combat noncommunicable diseases. Those diseases weighed heavily in Brunei Darussalam, where the promotion of health and a healthy lifestyle was high on the national health and development agenda. It looked to WHO to provide not only technical guidance but also a platform on which Member States could share experiences. WHO's leadership was crucial, particularly on cross-sectoral issues involving non-health bodies such as the trade and industry sectors. He supported the draft resolution.

Dr JACOBS (New Zealand) said that noncommunicable diseases were largely preventable through tackling the known risk factors and, for example, facilitating healthy choices for individuals and families. Win-win approaches must be sought to promote full multisectoral engagement in order to achieve balanced, workable, effective solutions. One important outcome of the forthcoming high-level meeting in New York would be improved tobacco control, in view of the link between smoking and various noncommunicable diseases, including maternal and child health, which were of particular concern for New Zealand's Maori people. New Zealand had consistently taken strong action to reduce harm from smoking and urged all countries to follow suit. In its experience, regularly publicizing the results of small health targets helped to drive improvements in the prevention and management of noncommunicable diseases. Early access to good primary care services was also instrumental to cost-

effective disease prevention and health promotion. Another positive outcome of the high-level meeting would therefore be a commitment to support WHO's efforts to strengthen health systems; the international organizations should coordinate their work to address the challenges of noncommunicable diseases. He strongly supported the draft resolution.

Dr PANTAZOPOULOU-FOTINEA (Greece) underlined the key role of prevention. Effective prevention of lifestyle diseases was a common goal at global and local levels. Success would require intersectoral involvement and international collaboration, in which context WHO had an important role to play. As part of its contribution to efforts to strengthen and enhance international cooperation on noncommunicable diseases, Greece had signed an agreement in March 2011 with the Regional Office for Europe establishing the Office for the Support to the Prevention and Control of Non-Communicable Diseases in Athens. Greece would provide € 2 million annually for that purpose, which it regarded as an investment in the common goal of exchange of knowledge, best practices and experiences in tackling noncommunicable diseases.

Ms HELFER-VOGEL (Colombia) said that the prevention and control of noncommunicable diseases formed an integral part of the national development plan in her country. The prevalence of noncommunicable diseases in Colombia was greatest among marginalized people and those living in poverty, who should therefore be the focus of prevention and control actions for healthy lifestyles.

Miss SIRINYA PHULKERD (Thailand) said that her country wished to cosponsor the draft resolution. Undue emphasis had been placed on the forthcoming high-level meeting of the General Assembly, whereas use of the many effective tools already available for combating noncommunicable diseases should be the more immediate concern. The increasing burden of noncommunicable diseases indicated underperformance, as in the case of work in the area of alcohol and childhood obesity, and inadequate financing. Increased resources alone were not, however, the answer; new ways of thinking were needed. Noncommunicable diseases were more difficult to deal with than communicable diseases because of the involvement of many factors and of sectors with different values and interests. Evidence suggested that the most effective, most sustainable way of dealing with noncommunicable diseases was to tackle the risk factors and social determinants and to look beyond the disease-based approach. The most cost-effective interventions, such as controlling the availability and marketing of unhealthy commodities and tax and price measures, were not welcomed by private-sector interests that profited from the epidemic of risky behaviours. Transparency, with focus on such potential conflicts of interest, was therefore crucial to a fruitful outcome to the problem of noncommunicable diseases.

Dr LEWIS FULLER (Jamaica) said that the high prevalence rates of noncommunicable diseases in Jamaica prevented it from achieving the Millennium Development Goals. National surveys had revealed an upwards trend in chronic noncommunicable diseases during the current decade, due to the risk factors associated with an unhealthy lifestyle. Action taken in countries of the Caribbean Community to halt that trend included a commitment to unite to stop the chronic noncommunicable diseases epidemic and annual observance of Caribbean Wellness Day to promote healthy lifestyles and physical activity region-wide.

The draft resolution should place more emphasis on health promotion and social marketing of healthy lifestyles and address the physical planning and reorganization of communities to provide enabling environments. She recommended the establishment of national multisectoral commissions on the policy aspects of noncommunicable diseases and, in recognition of their seriousness, integration of noncommunicable diseases into the Millennium Development Goals. Jamaica would play its part in cosponsoring the draft resolution and pursuing the initiative at the high-level meeting in September.

Dr BRENNEN (Bahamas) supported the draft resolution. The Bahamian approach to countering noncommunicable diseases incorporated a range of activities aimed at galvanizing maximum support

from a broad range of health sector and intersectoral stakeholders. Implementation activities included the development of a national health system strategic plan affording prominence to those diseases and the establishment of a committee composed of health care and community professionals to plan, implement and monitor relevant programmes. Prevention activities included the development of evidence-based nutrition and physical activity guidelines, a national tobacco control policy incorporating an initiative for smoke-free public places and a workplace wellness programme. Identification and surveillance activities comprised a community screening programme and a follow-up national STEPS survey for comparative purposes. With respect to treatment, a three-fold expansion of a pilot grant project for community organizations was planned in support of programmes promoting holistic lifestyle changes. Medications for noncommunicable diseases were provided free of charge. Against that background, the Bahamas favoured the establishment and dissemination of a database of global activities and best practices to aid countries to prevent and control noncommunicable diseases and avoid duplication of effort.

Dr GUTERRES CORREIA (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that noncommunicable diseases had emerged as the leading cause of death and disability in the Region, creating growing burdens of disease and health costs that were rapidly becoming unaffordable. Although cost-effective population-based interventions were available, healthy behaviour and access to health care were compromised by poverty and low literacy levels. Lack of surveillance and research data on noncommunicable diseases was another barrier to the effective planning and implementation of prevention and control programmes, as was lack of training for human resources, which were already limited and overburdened. Available health funds were, moreover, stretched thin to meet the acute demands of tackling communicable diseases. A regional meeting two months earlier had culminated in the Jakarta Call for Action on Noncommunicable Diseases and the formulation of 10 key messages for transmission to the high-level meeting of the General Assembly, from which tangible outcomes were expected.

Mr LARSEN (Norway) urged Heads of State and Government to participate in the forthcoming high-level meeting. The Moscow Declaration provided important input to the preparations for that meeting, to which WHO should also send a strong message. The cross-sectoral agenda for prevention and control required the involvement of ministries, organizations in the United Nations system, nongovernmental organizations and the private sector, although in that connection it was essential to remain alert to conflicts of interest. In taking the leading role in fighting the epidemic, including the preparation for and follow-up to the high-level meeting, WHO must demonstrate its ability to live up to the challenge. In addition to the palpable concern over noncommunicable diseases and the need for national and international action, the current debate had highlighted the trust placed in WHO on that score. As a cosponsor of the draft resolution, he appealed to the delegates of Samoa and Côte d'Ivoire to consider withdrawing their proposed amendments; in the first instance, small island States were an important component of developing countries and were included in the definition of that term; in the second, he recalled that the draft resolution was the result of protracted negotiations, in which Côte d'Ivoire had participated.

The CHAIRMAN informed the Committee that Côte d'Ivoire withdrew its proposal.

Dr IBITOMI (Nigeria) said that the attention to noncommunicable diseases should not reduce the priority or resources consecrated to the health-related Millennium Development Goals, which was a foreseeable consequence of the heavy burden of noncommunicable diseases in developed countries. A special fund or financing mechanism was therefore urgently needed to tackle noncommunicable diseases, similar to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr AL-THANI (Qatar) said that the high-level meeting to be held in New York would be a landmark event in the prevention and control of noncommunicable diseases, which were currently slowing progress towards a better world. Her country's national health strategy gave priority to those diseases, and the allocated budget would be increased annually in line with future expansion of work in that area. Preparations for the high-level meeting must have clear objectives in seeking to ensure a sufficient pool of human and financial resources for dealing with noncommunicable diseases. Technical support was needed to develop electronic data collection systems in order to evaluate progress.

Ms CHANETSA (Swaziland) supported the draft resolution but proposed inclusion of a reference in the preambular paragraphs to the Global Strategy for Infant and Young Child Feeding in view of the need for early nutrition in the context of primary prevention. With respect to paragraph 2, she proposed the inclusion of an additional subparagraph that would read: "to work comprehensively on primary prevention of noncommunicable diseases through ensuring early nutrition by enhancing rates of exclusive breastfeeding for the first six months, continued breastfeeding with adequate and safe complementary foods, and supporting women and families in carrying out these practices". The purpose of the proposed amendment was to ensure the coherence of policy decisions. Healthy diet, physical activity and the avoidance of risk factors were key elements in the prevention of noncommunicable diseases, on which a strong statement should be presented to the high-level meeting of the United Nations General Assembly in September.

Dr KOUILLA (Gabon) strongly supported the draft resolution, which reflected the global health challenges posed by noncommunicable diseases. Gabon was seeking solutions to those challenges at the domestic level through its national health development plan, which comprised programmes to combat tobacco use, drug addiction and noncommunicable diseases. An oncology centre was soon to be established, but additional human and financial resources would be needed for its operation. The control of noncommunicable diseases created an extra burden on the country's health expenditure, and he urged WHO to continue advocating additional funding to prevent noncommunicable diseases. The outcome of the forthcoming high-level meeting should include a global plan on noncommunicable diseases that was also applicable at national level, with the involvement of civil society. Measures taken locally should be monitored in order to assess their impact on the prevalence of the diseases.

Ms EL-HALABI (Botswana) said that urban growth in her country had led to more sedentary lifestyles, thus increasing the burden of noncommunicable diseases. Interventions had been introduced to address the most common modifiable risk factors and spread public health messages. School health programmes and health promotion policies offered new ways of empowering individuals to take responsibility for their own health. Risk prevention and management of noncommunicable diseases were integrated into Botswana's health service delivery system, data on the main noncommunicable diseases had been incorporated into the existing reporting system, and various centres of excellence had been opened. A WHO package of essential noncommunicable disease interventions was being tested in order to enable uniform management and the introduction of a high-quality, standardized approach at primary health care level. The absence of national data on the prevalence of noncommunicable diseases was a major challenge, however, and STEP 3 of the STEPwise survey had yet to be implemented. Botswana therefore requested support from WHO and other partners for data collection and substantive funding for tackling both noncommunicable and communicable diseases. She suggested that WHO organize an intersectoral ministerial meeting to discuss an approach to noncommunicable diseases, perhaps following the high-level meeting.

Dr ESPINOZA (El Salvador) recalled the statement made by his Government's Health Minister at the opening of the Health Assembly, which had drawn attention in particular to the problem of chronic renal disease in developing countries. There were two clearly identifiable causes of

noncommunicable diseases. The first was fragmentation of health systems by prioritization of vertical programmes, generally in the form of projects; when funds were no longer provided, the resulting conditions were worse than before implementation of the project. The second was the production and intensive use of pesticides and insecticides, many of which had been prohibited in the country in which they were produced but were still being sold illegally to developing countries. Two corresponding solutions existed: health system strengthening should be given priority over vertical programmes; and developed countries should shoulder their share of responsibility in calling for tighter controls on the manufacturers of pesticides and insecticides and prohibiting their export. Those two actions would have significant health and environmental benefits, which would be greater than those achieved by funding the prevention and control of a specific disease.

Professor GHODSE (International Narcotics Control Board) acknowledged that licit drugs, such as opiates for palliative care and psychotropic substances for managing mental illness, were essential for the treatment of some noncommunicable diseases and could improve quality of life. A report published by the Board showed, however, that 90% of the global consumption of opiate analgesics was in a group of developed countries, whereas 80% of the world's population had limited or no access to those medicines. The situation was similar with regard to the consumption of psychotropic substances. The present situation was therefore far from equitable. The Board's recommendations for improvements included training and education, identification of excessively restrictive legislation and requirements for drug use and infrastructural development. The Board considered that the issues of drug dependency and the use of drugs for treating noncommunicable diseases should be incorporated into the agenda of the high-level meeting of the General Assembly, and the Board was ready to work with WHO and the international community on the preparation and follow-up of that meeting.

Ms RIJKS (International Organization for Migration) said that migrants should have access to culturally appropriate care. In line with the Moscow Declaration, her Organization recognized the right of all, including migrants, irrespective of their legal migration status, to the highest attainable standards of physical and mental health. The global migrant population of an estimated 1000 million people would shape the health challenges of the future. Migrants met barriers in terms of access to health services, were exposed to a variety of risk factors for noncommunicable diseases and suffered from socioeconomic inequality, the loss of social networks, poor integration, poor health literacy and xenophobia, all of which could lead to unhealthy lifestyles. The Organization supported WHO's focus on noncommunicable diseases and also advocated migrant-sensitive health systems. She proposed that the Member States devise mechanisms for periodic reporting on implementation of resolution WHA61.17 on the health of migrants.

In the aftermath of conflicts and natural disasters, care should also be taken to re-establish systems of prevention, treatment and control of noncommunicable diseases and to integrate displaced migrants into host communities. The strategies should be transnational in scope and include collaboration between regional bodies, governments and multisectoral partners to increase the migration health capacities of public health systems.

Mr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that noncommunicable diseases were a barrier to poverty reduction, health equity, economic stability and human security, the most disadvantaged populations being the most vulnerable. National Red Cross and Red Crescent societies played a critical role in the global effort to combat noncommunicable diseases, working with national authorities to provide high-quality programmes and services to prevent disease and improve living conditions through community-based health programmes. Although the role of health professionals in treatment and care was important, it was equally important for governments to use the potential of volunteers with regard to disease prevention and control at community level, especially given the shortage of qualified health

staff for noncommunicable diseases in certain countries. Multi-stakeholder solutions and dialogue were needed.

Mr LEATHER (CMC - Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that his organization and the NGO Forum for Health supported WHO's action plan for the global strategy for the prevention and control of noncommunicable diseases and urged Member States to include mental health in their strategies. He noted that mental health had been included in a number of international resolutions and declarations. Furthermore, as mental disorders were linked to living conditions and were clearly implicated in the strong connection between noncommunicable diseases and poverty, the Commission on the Social Determinants of Health had affirmed that health strategies should build on the premise that improved quality of life and poverty eradication were fundamental to improving health and well-being. Mental disorders and other noncommunicable diseases were closely linked; for example, people with diabetes were twice as likely to suffer from depression, and treating both diseases improved patient compliance and cut costs. WHO should commit to action on mental health and integrate it into its approach to noncommunicable diseases.

Professor BERO (The Cochrane Collaboration), speaking at the invitation of the CHAIRMAN, urged WHO to use systematic, unbiased reviews conducted by independent organizations like hers as the basis for policies on the prevention, diagnosis and treatment of noncommunicable diseases. Although a publicly available database containing information on diagnostic and medical products could be useful, the information must be evidence-based and free from commercial bias. Many studies had shown that clinical trials of treatments sponsored by a single pharmaceutical company had produced results that favoured the company's products. WHO action plans and guidelines for the prevention of noncommunicable diseases must be based on the best available, unbiased evidence.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, said that September's high-level meeting of the United Nations General Assembly should empower Member States to take effective legislative action to promote healthy diets for consumers through, inter alia, reformulation of foods, improved information, the removal of barriers to breastfeeding and, most importantly, protection from subtle and pervasive forms of marketing, such as sponsorship. The development and monitoring of nutritional standards and policy definitions must be government-led and free from conflicts of interest; experience had shown how the influence of the powerful food industry in multistakeholder initiatives could distort public health priorities. Her organization did not object to consultations with food companies, but it was concerned that companies might be allowed to fund programmes, guide policy formulation and identify priorities. She urged WHO to recognize the key role of marketing controls, protection of breastfeeding and promoting optimal complementary feeding as integral components of its noncommunicable disease strategy.

Ms RUNDALL (Corporate Accountability International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, said that tobacco- and diet-related diseases were the result of corporate marketing and sales. The tobacco industry continued to flout Article 5.3 of the WHO Framework Convention on Tobacco Control, which recognized its fundamental conflict with public health policies. The private sector was set to play an increasing role in shaping policies and identifying priorities, and Member States must heed the call to remain vigilant in order to ensure that their policies on food and water were protected against companies' inherent conflicts of interest. At the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Diseases in Moscow in April 2011, for instance, the panel in the working group on food had consisted solely of representatives of the food industry, who had promoted their own partnerships and pledged voluntary self-regulation; it was to be hoped that the situation would be different at the high-level meeting of the United Nations General Assembly. Member States could not waste time or resources on unsustainable, unaffordable, ineffective solutions such as bottled

water, commercially sponsored education and processed foods alleged to have curative qualities. They should therefore strive to create clear, enforceable public health, nutrition and water standards that went beyond individual conflicts of interest and also addressed institutional conflicts of interest.

Ms HAGAN (Global Health Council, Inc.), speaking at the invitation of the CHAIRMAN, urged Member States to approve the draft resolution. The prevention of, and treatment and care of patients with, noncommunicable diseases must be incorporated into existing public health policies. Governments should develop inclusive national health and development plans in partnership with all relevant ministries, civil society and the private sector, and policies should provide incentives for making more widely available tools and technology for cost-effective management and complementarity of treatment and care. Decision-making should involve all society and be based on diverse expertise at national and international levels, such as the proposed world health forum.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, called on Member States and the Secretariat to ensure that the high-level meeting of the United Nations General Assembly took decisive action on the prevention, early diagnosis and long-term management of all noncommunicable diseases. Member States should ensure that WHO's global strategy was implemented equitably for prevention, for diagnosis, for treatment, for care and for support and that the focus was not confined to the four specified diseases. Its effectiveness should be ensured by strengthening health systems. Patients had to have a say in the design, leadership, implementation, monitoring and evaluation of effective, sustainable interventions, and patients' organizations should play an active role in formulating, implementing and monitoring legislation, health policies, regulatory frameworks, guidelines and standards. Emphasis should be placed on improving health literacy, increasing research on the prevalence, incidence and impact of noncommunicable diseases on the lives of patients, families and caregivers, and promoting early diagnosis and treatment to reduce morbidity and mortality. All policies should be based on the fundamental right to patient-centred health care based on the needs and choice of the individual patient, ensuring autonomy and independence.

Ms ADAMS (International Council of Nurses), speaking at the invitation of the CHAIRMAN, commended WHO's leadership in addressing noncommunicable diseases. The nursing workforce had a leading role to play in noncommunicable disease prevention, refocusing health policy and creating supportive environments that promoted healthy behavioural choices. Her organization had therefore launched a noncommunicable disease initiative to develop global nursing capacity, initially in eight countries, where nurses were preparing action plans and implementation strategies. It was also providing training and capacity development in diabetes and depression in five countries in southern Africa. Despite the potentially significant role of nurses, the global crisis in human resources for health in general and the shortage of nurses in particular represented a major barrier in many countries. Without the full involvement of nurses, including in policy discussions, the objectives of global strategies for prevention and control of noncommunicable diseases were unlikely to be implemented. She urged the Secretariat and Member States to improve the quality and quantity of interventions by investing in nursing and to make optimum use of the potential of nurses in strengthening appropriate health-care system responses to noncommunicable diseases.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the Moscow Declaration, which highlighted the value of prevention and the need for all stakeholders to take responsibility for tackling noncommunicable diseases. To be effective, multistakeholder strategies must be fully integrated into health-care systems and extend beyond the traditional health sector. As most noncommunicable diseases were preventable, lifestyle choices and behaviours of individuals were central to any control strategy, which should include increasing health literacy, raising awareness of risks and informing

people about ways to effect simple behavioural changes. The increased prevalence of noncommunicable diseases posed a mounting challenge to health-care systems worldwide, and to public and private finances. Investing in prevention would contribute to higher economic growth and allow limited resources to be efficiently channelled to patients most in need.

The Federation's members had many new medicines in the pipeline to treat noncommunicable diseases, although further innovation would certainly be needed. They were also involved in ensuring that the medicines were appropriate for, and made available in, resource-poor settings. They worked in partnership with governments, intergovernmental organizations and civil society to help to strengthen health-care capacity in developing countries and educate populations at risk. They had implemented workplace wellness programmes that benefited their many employees worldwide. The Federation looked forward to sharing its experience as a leader in innovation and delivery of medicines and to listening to other stakeholders with a view to identifying efficient, effective and sustainable solutions to improve health and nurture future innovation.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, commended WHO's leadership in preventing and controlling noncommunicable diseases and pledged her organization's cooperation. Good nutrition, especially in early life, was a key measure. In some countries, foods introduced after exclusive breastfeeding contributed to micronutrient deficiencies and excessive energy intake. Appropriate complementary foods for children could improve the intake of micronutrients needed to support the growing needs of infants and young children, thereby addressing known noncommunicable disease risk factors. Targeted programmes and initiatives to increase the availability of iron-fortified complementary foods had dramatically improved health outcomes and reduced anaemia. Exclusive breastfeeding for the first six months of life and the timely introduction of safe and appropriate complementary foods beyond six months were essential for children's health development and protecting against noncommunicable disease risk factors. The dietary food industry continued to invest in research and development to enhance nutrition throughout the life cycle and to ensure that its foods met the highest nutritional, safety and micronutrient needs of infants and adults according to international standards, taking into consideration known noncommunicable disease risk factors. The organization's members looked forward to supporting the efforts of Members States, the United Nations and the Secretariat to prevent noncommunicable diseases by developing evidence-based and comprehensive guidance for complementary feeding in a way that took into account the expertise and capacities of all stakeholders.

Mr PATON (Union for International Cancer Control), speaking at the invitation of the CHAIRMAN and on behalf of the International Diabetes Federation, the International Union against Tuberculosis and Lung Disease and the World Heart Federation, said that the four organizations and other partners formed the NCD Alliance, which was committed to working with Member States, the Secretariat, civil society and the private sector to ensure the success of the high-level meeting of the United Nations General Assembly on noncommunicable diseases and to support global actions against those diseases. He urged Member States to expand national responses to noncommunicable diseases by investing in coordinated multisectoral action and implementing a few priority interventions with timed targets and indicators; to support priority interventions to prevent noncommunicable diseases globally; to ensure prevention, early detection, treatment and control of noncommunicable diseases by strengthening primary health care systems and increasing access to quality assured essential medicines, technologies and affordable vaccines; to raise the priority of funding for prevention and control of noncommunicable diseases on the global health agenda; to establish goals and targets to reduce major risk factors and noncommunicable disease mortality rates; and to report regularly to the United Nations on progress towards those objectives. The high-level meeting would be a unique opportunity to raise the profile of noncommunicable diseases and to secure commitment from Heads of Government for a coordinated response, and for the allocation of increased resources.

Dr EISELÉ (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, said that oral diseases were among the most common chronic, noncommunicable diseases. They represented a significant burden on overall health, and shared risk factors with other noncommunicable diseases, as recognized in resolution WHA60.17 on oral health. The burden of oral diseases was rising owing to rapidly changing lifestyles, especially in low- and middle-income countries, which were the least able to deal with the consequences in terms of poor health outcomes and the burden on national health budgets. An integrated, collaborative approach to noncommunicable disease prevention that included oral disease prevention and health promotion would have significant benefits in terms of strengthening health systems and oral health-care delivery. His organization worked closely with the WHO Global Oral Health Programme on integrated approaches to disease prevention based on common risk factors and health promotion. It urged WHO to recognize oral diseases as major global noncommunicable diseases and to call for their inclusion in the outcome document from the United Nations General Assembly's high-level meeting in September 2011.

Ms LACHENAL (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN and on behalf of the NGO Forum for Health and the Alliance for Health Promotion, said that mental illnesses were not only a risk factor for other noncommunicable diseases, but were often a consequence of one of those diseases. Unless mental illnesses were tackled explicitly, noncommunicable disease initiatives would be less effective and, as research had shown, would cost more. It might not be possible at present to include all mental illnesses, but the WHO mental health Gap Action Programme had shown that there were cost-effective, evidence-based interventions for a limited set of diagnoses, and those should be included as part of the noncommunicable disease armamentarium. Mental illnesses should be included in some form as part of the action plan, recognizing the links with other noncommunicable diseases and the latest scientific developments in the area. Efforts to combat noncommunicable diseases should not be undermined at the outset by the exclusion of mental illnesses and substance abuse.

Dr EISELÉ (The World Medical Association, Inc.), speaking at the invitation of the CHAIRMAN and on behalf of the International Council of Nurses, the International Pharmaceutical Federation, the World Dental Federation and the World Confederation for Physical Therapy, said that the five organizations made up the World Health Professions Alliance. She urged Member States to take a holistic view of noncommunicable diseases, and not to try to tackle them individually or to reach a position where communicable and noncommunicable diseases competed for funding. Health professionals had a major role in reducing the global noncommunicable disease burden through appropriate action on health promotion, disease prevention, treatment and rehabilitation, and advocating research and finance. However, the global crisis in human resources for health was a significant barrier to progress in many countries. Action was also needed on social determinants of health. She supported WHO's leadership role, especially in emphasizing preventive health policy, and encouraged Member States to develop health systems built on a primary health care model and including prevention, rehabilitation and specialized health services.

Dr KAYI (Medicus Mundi Internationalis - International Organization for Cooperation in Health Care), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that the noncommunicable disease initiative should be broadened to include mental health. It was disappointing that no reference was made to the work of the Commission on Social Determinants of Health in the Secretariat's report. Unhealthy behaviours were much to blame, but structural determinants such as education, income, gender and ethnicity were also underlying causes of noncommunicable diseases and behavioural risk factors. There was also a crucial equity dimension, with variations closely linked to the social and environmental factors, not just individual behaviours. Preventive measures for social and environmental factors must be included in any outcome document from the United Nations General Assembly's high-level meeting.

In parallel with prevention, Member States should enhance access to affordable treatment for noncommunicable diseases. The draft resolution should spell out the responses of Member States and the Secretariat in terms of initiating legal and policy measures to ensure access to affordable diagnostic tools and treatment, in particular the full use of the flexibilities of the Agreement on Trade-Related Aspects on Intellectual Property. However, rational use of medicines and diagnostic tools must be vigorously promoted in order to avoid "over-servicing", which would burden health systems. It was also important to curb the practices of industries, such as food and agricultural corporations, that contributed to the prevalence of noncommunicable diseases. The draft resolution should therefore incorporate a call for the development of a code of conduct regulating the advertising and promotion of their products. The report gave insufficient detail on the health systems implications of noncommunicable diseases. Comprehensive primary health care services should be strengthened as the basis for chronic disease management, which called for ongoing follow-up and monitoring, and clinical audit. The drive to give more prominence to noncommunicable diseases was being conducted by some distinguished public interest civil society networks but also by some large transnational pharmaceutical companies whose main interests were marketing and profits. WHO should have a rigorous set of protocols for identifying and protecting against conflict of interest at the institutional level.

Mr Ming-Neng SHIU (Chinese Taipei) acknowledged the prevention and control of noncommunicable diseases as a high priority for Chinese Taipei, which focused on four main risk factors: tobacco use, unhealthy diet, physical inactivity and the harmful use of alcohol. A range of legislation had been introduced to combat tobacco and alcohol-related hazards; smoking was banned in most indoor public spaces; the first smoking helpline in Asia had been established and clinical smoking cessation services were funded. Legislation was being prepared with respect to unhealthy diet and lack of exercise, and a nationwide campaign on obesity prevention and control was to be launched. A comprehensive monitoring system for noncommunicable diseases and related risk factors was in place, with universal coverage for detection and treatment, such as population-based screening for cancer. Health insurance covered both treatment and special management programmes for noncommunicable diseases.

Dr ALWAN (Assistant Director-General) thanked Member States for their comments and for their contributions since the endorsement of the action plan for the global strategy for the prevention and control of noncommunicable diseases in 2008. Their contributions to the draft resolution had been encouraging and they had provided valuable guidance, which would be reflected in WHO's workplans on prevention and control of noncommunicable diseases. Referring to preparations for the forthcoming high-level meeting of the United Nations General Assembly, he concurred that mental health disorders were a major public health problem, with inadequate access to appropriate health-care interventions in low- and middle-income countries, as well as in some high-income countries. The Secretariat was giving the matter priority through the mental health Gap Action Programme, and it aimed to expand activities. It had also developed evidence-based guidelines focusing on affordable, effective interventions that were being piloted in several countries across the all WHO's regions. It was hoped that the high-level United Nations General Assembly meeting would make a contribution in that area, as any action on strengthening health systems' responses to noncommunicable diseases would have an equally positive impact on improving access to health care for people with mental health disorders, particularly in areas of financing, health information systems, and access to technologies and medicines. WHO had highlighted the importance of mental health disorders in the *Global status report on noncommunicable diseases 2010* and in other initiatives in preparation for the high-level meeting.

WHO took the guidelines on interaction with commercial entities very seriously in its work with partners, and was taking every possible precaution to avoid conflicts of interest in accordance with the resolutions and recommendations of the governing bodies. He expressed appreciation to The Cochrane Collaboration for its assistance in work on evidence-based guidelines. The positions and

recommendations on interventions set out in the *Global status report on noncommunicable diseases 2010* had been based on a careful review of evidence and had taken into account cost-effectiveness and affordability for low- and middle-income countries.

The Secretariat's report focused on WHO's preparations for the forthcoming high-level meeting rather than the Organization's strategies in relation to noncommunicable diseases. Further information on action for health system strengthening and improving access to health care for noncommunicable diseases was set out in the action plan for the global strategy for the prevention and control of noncommunicable diseases and in the *Global status report on noncommunicable diseases 2010.*

The DIRECTOR-GENERAL also thanked the many speakers for their comprehensive comments. She welcomed the strong support expressed for WHO's leadership role in the prevention and control of noncommunicable diseases, and assured the Committee that she would work with all partners, including other organizations in the United Nations system, civil society, academia, and scientific experts, to provide support to countries in seeking public health solutions and cost-effective, affordable interventions based on the best possible evidence, avoiding any conflict of interest.

The fight against noncommunicable diseases would be long and would require sustained momentum. It was important to use the opportunity provided by international meetings to renew commitment to action and to monitor and measure progress in the prevention and control of noncommunicable diseases. Regional consultations and the Moscow meetings had paved the way for the forthcoming high-level meeting of the United Nations General Assembly. Other future meetings included the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19–21 October 2011); the Fifteenth World Conference on Tobacco or Health (Singapore, 21–24 March 2012); and the Eighth Global Conference on Health Promotion (Helsinki, June 2013). Those meetings were interconnected, and provided a platform for joint renewal of commitment and action. Control of tobacco was of special concern given the aggressive tactics of the tobacco industry reported at country level.

The CHAIRMAN invited comments on the draft resolution. It was his understanding that the amendments proposed by Côte d'Ivoire, Samoa and Swaziland had been withdrawn.

Mr TUITAMA LEAO TUITAMA (Samoa) thanked the sponsors, in particular Norway, for their efforts to achieve consensus on the draft resolution. He was prepared to withdraw the proposed amendment, having been assured that the definition of developing countries included the small island countries, so that the latter's needs would not be neglected.

Dr DOUA (Côte d'Ivoire) said that Côte d'Ivoire had proposed a minor amendment involving the translation of the English word "challenge", which should be rendered by "*défi*" in French rather than "*répercussion*". He agreed to withdraw the other proposed amendments.

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

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: Item 13.7 of the Agenda (Document A64/16)

The CHAIRMAN drew attention to the following draft decision on substandard/spurious/falsely-labelled/falsified/counterfeit medical products proposed by the

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA64.11.

delegations of Canada, Monaco, Russian Federation, Switzerland, United States of America and Zambia, which read:

> The Health Assembly considered the report of the working group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products contained in document A64/16 and decided to accept the "Next Steps" contained in the report. The Health Assembly specifically decided to extend the period set out in decision WHA63(10) in order to allow the working group to complete its work as soon as possible.
>
> It was further decided that the working group should resume its work as soon as possible following the Sixty-fourth World Health Assembly and report on its work to the Sixty-fifth World Health Assembly through the 130th session of the Executive Board.

Mr MWAPE (Zambia), speaking as Chairman of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products, recalled that in decision WHA63(10) the Health Assembly had decided to establish the time-limited Working Group to examine matters concerning four specific issues (subparagraphs 3(a)-(d) of the decision) and that the Working Group should make specific recommendations in relation to those issues to the current Health Assembly. However, the Working Group had been constituted only in 2011 and had met only once, from 28 February to 2 March. The discussions had concentrated on arriving at a better understanding of WHO's work in the area and a clear articulation of the concepts involved, with a view to identifying principles and further clarifying the respective positions of delegations. Despite some progress, substantial differences persisted between delegations. Much work remained to be done and the Working Group had not reached the stage of making recommendations. Consequently, it requested the Health Assembly to consider extending its term to allow it to engage in further deliberations and report to the Sixty-fifth World Health Assembly through the Executive Board.

Dr DAULAIRE (United States of America) said that ensuring the quality, safety and efficacy of medical products was a shared mission, along with securing the increasingly complex global supply chain of medicines. As a result of major scientific and technological breakthroughs and globalization, regulatory authorities and health systems had to adapt to functioning in more complex environments. Interdependent relationships and networks would be needed to counter threats to the integrity of medicines and supply chain security. The United States continued to support the work by the International Medical Products Anti-Counterfeiting Taskforce to address those threats.

He endorsed the proposal to extend the term of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit Medical Products, provided that its recommendations were science-based, measurable and practical and that its mandate as a time-limited and results-oriented working group continued to apply.

Dr VENEGAS (Uruguay), speaking on behalf of the Member States of the Union of South American Nations, said that falsified medical products affected developed and developing countries alike. Regulation by strong health authorities was needed to ensure the quality, safety and efficacy of all medical products being marketed and distributed. The health authorities in all 12 South American countries had been successfully working together under the auspices of the South American Council of Health on combating the falsification of medical products. The region's governments were committed to guaranteeing access to good-quality medicines at affordable prices, and fighting falsification must not jeopardize universal access to health care. He continued to support the decision taken at the previous Health Assembly to establish the Working Group; although it had met only once, it had overcome mistrust and concerns about conflicts of interest. He therefore supported the proposal to

extend the term of the Working Group in the hope that it would meet twice before the next Health Assembly.

Ms ESCOREL DE MORAES (Brazil) welcomed the work of the Working Group and acknowledged the able leadership of Ambassador Mwape. Brazil had been closely engaged in the Working Group's initial work, and the long delay in its deliberations was regrettable. The Working Group had indeed overcome its members' divisions and, provided it operated in a transparent manner, was the only means of enabling WHO to make a strong response to fake medicines. She therefore supported the proposal to extend the term of the Working Group in the expectation that it would meet at least twice before the next Health Assembly. She reiterated Brazil's commitment to combating falsified medicines, but insisted that the issue must be addressed in conjunction with the need to ensure universal access to medicines.

Mr DESIRAJU (India), speaking on behalf of the Member States of the South-East Asia Region, reiterated the importance they gave to access to good-quality, safe, efficacious and affordable medical products, and recalled that efforts had been made deliberately to confuse the issues of quality and intellectual property rights. He affirmed WHO's role in ensuring availability to good-quality, safe, efficacious and affordable medical products. He commended the work of the Working Group under Ambassador Mwape, even though it had not been set up until nine months after the adoption of decision WHA63(10). It had clearly differentiated between public health and intellectual property rights and made progress on terminology. WHO's priority, as the Director-General had made clear to the Working Group, was to protect populations from the harm caused by poor-quality, unsafe medicines by means of strict regulatory control, strict enforcement of quality standards and diligent pharmacovigilance.

He noted with relief that the International Medical Products Anti-Counterfeiting Taskforce had physically moved out of WHO's headquarters in response to demands by many developing countries, since the Taskforce's agenda was perceived to be dominated by intellectual property rights. Future discussions on enforcement of intellectual property rights should remain separate from work on the quality, safety and efficacy of medicines.

He called on the Health Assembly to extend the term of the Working Group and draw up a clear meeting schedule, to include up to three formal meetings before the next Health Assembly. The Working Group should not be sidetracked into discussions of terminology, but should discuss the possibility of establishing a Member State-driven mechanism to deal with quality, safety and efficacy issues, including strengthening drug regulatory authorities, provided that the mechanism was transparent, avoided conflicts of interest, and had a clear mandate. The Secretariat should continue to work on areas where a consensus had been reached by the Working Group. It should terminate all relations with the International Medical Products Anti-Counterfeiting Taskforce until the Working Group completed its mandate.

Professor ADITAMA (Indonesia) commended the establishment of the Working Group and its progress to date. Ensuring access to affordable medicines, technologies and other health products was essential to the protection of people in need. Principles of safety, efficacy and quality of medical products and promotion of the rational use of medicines should be at the heart of national and international policies, and compromised medical products undoubtedly represented a threat to health and well-being that WHO should counter. WHO should retain its impartial leadership in setting standards for ensuring the safety, efficacy and quality of medical products in a transparent and fair process driven by Member States and based on public health considerations. However, there should be no overlap between consideration of measures related to compromised products and those concerning enforcement of intellectual property rights. The term "substandard" should not be used to refer to medical products classified as spurious/falsely-labelled/falsified/counterfeit. He welcomed the move of the International Medical Products Anti-Counterfeiting Taskforce office away from WHO

headquarters. Indeed, WHO should distance itself from the Taskforce, and the relationship between the two organizations should be redefined in favour of Member States. WHO had a crucial role to play in strengthening drug regulatory authorities, especially in developing countries, which was a key factor in combating products of compromised quality, safety and efficacy. He supported extension of the Working Group's term.

Dr IBITOMI (Nigeria) also supported extension of the term of the Working Group but urged it to fulfil its mandate as soon as possible. The developing countries were concentrating on the prevention and control of communicable diseases but lacked adequate facilities for monitoring the contribution of substandard/spurious/falsely-labelled/falsified/counterfeit medical products to their deplorable health indicators; while the Working Group continued its work, people were dying from the effects of such products. He therefore urged the Working Group to accelerate action to achieve the objectives stated in the Working Group's report (document A64/16, Annex, paragraph 7). He supported the continued participation of WHO in the Taskforce.

Dr FOURAR (Algeria) said that the availability of good-quality, safe, effective and affordable medical products was a major concern of the Member States of the African Region. WHO should therefore play a major role in combating the manufacture, sale and consumption of counterfeit products, particularly in view of economic globalization. The volume and sophistication of the trade in such products across borders rendered their manufacture highly lucrative, particularly in developing countries with weak border controls and regulatory systems. The situation was exacerbated by the inaccessibility of official medical products in poor communities, partly owing to the position adopted by major pharmaceutical manufacturers. Their monopolies prevented manufacture of generic versions and kept prices high so that low-income countries were unable to meet the needs of their people for safe and effective medicines. Intellectual property rights were an important aspect of encouraging public health innovation and were one of the determinants of access to affordable medicines. The fight against counterfeit medicines was therefore linked to a complex and intersectoral area.

Counterfeit medicines endangered the health of consumers. Countries must adopt a common approach and WHO had to fulfil its role by setting international norms for pharmaceutical products and promote measures to ensure the availability of good-quality and affordable medicines. Member States should respect those norms and principles. He welcomed the establishment of the Working Group and its progress to date. It should give attention to WHO's provision of support to countries in strengthening national capacity for pharmaceutical regulation and the implementation of effective coordination and collaboration to ensure regional and subregional harmonization in that area, and in promoting collaboration between national regulatory authorities for exchange of information and inspection techniques. It should also consider setting up an intergovernmental negotiating body for the preparation of an international legal instrument to counter the manufacture, export, import and trade in counterfeit products and to regulate surveillance of supply and distribution systems. He supported extending the term of the Working Group and urged Member States to show flexibility and a spirit of compromise in the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Dr GOUYA (Islamic Republic of Iran) noted the continuing growth of the criminal trade in substandard/spurious/falsely-labelled/falsified/counterfeit medical products which seriously affected his country, other countries in the Eastern Mediterranean Region and developing countries. International support was essential to successful countermeasures. He commended the progress of the Working Group to date and supported extension of its term by at least one year. The Working Group's report should be submitted to the Sixty-fifth World Health Assembly.

Ms LANTERI (Monaco) said that it was paramount that the international community set about controlling and preventing the manufacture, distribution and use of substandard/spurious/falsely-

labelled/falsified/counterfeit medical products. International and multisectoral cooperation was vital and should involve health, legal, police and customs authorities. She welcomed the work of the International Medical Products Anti-Counterfeiting Taskforce in that regard. The Secretariat should also work to enable Member States better to identify and prevent the distribution and use of such products. She welcomed the progress made by the Working Group and agreed that its term should be extended to allow it to finish its work as quickly as possible. The draft decision contained a provision for the Working Group to report on its work to the Sixty-fifth World Health Assembly.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that the candidate countries Turkey, Croatia, The former Yugoslav Republic of Macedonia, Montenegro, Iceland, the countries of the Stabilisation and Association Process and potential candidates Albania and Serbia, as well as the Republic of Moldova and Armenia aligned themselves with her statement. Ensuring the safety, quality and efficacy of medical products should be a global health priority. Concern had been growing about substandard/spurious/falsely-labelled/falsified/counterfeit medical products, and the increase in, and sophistication of, the manufacture of such products and their complex distribution patterns had resulted in their entry into the supply chain of lawful products, seriously undermining public confidence in health-care systems. As the problem affected all countries, WHO should continue its important role in fighting counterfeit medical products, particularly with regard to its normative, practical and implementation-related work.

The report of the Working Group pointed to numerous shared concerns, emphasizing the need for global action. The European Union supported the measures being taken by WHO, listed (document A64/16, Annex, paragraph 6) as enhancing the availability of safe, good-quality medical products and strengthening national regulatory authorities and health systems. Intensification of control and prevention should begin without delay. She acknowledged the concerns raised during the meeting of the Working Group about governance of the International Medical Products Anti-Counterfeiting Taskforce. Although she considered that the Taskforce had been efficient, some matters, including definitions and the nature of the relationship between WHO and the Taskforce, required further thought and discussion. She therefore welcomed the proposed extension of the term of the Working Group as that would allow it to concentrate on the outstanding issues and avoid any duplication of work. She urged participants to show willingness to reach agreement on issues in order to make sure that the work produced results. When the Working Group reconvened, it should look primarily at efforts to counter falsified medical products and their production, while differentiating clearly between substandard and falsified medicines and maintaining a public health focus. Any discussions should also avoid issues related to the infringement of intellectual property rights.

The problem of substandard/spurious/falsely-labelled/falsified/counterfeit medical products was complex, ranging from policy questions on the availability and affordability of medicines to the criminal acts performed by those who deliberately manufactured and sold falsified medicines, regardless of the implications for public health. Although each issue should be addressed individually, strengthening national regulatory capacity was also vital. Questions on the quality and affordability of medicines were vital and were being discussed in other forums within WHO. In parallel with any further discussion by the Working Group, Member States and the Secretariat should concentrate on improving the quality, safety and efficacy of medicines from producers who wished to manufacture legitimate products but lacked the capacity to do so.

Mr HAJI (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, expressed appreciation of the Director-General's leadership in the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products. Such products represented a major public health threat as their illegal manufacture, distribution, widespread availability and indiscriminate use were detrimental to health and could lead to therapeutic failure, exacerbation of disease, disability and injury, wastage of scarce resources, loss of confidence in health-care systems, and death. Poor legislation, inadequate enforcement of existing legislation, lack of any harmonized

definition of counterfeit medical products, the high cost of existing lawful medical products and weak national medicines authorities were the main reasons for the proliferation of such products, which affected the African Region most. In addition, manufacturing of such products was mainly driven by the prospect of big profits.

In accordance with decision WHA63(10), the Regional Office for Africa had set up a Regional Task Force and organized a consultative meeting with Member States in July 2010 at which measures proposed included the strengthening of, and networking between, national regulatory authorities, professional organizations and law enforcement agencies.

The Working Group had been established as a time-limited and results-oriented group expected to make specific recommendations. Welcoming its progress, he noted that it had not yet completed its work and he therefore supported the proposal that its term be extended to allow it to do so.

Mr ROSALES LOZADA (Plurinational State of Bolivia) said that his Government was firmly committed to the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products. He supported the draft decision to extend the term of the Working Group, which was an appropriate forum for discussing the issue. It was important to disassociate WHO from past parallel initiatives that had generated much controversy and had not been prompted by public health considerations. He supported the proposal of the delegate of Uruguay that the Working Group should hold at least two more meetings before the 130th session of the Executive Board in January 2012.

Dr MOHAMMED (Iraq) said that globally unified standards for pharmaceutical products and companies were important and that standards for vaccines should be included in national legislation. Collaboration with the public sector and nongovernmental organizations should be strengthened and the importance reaffirmed of monitoring standards of medical products. In addition, all medical products should be registered in order to allow regulation and control of the products, their distribution and use. Work should concentrate on setting quality standards and ensuring the availability of medical products at affordable prices and should avoid mixing discussion of intellectual property issues with issues related to substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

Ms WISEMAN (Canada) said that, as the leading global health body, WHO must show leadership in the fight against substandard/spurious/falsely-labelled/falsified/counterfeit medical products. She supported the proposed extension of the term of the Working Group but considered that the time-limited and results-oriented nature of the mandate should continue. Discussion of further meetings of the Working Group was premature and she urged its members to pledge to complete the work as soon as possible. It was important that the working group continue to build on its progress to date.

The International Medical Products Anti-Counterfeiting Taskforce was the sole forum where national regulatory authorities could work together and with other sectors. Participation in the Taskforce's discussions had contributed to Canada’s success in controlling and preventing the manufacture and distribution of counterfeit medical products. It was important that any outstanding governance and mandate issues should be addressed in order to allow WHO to continue its leadership role in that area, particularly with regard to the setting of norms and standards and capacity building.

Dr RUBERU (Sri Lanka) said that Sri Lanka was one of the few countries in the world to provide free access to health care for its entire population, with supply of pharmaceutical products accounting for a large proportion of the health budget. In recent years the cost of pharmaceutical products had increased for a variety of reasons, resulting in a gap between required and available funds in the national budget. Rational prescribing of medicines and efficient management of them were therefore crucial. Highlighting the role that the introduction of good-quality generic pharmaceutical products had played in his country’s health-care system, he drew attention to the

national legislation and regulatory framework introduced in order to guarantee good-quality, safe and efficacious medical products on the domestic market.

He welcomed the work of the Working Group and its examination of the role of WHO both in ensuring availability of good-quality, safe and affordable medical products and in the prevention and control of the former medical products. His country would contribute constructively to its continued activities, one focus of which should be on making developing countries better able to produce good-quality generic medicines through technology transfer and funding. He supported the proposal to extend the term of the Working Group.

The Secretariat should not allow agencies responsible for enforcing intellectual property rights, such as the International Medical Products Anti-Counterfeiting Taskforce, to affiliate their work with that of WHO.

Dr NIRACHA USSAVATHIRAKUL (Thailand) noted the progress made at the first meeting of the Working Group. She supported the request to extend its term by one year, but emphasized that, in its work on counterfeit medical products, WHO should focus on public health issues alone and not intellectual property rights. Cooperation with any outside entity, such as the International Medical Products Anti-Counterfeiting Taskforce, should be transparent and avoid conflicts of interest. WHO should therefore suspend all relations with the Taskforce until the Working Group's work was finalized and its recommendations adopted by the Health Assembly.

Dr YANO (Kenya) expressed concern at the fact that the Working Group had met only once, after a delay, and had been unable to complete its mandated work. Acknowledging the importance of improving access to affordable, quality, safe and efficacious medicines, he supported the request to extend the Working Group's term by one year.

Mr KUDO (Japan) said that Japan was supporting WHO's activities related to combating counterfeit medical products by conducting training and making professionals available, thereby helping to improve the accessibility, quality and rational use of medicines in developing countries. Japan supported WHO's involvement with the International Medical Products Anti-Counterfeiting Taskforce, which played a significant role. However, the failure of the international community to strengthen measures to combat counterfeit medical products was a matter for concern. The measures, monitoring system and inspection methods contained in the Taskforce's guidelines should be actively implemented. He endorsed the request to extend the Working Group's term.

Mr BEN AMMAR (Tunisia) said that, thanks to a State-supervised system of distributing medical products, Tunisia was free of counterfeit products but could not remain indifferent to events elsewhere. While the debate had reached stalemate over terminology, hundreds of lives were at risk owing to counterfeiters' greed and a lack of means to control the markets. As the counterfeiting of products was a matter of international public health, WHO was the right forum for resolving the problem. The unfortunate confusion over intellectual property rights in connection with the International Medical Products Anti-Counterfeiting Taskforce might lead to serious problems with regard to the medicines supply chain. The Taskforce had been set up precisely because of the lack of consensus on establishing an international convention and should not be abandoned until a better alternative approach could be adopted.

Dr SINOLINDING (Philippines) commended the work of the Working Group on counterfeit medical products from a public health perspective and agreed that it was important to improve access to affordable, good-quality, safe and efficacious medicines. WHO should continue to strengthen national regulatory authorities and health systems, while supporting work on generics and the rational selection and use of medical products. He looked forward to the completion of the Working Group's mandate.

Dr AYDINLI (Turkey) said that, despite national and international countermeasures, medical products were being increasingly counterfeited. According to the European Parliament, 1% of the medicines sold in Europe through the lawful supply chain were falsified. In the rest of the world, the figure could be as high as 30%. Since 1 January 2010, Turkey had been applying a tracking system aimed at monitoring medicines in cooperation with the whole supply chain. Products were identified by a serial number and code, allowing medicines to be traced from producer to end user. The system covered prescription and non-prescription medicines as well as medical nutritional products. Convinced that national efforts should be supported by an international commitment to promoting access to affordable, good-quality medicines, Turkey was willing to share its experience with other countries.

Ms TOLSTOÏ (France) said that France was committed to combating the growing threat of falsified medical products to international public health. She reassured France's partners that the fight against counterfeit medicines was not intended to block trade in generic medicines, which were also being counterfeited. Although in her view the term "falsified" was the most appropriate, the Working Group should be left to decide on the terminology. WHO had a central role to play in the fight against counterfeit products, France and many other Member States fully supported the work of the International Medical Products Anti-Counterfeiting Taskforce, whose multidisciplinary nature should be preserved. It was to be hoped that the Working Group would complete its work before the Sixty-fifth World Health Assembly.

Dr AGHNAJ (Morocco) commended WHO's role in ensuring the safety, quality and efficacy of medical products and the deliberations of the Working Group, which should be authorized to continue its work for another year. Given the international scale of the problem, more should be done in Africa to combat counterfeit medical products. Cooperation and partnerships between developing countries should be enhanced, for example by designating a regional reference laboratory. Morocco's national medicines quality control laboratory possessed the necessary experience and expertise.

Mr CONSTANT (Trinidad and Tobago) said that all the proposals made by the Working Group in its report would benefit countries in their fight against counterfeit medical products, especially small developing countries such as his. With their small national regulatory agencies they faced several challenges, including an underdeveloped medicines manufacturing sector and imported counterfeit products; a programme to monitor and regulate imports must be established. The proliferation of Internet trade in medical products made a necessity of good practices. Regional harmonization, as exemplified by the activities of the Pan American Network for Drug Regulatory Harmonization, was another useful method of combating counterfeit medicines. The Network's relevant working group had proposed several initiatives for harnessing national experience through international linkages.

Dr FRANCO GAME (Ecuador) welcomed the Working Group's report. As good-quality, safe and efficacious medicines were essential to enjoyment of the right to health, it was incumbent on States to ensure access to them. There had nevertheless been a considerable increase in the number of falsified medicines on the market, owing in part to weak health vigilance systems. Governments should implement national and regional strategies to end unscrupulous practices. She supported the request to extend the Working Group's term.

Ms ZHANG Xiaobo (China), noting the Working Group's report, expressed her country's support for WHO's work on combating counterfeit medical products from a public health perspective. WHO should provide an international platform for the exchange of information, supporting national regulatory bodies and promoting public awareness. Member States should do more to exchange information and cooperate in combating counterfeit products while respecting each country's own

legislation. The Working Group should focus on improving the definitions of counterfeit products in order to make the fight against counterfeit products more effective. China agreed to the extension of the Working Group's term.

Dr LEWIS FULLER (Jamaica) welcomed the leading role of WHO in combating substandard/spurious/falsely-labelled/falsified/counterfeit medical products and their adverse effect on public health. The provision of good-quality, safe and efficacious products must remain a priority for the Organization since it was particularly relevant to countries, like Jamaica, lacking the capacity to manufacture their own products.

She welcomed the report of the Working Group, in particular the recommendation for an intergovernmental negotiating body to draw up legally binding instruments to combat those compromised products. She recommended that other relevant existing documents also be taken into consideration by the Working Group as it continued its work.

Dr Ming-Neng SHIU (Chinese Taipei) also welcomed the report of the Working Group. Chinese Taipei had a well-established system of evaluation and surveillance to ensure the quality, safety and efficacy of medical products. The provision of legitimate medicines, provided by medical services and covered by health insurance, was always guaranteed. Illegal drugs could be obtained in Chinese Taipei through various channels, and some dealers even managed to promote them through the media and misleading health education programmes. Countermeasures had been introduced, including an interdepartmental task force.

He welcomed WHO's three future roles, as proposed in the report. Chinese Taipei would continue to collaborate with government agencies and others in combating illegal medical products and halting the spread of counterfeit drugs.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that, in countries with a high burden of communicable diseases, falsified medical products had already begun to result in drug resistance and reverse achievements made. In several regions people were also at risk from medicines that might have been accidentally adulterated, produced to a poor standard and/or degraded by poor storage facilities. Such issues should not be ignored, but it was important to distinguish them from deliberate falsification. Falsification of medicines had remained a global threat to public health since a resolution on the issue had first been proposed in 2008. Member States should pledge themselves to take definitive action to prevent the falsification of medicines and ensure that trust in health systems was not dented.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, drew attention to the dire effects of falsified medicines on people's health, including causing drug resistance or even death. Vigorous action was needed from the global community to tackle a growing phenomenon: in 2010, a 10% rise compared with two years before had been reported in the number of substandard/spurious/falsely-labelled/falsified/counterfeit products, with a significant proportion affecting licensed wholesale distributors or pharmacies.

A multistakeholder and multidisciplinary response led by the Secretariat and Member States was needed, with both local and global cooperation, in order to ensure patient safety and halt the production of those compromised medicines.

Mr GOPAKUMAR (CMC - Churches' Action for Health), speaking at the invitation of the CHAIRMAN, noted the right of all people to access to safe, good-quality and efficacious medicines. A requirement was the assured availability of satisfactory medicines at affordable prices, as that would remove the incentive to trade in or purchase compromised medicines.

Efforts to address the issue should also involve strengthening drug regulatory systems, particularly in African countries. He therefore urged Member States to switch their attention from short-term solutions to the root causes of the proliferation of compromised medicines.

Mr MWANGI (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that substandard/spurious/falsely-labelled/falsified/counterfeit medical products posed a real threat to patients and the quality and safety of the medicines available to them. Such products also risked eroding patients' trust in health-care systems and failed treatment of illnesses or diseases. WHO should therefore take the lead with urgent action to protect patients globally, bringing together all relevant stakeholders to address the issue. As patients often lacked sufficient knowledge or choice to avoid exposure to those compromised products, all partners needed to work to ensure that adequate information and solutions were provided.

The DIRECTOR-GENERAL expressed appreciation of the comments made by Member States and others and reaffirmed her commitment to supporting the work of the Working Group in order to counter definitively the risks posed by substandard/spurious/falsely-labelled/falsified/counterfeit medical products.

The CHAIRMAN said that he took it that the Committee wished to approve the draft decision.

The draft decision was approved.[1]

Health-related Millennium Development Goals: WHO's role in the follow-up to the high-level plenary meeting of the sixty-fifth session of the United Nations General Assembly on the review of the Millennium Development Goals (September 2010): Item 13.3 of the Agenda (Documents A64/11, A64/11 Add.1 and EB128/2011/REC/1, and resolution EB128.R1) (continued from the ninth meeting)

The CHAIRMAN drew attention to a revised version of the draft resolution on WHO's role in the follow-up to the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), which incorporated the amendments proposed during the Committee's ninth meeting and which read:

> The Sixty-fourth World Health Assembly,
>
> **PP1** Recalling resolutions WHA63.15 and WHA61.18 on monitoring of the achievement of the health-related Millennium Development Goals, and WHA63.24 on accelerated progress towards achievement of Millennium Development Goal 4 to reduce child mortality: prevention and treatment of pneumonia;
>
> **PP2** Expressing deep concern at the slow pace of progress in achieving Millennium Development Goals 4 and 5 on reducing child mortality and on improving maternal health;
>
> **PP3** Acknowledging that much more needs to be done in achieving the Millennium Development Goals as progress has been uneven among regions and between and within countries, despite the fact that developing countries have made significant efforts;
>
> **PP3bis Recognizing that adequate antenatal care reduces the risks of maternal mortality, prematurity and other poor related outcomes that will increase the challenges of taking care of very young neonates; [Jamaica]**
>
> **PP4** Recognizing the need to work towards greater transparency and accountability in international development cooperation **regarding health [USA]**, in both donor and developing

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as decision WHA64(10).

countries, focusing on adequate and predictable financial resources as well as their improved quality and targeting;

PP5 Welcoming the United Nations Secretary-General's Global Strategy for Women's and Children's Health launched at the United Nations High-level Plenary Meeting of the General Assembly on the Millennium Development Goals (New York, September 2010), and acknowledging the strong political and financial commitment by Member States to follow up and implement the strategy;

PP6 Noting the United Nations Secretary-General's request that WHO lead a process to determine the most effective international institutional arrangements for global reporting, oversight and accountability on women's and children's health, including through the United Nations system;

PP7 Stressing that the monitoring of resource flows and results is a vital requirement for improving the accountability and responsiveness by governments and international development partners **in addressing health issues; [USA]**

PP8 Welcoming the establishment of the Commission on Information and Accountability for Women's and Children's Health, which consists of high-level representatives;

~~**PP9** Noting that the objectives of the Commission on Information and Accountability for Women's and Children's Health are:~~

~~(1) to determine international institutional arrangements for global reporting, oversight and accountability on women's and children's health this accountability framework will encompass results and resources, and identify the roles of the different partners involved;~~

~~(2) to identify ways to improve monitoring of progress towards women's and children's health while minimizing the reporting burden on countries, including establishing a set of core indicators, efficient investment in data generation and better data sharing;~~

~~(3) to propose actions to overcome major challenges to accountability at the country level, including strengthening of country capacity and addressing major data gaps such as the monitoring of vital events;~~

~~(4) to identify opportunities for innovation provided by information technology that will facilitate improved accountability for results and resources, and to propose ways of ensuring that these opportunities are harnessed to bring maximum benefits to countries;~~ **[Thailand]**

PP10 Stressing that ~~aspects~~ **concerns [USA]** related to health equity and rights should also be addressed in efforts to achieve the Millennium Development Goals;

PP11 Stressing ~~furthermore~~ **[Canada]** that the Commission ~~on Information and Accountability for Women's and Children's Health~~ **[Canada]** should take into account relevant existing data collections and existing performance indicators**;**

PP12 Welcoming the final report of the Commission and its set of recommendations for strengthening accountability for resources and results in women and children's health, [Canada]

1. REQUESTS the Executive Board:

(1) to hold a discussion at its 130th Session in January 2012 on the implementation of the recommendations of the Commission; [Canada]

2. URGES Member States: [Thailand]

(1) to implement the recommendations provided by the Commission on Information and Accountability for Women's and Children's Health to improve the accountability of results and resources; [Thailand]

3. REQUESTS the Director-General:

(1) to ensure the effective engagement of all ~~key~~ **[Canada]** stakeholders in the **follow-up to the [Canada]** work of the Commission; ~~on Information and Accountability for Women's and Children's Health~~ **[Canada]**

(2) to report to the Sixty-~~fourth~~ **fifth [Canada]** World Health Assembly on progress **achieved** ~~in the work of the Commission on Information and Accountability for Women's and Children's Health~~ **[Canada]** in connection with the agenda item concerning the Millennium Development Goals.

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed further amendments to the draft resolution. In the third preambular paragraph bis, the term "poor related outcomes" should be replaced by "complications of pregnancy and delivery that can result in poor health outcomes for mothers and newborns", and the end of that paragraph the words "very young" should be deleted. A footnote should be added to the words "URGES Member States" in paragraph 2, reading "And regional economic integration organizations, as appropriate".

Mr BLAIS (Canada), supported by Dr WALAIPORN PATCHARANARUMOL (Thailand), proposed further amendments to some sections of the draft resolution that Canada had previously amended, in order to strengthen the text. Paragraphs 1 and 2 should be inverted, while in original paragraph 1, the words "to hold a discussion" should be replaced by "to review progress", and the clause should be restructured to read: "to review progress on the implementation of the recommendations of the Commission, starting at its 130th session in January 2012".

In subparagraph 3(2) the words "to the Sixty-fifth World Health Assembly" should be replaced by "annually until 2015 to the Health Assembly".

The CHAIRMAN said that he took it that the Committee wished to approve the draft resolution, as amended.

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

The meeting rose at 15:25.

= = =

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA64.12.