FIFTH MEETING

Wednesday, 18 May 2011, at 14:50

Chairman: Dr W. AMMAR (Lebanon)

1. PROGRAMME AND BUDGET MATTERS: Item 12 of the Agenda (continued)

Medium-term strategic plan 2008–2013 and Proposed programme budget 2012–2013: Item 12.3 of the Agenda (Documents A64/7, A64/7 Add.1, A64/7 Add.2 and A64/47) (continued)

Dr TAKEI (Japan) acknowledged the revision of the Medium-term strategic plan and the Proposed programme budget 2012–2013 in line with comments from Member States, particularly in the light of the Director-General's initiatives for reform. He welcomed the realistic transitional budget, with its increased allocations for high-priority strategic objectives, and he supported the modifications. However, given the current global economic situation, it would be hard to increase the total budget by increasing contributions and he therefore assumed that the total contribution would be the same for the biennium 2012–2013. Further efforts must be made to ensure the implementation of the current budgeted programme and, in particular, to ensure revenues, for example, by strengthening positive incentives for contributions similar to the practice within ILO. Also, donor contributions should be made more transparent.

The suggestion that the deficit in voluntary contributions for some programmes could be covered by using assessed contributions could lead to a reduction in productivity across the Organization. Less-productive programmes, instead of being financially supported, should be re-evaluated and show improved performance before receiving additional allocations.

He welcomed the 27% and 25% increases in budget allocations for strategic objectives 3 and 6 respectively, but asked how the increased budget would be managed during the current financial crisis. Japan would continue to support and work closely with the Secretariat to tackle the global health agenda and improve health for all.

Dr EZAATI (Uganda), speaking on behalf of the Member States of the African Region, said that the programme budget must be aligned with the Organization's core functions, with the emphasis on efficiency in expenditure. He commended the embrace of change and continuity within limited resources, without losing the focus on the Millennium Development Goals. A significant portion of appropriations for the strategic objectives had been earmarked for use in the African States, which required support in order to be able to tackle the heavy burden of disease. It was unfortunate that the total budget had been reduced in all regions, but especially so given the specific problems affecting Africa. He expressed concern regarding the large reductions in financing for health systems, HIV/AIDS, tuberculosis and malaria, and maternal and child health, which would impede the Region's attainment of the Millennium Development Goals. Additional resources should be sought in the medium term to finance those and other underfunded essential programmes. Innovative funding mechanisms should be developed and more predictable and reliable sources found in order to reduce WHO's dependence on voluntary contributions. He also urged Members in the African Region to fulfil their commitments as regards assessed contributions to the programme budget.

Dr LIU Peilong (China) noted the draft Proposed programme budget of US$ 3959 million, which was US$ 581 million lower that that for the preceding biennium. In the light of identified potential income, that figure was more realistic, and he therefore supported the budget proposals.

Given the current global financial difficulties, the Proposed programme budget emphasized the strategic objectives for meeting the health-related Millennium Development Goals, in particular maternal and child health, chronic diseases and health system strengthening, funding for which areas had increased from 17% to 27% over the previous budget, an increase that he welcomed.

Most financing for the Proposed programme budget would come from earmarked contributions, and only 34% from un-earmarked contributions, a proportion that was beneath the 40% objective outlined in the reform process. Voluntary flexible contributions should be encouraged, and the reform provided an ideal opportunity in that regard. He supported the draft appropriation resolution.

Mr PELLET (France), endorsing comments made by the delegate of Germany, supported the budget that had been revised at the request of Member States and which provided a good basis for discussions on the future of financing for WHO. He made two specific recommendations about the rebalancing of resources. The first was to break the equation between the strategic objectives and the earmarking of voluntary contributions. That could be done by means of different formulations between the earmarking and the 13 objectives, which could be regrouped or specifically and individually earmarked. Further, the net of international organizations implicated in funding could be cast wider, as the themes did not belong uniquely to WHO but to the United Nations system. WHO's partners could contribute, also thereby breaking the equation.

Secondly, increased private and non-State contributions (almost exclusively earmarked) must be systematically linked to a better alignment of contributions on priorities. It was necessary to be absolutely clear about which activities could be financed by non-State partners; anything to do, on the other hand, with the modernization and governance of WHO must come under its regular budget since what was at stake was the management of the Organization in the interests of all its Member States.

Ms BLACKWOOD (United States of America) supported the proposed budget, which was based on projected income and which indicated a further move towards results-based management. She looked forward to additional progress in that regard during the reform process and to regional perspectives being addressed.

Ms BENNETT (Australia) supported the Proposed programme budget 2012–2013, which included a pledge to redouble efforts on child and maternal health and health system strengthening. However, she shared concerns expressed by other delegates about the reduced allocations for the corresponding strategic objectives 4 and 10, which were essential for attaining the health-related Millennium Development Goals 4 and 5.

She welcomed the planned increase in fully and highly flexible funding, and encouraged all donors to support WHO with core voluntary contributions, to ensure a flexible response to priority issues.

Dr GULLY (Canada), supporting the Proposed programme budget 2012–2013, commended the Secretariat's efforts in bringing it closer to predicted income levels. However, the budget would probably still result in a deficit at the end of the biennium. As moving too quickly from an aspirational budget to a realistic balanced budget might create short-term savings but long-term damage, he supported the adoption of the budget as proposed on the understanding that it was transitional and that any subsequent budget would be fully balanced.

Changes to the budget planning cycle should be considered during discussions on financial reform, with particular regard to improving the function of governing bodies. It was to be hoped that the Programme, Budget and Administration Committee and the Executive Board would be further engaged in the budget process.

Concerning the statement made by the delegate of Panama, he emphasized the importance of the final paragraph on the need to review budget and allocation mechanisms as part of the reform process.

Dr JAMA (Assistant Director-General) welcomed all the comments made on the budget proposal, which had been subject to long consultation. The improvements already made would be further strengthened during the upcoming review process.

The revised budget was based on the expenditure level from the biennium 2008–2009 and the projected income for the biennium 2010–2011. Funding for strategic objectives relating to Millennium Development Goals 4 and 5 had been increased as requested by Member States, and allocations would be further increased by as much as 30% if contributions rose. He reiterated that strategic objective 4 was not alone in addressing the Goals; strategic objectives 1 and 2 both contributed to improving maternal and child health through immunization programmes, poliomyelitis eradication, programmes on HIV/AIDS, tuberculosis and malaria, and health system strengthening. Further emphasis would be placed on the equal distribution of funds across the WHO major offices and between the strategic objectives. It would be important to seek more predictable and flexible financing to address the need for resources.

Projected income, as stated to the Programme, Budget and Administration Committee, remained at US$ 4000 million; however, some parts of the Programme budget 2010–2011 would not be fully funded. WHO would continue to seek additional flexible contributions in order to align funding with identified priorities. Should the projected income for the biennium 2012–2013 increase, the overall budget and budget allocations would also be reviewed. Any approved work plans would need to be based on detailed projected income and spending both in regional offices and at headquarters.

The reduction and redistribution of budget allocations meant that resources for strategic objectives 12 and 13 had been reduced by 3% and for headquarters by 5%; however any extra income would be directed to those strategic objectives to ensure all results indicated in the Proposed programme budget. It was hoped that direct financing of some programmes such as the UNICEF/ UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases would also raise additional funding.

The DIRECTOR-GENERAL said that work on a new budget process would begin immediately after the current session of the Health Assembly. Particular attention would be given to evaluation of the existing validation mechanism, to ensure that the budget allocations to the six WHO regional offices and to headquarters were fair and equitable. Greater clarity was indeed needed about the respective roles and functions of different levels of the Organization. The allocation of resources should reflect those functions and produce results. She intended to improve the articulation of what had been achieved with the resources provided. Work on those issues would begin immediately.

Referring to the comments by the delegates of France and Germany, and on the understanding that their comments were in line with the position of the European Union, she asked whether the Committee wanted budget appropriations in the Proposed programme budget 2012–2013 to be provided for each of the existing strategic objectives or grouped into two consolidated sections, one covering strategic objectives 1–11 and the other strategic objectives 12 and 13. Those options could necessitate having two appropriation resolutions, or one with two sections. She pointed out that if the strategic objectives were consolidated, it would not be possible to generate comparative data for the last budget cycle of the Medium-term strategic plan; she recognized that Member States on balance accepted that limitation in view of the advantages of a transitional budget and the accountability offered by the new budgeting process. She asked Member States for guidance.

Dr PÁVA (Hungary) clarified that the European Union was prepared to accept the Proposed programme budget as a transitional budget.

Mr PELLET (France) specified that he had spoken on behalf of his country and not the other Member States of the European Union, whose statement he supported. He was prepared to accept the

Proposed programme budget as had been presented to the Committee, on the understanding that it was transitional. The priority should not be the superficial look of the budget but the future funding reform, as he had noted earlier. He had provided the Secretariat with recommendations on how to move forward, but was not requesting that the budget be reformulated.

The DIRECTOR-GENERAL thanked Member States for their clarifications and expressed the hope the Committee would therefore approve the draft resolution as it stood.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in document A64/7 Add.2.

The draft resolution was approved.[1]

The future of financing for WHO: Item 11 of the Agenda (Documents A64/4, A64/4 Add.1 and A64/INF.DOC./5) (continued from the fourth meeting, section 1)

Ms ESCOREL DE MORAES (Brazil) reiterated her grave concern about the content of document A64/INF.DOC./5, which outlined a plan for implementing future financing reforms. She was particularly concerned at the reference to "a mechanism to pool funds from the private sector". She sought clarification as to whether, when approving the draft resolution during the previous meeting, the plan contained in the information document had also been approved by the Committee, as she disagreed with its content and was unable to endorse it.

The DIRECTOR-GENERAL said that she had taken note of the comments made by the delegate of Brazil, and specified that the Committee had only approved the draft resolution. The suggestions contained in document A64/INF.DOC./5 were for information only and would form the basis of any future implementation plan only after further consultations.

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

Health system strengthening: Item 13.4 of the Agenda (Documents A64/12, A64/13, and EB128/2011/REC/1, resolutions EB128.R8, EB128.R9, EB128.R10, EB128.R11 and EB128.R12) (continued from the first meeting, section 3)

Ms BARRY (International Council of Nurses), speaking at the invitation of the CHAIRMAN, welcomed the close alignment between Member States' priorities and the WHO document *Strategic directions for strengthening nursing and midwifery services - 2011–2015.*[2] The global financial situation presented a major challenge to health system strengthening; and the shortage of human resources for health made optimal progress unlikely. Making good that shortage was most important, and WHO should lead the way by filling the vacant nursing and midwifery posts at all levels as well as

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA64.3.

[2] Document WHO/HRH/HPN/10.1.

that of Chief Scientist. Such posts made for effective and efficient solutions that would build on proven results and facilitate partnerships with nurses and midwives.

The International Council of Nurses closely monitored the global nursing situation and sought policies and practical solutions that reduced costs and improved quality. Member States must work together through technical cooperation to provide capacities by establishing and achieving country-focused priority targets. In the past, nurses had proved their ability to meet the needs of the public, as well as expand their scope of practice and assist in health system design. However, WHO needed to make wise investments to address the workforce crisis by encouraging flexible working practices and positive work environments. Inadequate educational investment and outdated regulatory mechanisms were restricting nurses' contributions and preventing an increase in access to primary and other health-care services. Investment needed to be increased at all levels, and stakeholders must work together to achieve the health-related Millennium Development Goals, renew primary health-care systems and implement sustainable health delivery networks.

Ms BREARLEY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, reiterated the call she had made during the 128th session of the Executive Board for increased commitment to equitable health financing. She urged Member States to ensure that the draft resolution contained in resolution EB128.R8 fully reflected the evidence-based recommendations contained in *The world health report 2010* on how health financing could help countries to move towards universal coverage of quality and essential health care. That would require large risk and resource pools, as well as the removal of regressive direct payments for health care. The word "significant" should therefore be deleted from subparagraph 1(1) of the draft resolution.

Governments and development partners that provided Member States with technical and financial support on health financing, backed by WHO, should increase their commitment to implementing the findings of the report and ensuring that support was harmonized and evidence-based.

She welcomed the two draft resolutions on human resources for health contained in resolutions EB128.R9 on health workforce strengthening and EB128.R11 on strengthening nursing and midwifery. Member States should develop or strengthen their health workforce plans to include retention strategies in rural and remote areas and address inequitable workforce distribution. All health workers were entitled to a living wage paid promptly and reliably, which required sufficient resources. She called on the Secretariat and Member States to influence IMF to ensure that countries with critical shortages had the flexibility required to allocate an adequate budget share to health.

In order to build on momentum created by the launch of the United Nations Secretary-General's Global Strategy on Women's and Children's Health in September 2010, she called on Member States to further commit themselves to the need for new, substantial and specific actions to expand, equitably distribute and better support their health workforces.

Ms BRIDGES (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, welcomed WHO's recognition of the valuable contribution of midwives and nurses to the provision of health services, as they constituted the majority of the health workforce in many countries. However, in some Member States, midwives and nurses were not included in the development and planning of recruitment and incentive programmes and, as a result, recruitment and retention strategies for midwives and nurses were omitted. When midwives and nurses were included, they ensured the development of context-specific recruitment and retention appropriate to their contribution to health-care provision. That included measures such as remuneration, conditions of employment and improvement of work environments. Such measures would go a long way to curbing migration rates, which harmed health-care provision.

Professional associations such as hers were well placed to interact with governments and policy-makers. It had recently produced documents on midwifery education, regulation framework and

competencies, which were available to governments when planning human resource programmes and developing workforce improvement strategies. Midwives' associations were a powerful conduit for the flow of information and expertise between governments and the profession. She therefore urged Member States to include midwives and nurses in policy-making at government level to develop and plan appropriate human resource programmes.

Ms STAFFELL (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that health systems across the world were under pressure and would not be able to cope if they continued to focus on the disease and not the patient. A sustainable approach to health system design and delivery needed to be based on patient-centred health care, which encompassed respect for the unique needs, preferences and values of individuals as well as their autonomy and independence; choice and empowerment; patient involvement in health policy; and access and support to receive safe, quality and appropriate health-care services and information. Those principles should be at the core of WHO's activities.

It was essential that robust national or district health policies and strategies be based on broad and continuous consultation and engagement of all relevant stakeholders, including patients; Member States should establish frameworks to involve patients in all policy development. WHO had a key role to play in both exemplifying patient involvement in its own practice and helping governments to establish models of patient involvement. The Alliance would continue to work with WHO and Member States in that regard.

Ms VICTOR (World Vision International), speaking at the invitation of the CHAIRMAN, supported the primary health-care principles of equity and participation through a multisectoral approach, in particular in planning and budgeting, as well as the strengthening of national health systems, policies, strategies and plans to ensure that evidence-based approaches were used. WHO should speak out at national level to encourage more nurses, midwives and communities to be involved in health system and policy dialogue, planning and evaluation, to improve workforce retention and performance. In that respect, she supported the draft resolution contained in resolution EB128.R11. Engaging in health policy dialogue required an understanding of political influence. More national positions should, therefore, combine technical capacity with experience in navigating the political environment.

In the draft resolution on sustainable health financing structures and universal coverage, as contained in resolution EB128.R8, she requested that the word "significant" be removed from the first line of subparagraph 1(1), as it would be hard to measure and any direct payment would be a barrier to access. Tools should be developed to assist countries moving away from user fees towards pro-poor measures, supporting the implementation of evidence-based approaches.

With regard to human resources, more investment was required to improve training and retention strategies in countries with the highest numbers of maternal and child deaths. Coercive mechanisms should be replaced by better incentives such as housing and educational opportunities for those agreeing to work in rural areas.

She supported WHO's role in developing enhanced systems for regulating and coordinating international health efforts in developing countries, which would give resources a greater effect on health outcomes, but requested that any involvement in such activities be more transparent.

WHO should continue to provide technical leadership in global health governance in line with discussions being held on the future of financing of WHO. Her organization would continue to work with Member States, the Secretariat and partners towards the strengthening of health systems in an effort to achieve the health-related Millennium Development Goals.

Dr CHIKERE KADURU (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, said that the report on health system strengthening showed a

move towards people-centred primary care, as well as towards the protection and promotion of health in communities. Such an approach should be rooted in the education of health workers. There was a need globally to scale up and transform health workers' education, with sharper focus on primary health care. Innovative curricula with emphasis on the social determinants of health should be developed to promote social accountability and multidisciplinary teamwork. National health plans should include approaches to strengthen relevant educational institutions.

Increased funding, an adequate educational infrastructure, and the scale-up of education would ensure an adequate number of graduates in relation to a country's population size and burden of disease. It was also important to link educational institutions with health systems where graduates would be practising. Engaging students in the community and in rural outreach services during their education would give them a further understanding of the reality of health-care delivery and the population's health needs. He urged Member States to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel, in order to ensure a sustainable health workforce appropriate to national health needs. It was important to reduce countries' dependence on active recruitment and ensure the better distribution of the health workforce through planning, education, training and retention strategies. The Federation would continue to offer a student perspective at the global and national levels to ensure that policies and systems were developed in consultation with health-care students.

Professor BERO (The Cochrane Collaboration), speaking at the invitation of the CHAIRMAN, supported the draft resolutions on health system strengthening contained in resolutions EB128.R8, EB128.R9, EB128.R11 and EB128.R12. She welcomed the fact that the Health Assembly urged Member States to use and implement evidence-based findings related to health worker education and training, as outlined in EB128.R9. Such evidence was available, and should be evaluated and used to inform all resolutions and policies related to health system strengthening. Research summaries and policy briefs derived from systematic reviews were also available to inform decisions.

Dr Chung-Liang SHIH (Chinese Taipei) said that, since the universal single health insurance system had been established in in 1995, coverage in Chinese Taipei was more than 99% and was funded by 6.9% of the gross domestic product. The health-care system had been successfully integrated into the social security system so as to establish a comprehensive and people-centred delivery network. In response to an ageing population, decreasing birth rate, and significant immigrant population, the Department of Health had become the Ministry of Health and Welfare. It would provide a well-rounded social security system, including geriatric medical care, long-term care facilities, rehabilitation for physical or mental health disability, protection of children and women's rights and social insurance, in order to enhance community welfare while developing an efficient and effective public health system.

Increasing suicide rates were becoming a global issue. In 2005, Chinese Taipei had made suicide prevention a major health policy area, setting up a Centre for Suicide Prevention which provided a 24-hour toll-free counselling service, home visits and a suicide notification network. Locally, community centres provided education on mental health issues and substance abuse. Suicide had been reduced by 12% over the previous five years, and was no longer among the top 10 causes of death. Suicide prevention was still a priority, despite the country's being affected by recent financial difficulties and natural disasters.

Dr ETIENNE (Assistant Director-General) noted the unanimous view that health systems were important in achieving health outcomes, and the need for integrated, comprehensive, well-functioning health systems that were able to respond to existing challenges but that also possessed the resilience and flexibility to respond to emerging challenges, including emergencies and disasters. She had also noted the emphasis on an overall country-specific approach that included all stakeholders. The

Secretariat was committed to expanding efforts to promote national health policy dialogue and to support the definition of national health strategies, policies and plans. Such national instruments were the best ways to deal with country-specific issues, reach balance and coherence between specific life-cycle programmes and other health system elements, and form the basis for donor alignment and harmonization.

Health systems must, indeed, be strengthened through the primary health-care approach, encompassing the principles of equity, solidarity and social justice for human rights. The Secretariat was actively pursuing that approach which embodied universal coverage, people-centred primary care, health in all policies, and inclusive governance, as exemplified in its strategy on HIV/AIDS and the report on noncommunicable diseases.

The world health report 2010 on the financing of universal coverage had been broadly accepted, but had led to an increase in demand by Member States requiring support for reform. Limited capacity meant that the Secretariat was engaging directly with partners to meet that demand.

The health workforce crisis was a long-standing problem in many countries and the Secretariat was working on transformative education, retention policies, monitoring and evaluation especially in countries in crisis, and the plan of action for the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel. Nursing and midwifery constituted an important component of the health system, and as such deserved the emphasis being given by the Secretariat.

Given the financial crisis, the Secretariat was exploring new ways of working to maintain the momentum on health system strengthening, and it would work with all partners to support Member States in that endeavour. The leadership of Member States would be crucial in building national health systems able to address the full range of challenges.

The CHAIRMAN invited comments on the draft resolution contained in resolution EB128.R8.

Dr JADEJ THAMMATACHAREE (Thailand) said that the draft resolution was a landmark in the support for countries to move towards universal health care, and thereby attain the Millennium Development Goals. In January 2012, Thailand would host a global conference on universal health care, facilitating discussion on how to move from commitment to implementation, in which he invited policy-makers from all Member States to participate. The move to universal health care needed to be an intersectoral initiative and in Thailand involved various ministries and stakeholders, including the ministries of finance, and labour and development, as well as trade unions and the private sector. The universality of health care should be a global priority and, as such, discussed by the United Nations General Assembly.

He proposed four amendments to the draft resolution. A new subparagraph 1(1) should be inserted to read: “to consider proposing an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly;”. New text should be inserted at the end of subparagraph 1(11): “, including tracking the flows of health expenditures through the application of standard accounting frameworks;”; a new subparagraph 2(1) should read: “to communicate with the United Nations Secretary-General in order to insert an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly;”; and at the end of subparagraph 2(5) the phrase should be added: “, including strengthening capacity in tracking resource flows through the application of standard accounting frameworks;”.

Dr PÁVA (Hungary), speaking on behalf of the European Union, said that she needed more time to consider the amendments proposed. She asked for clarification from the Legal Counsel on the feasibility of requesting that an item be submitted for inclusion on the provisional agenda of the United Nations General Assembly. Further clarification was also required on the extra workload that might result from the amendment to subparagraph 2(5), with regard to the obligations of national health governance.

Ms WAKEFIELD (United States of America) requested that the words "comply with" in the second line of subparagraph 1(4) be deleted and replaced with "implement". She furthermore asked to see all the amendments proposed by the delegate of Thailand in writing.

Ms McKEOUGH (Office of the Legal Counsel), speaking at the request of the CHAIRMAN, said that her Office also wished to see the amendments proposed by the delegate of Thailand in writing before commenting on the inclusion of an item on the provisional agenda of the United Nations General Assembly.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R8, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R9.

It was so agreed.

Ms WAKEFIELD (United States of America) requested that the word "synergies" in the fourth line of subparagraph 2(1) be deleted and replaced with "coherence and coordination".

Dr JARUAYPORN SRISASALUX (Thailand) proposed the addition of a new fourth preambular paragraph bis, reading: "Recognizing the transformative scaling-up of faculty members in health professional training institutions, both quantity, quality and attitude are prerequisites for sustainable, transformative scaling-up of health professionals;". Furthermore, a new subparagraph 1(5)bis should be added, reading: "to expand, strengthen and reorient the faculty members of health professional training institutions in terms of quantity, quality, skill-mix and attitudes relevant to the implementation of the transformative scaling-up of health professionals;".

Dr PÁVA (Hungary) asked for more time to consider the proposed amendments and requested that they be distributed in writing.

Ms BENNETT (Canada) supported the amendment proposed by the delegate of the United States of America and seconded the request to see the changes proposed by the delegate of Thailand in writing. She asked for clarification of terms such as "attitudes" with respect to the workforce.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R9, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R10.

It was so agreed.

Ms WAKEFIELD (United States of America) suggested that the third preambular paragraph of the draft resolution be amended to read: "Reaffirming that countries should ensure the protection of the health, safety and welfare of their people and should ensure the resilience and self-reliance of the health system…".

Dr ORAPAN THOSINGHA (Thailand) said that the draft resolution would provide Member States with guidelines for the effective emergency preparedness and response to reduce the death tolls, disabilities and suffering caused by increasing incidences of human-made and natural disasters. To reinforce the message regarding the need for greater political and financial commitment, however, she suggested that the words "and effective law enforcement in the management of health hazardous

agents" be inserted after "and other measures" in the fourth line of subparagraph 1(1); and that the word "protect" at the end of that line be deleted and replaced with "increase".

In order to reflect the increasing importance of chemical emergency management, a new subparagraph 1(2)bis should be added, reading: "To establish transparent inventories and transportation of hazardous chemicals and share among concerned government and other related agencies responsible for emergency and disaster management in order to support specific emergency preparedness and appropriate responses to different chemical agents;".

Subparagraph 1(4) should be amended to read: "to establish, promote and foster regional and subregional collaboration, not limited to the WHO regional structure, including the sharing of experience and expertise…"; and subparagraph 1(5) should be amended to read: "to strengthen the role of the local health workforce in the health emergency management system including preparedness, responses and recoveries to provide local leadership and health services, through enhanced planning, training for all health care workers, and access to other resources;". Furthermore, in view of the Director-General's duty to support regional and subregional networks, including those outside the WHO regional structure, a new subparagraph 2(5)bis should be added, reading: "To support regional and subregional networks in their collaboration on emergency and disaster management, including those outside the WHO regional structure;". The fourth line of paragraph 3 should be amended to read: "…for the World Health Organization's role in health emergency and disaster management matters.". As it was customary in Health Assembly resolutions to present requests to the Director-General in the final operative paragraph, the order of paragraphs 2 and 3 should be reversed and the numbering amended accordingly.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R10, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R11.

It was so agreed.

Ms WAKEFIELD (United States of America) requested that the word "must" on the fifth line of subparagraph 1(4) be deleted and replaced with "should". Meanwhile, the word "renumeration" on the third line of subparagraph 1(8) should read "remuneration".

Dr SUCHITTRA LUANGAMORNLERT (Thailand) said that the text represented another milestone in the Secretariat's continuing efforts to strengthen frontline nursing and midwifery services, which formed the backbone of health systems. Outlining the progress made by professional bodies in Thailand in terms of monitoring and improving the education, working conditions and health of nurses and midwives, she welcomed the release of the Strategic Directions for Strengthening Nursing and Midwifery Services for 2011–2015, which would be translated into the country's 10-year national nursing and midwifery development plan (2007–2016).

She proposed several amendments. In paragraph 1, the words "demonstrate their commitment to strengthening nursing and midwifery by" in the introductory sentence should be deleted; the words "and systems for sustaining the competencies" should be inserted before "consideration must be given" at the end of the fourth line of subparagraph 1(4); the end of that subparagraph should be amended to read: "midwifery researchers, educators and administrators;"; the words "career development and advancement" should be added to the third line of subparagraph 1(8), after "conditions of employment"; the word "introducing" at the beginning of subparagraph 1(9) should be deleted and replaced with "establishing national mechanism in order to develop infrastructure that supports"; and the end of subparagraph 1(10) should be amended to read: "…loss of trained nursing staff; as well as implementing effective rural retention policies and interventions;". The end of subparagraph 2(1) should be amended to read: "…and regional posts, including chief nurse scientist at

WHO headquarters;"; and a new subparagraph 2(5)bis should be inserted, reading: "to strengthen nurse and midwife datasets as an integral part of the national health workforce information systems, and maximize use of this information for evidence-based policy decisions;".

Ms CHASOKELA (Zimbabwe) suggested that, in order to align the text on different educational models, the words "entry-level" in the third line of subparagraph 1(4) should be deleted and, further to the amendments proposed by the delegate of Thailand, that the words "and systems of maintaining ongoing competencies" should be added to the fourth line after "nurses and midwives". Secondly, to strengthen the reporting cycle and ensure continuity, the words "and thereafter every three years" should be inserted after "World Health Assembly" in subparagraph 2(6).

Mr RAKUOM (Kenya) observed that the draft resolution aimed at strengthening services at the primary, secondary and tertiary levels of health care, including prevention, promotion, curative care and rehabilitation. To that end, it urged Member States and requested the Director-General to invest in the education, production, recruitment and retention of more nurses and midwives, who formed the bulk of the health workforce at the country level and who were key to progress in efforts to achieve the Millennium Development Goals. Kenya, which had participated in the development of transformative education for nurses and midwives, was concerned that their numbers within WHO were dwindling; that inadequate resources were made available to convene regular meetings of nursing and midwifery leaders in Africa; and that governance of the professions needed strengthening nationally, regionally and globally. The resolution would facilitate national, regional and global strategic planning and implementation of efforts to tackle the problems, and he supported the amendments proposed by the delegates of Thailand and Zimbabwe.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution contained in resolution EB128.R11, and that the Committee should turn its attention to the draft resolution contained in resolution EB128.R12.

It was so agreed.

Miss NANOOT MATHURAPOTE (Thailand) said that, in the light of the need for capacity-building to enable countries to develop national health policies, strategies and plans tailored to their respective socioeconomic, political and cultural circumstances, she supported the draft resolution but had some amendments to propose in order to strengthen the text.

The second line of the fifth preambular paragraph should be amended to read: "…within and beyond government, including civil society organizations, the private sector, health professionals and academia, …". Second, the words "evidence-based" should be added to subparagraph 1(5) before "evolving challenges", and a new subparagraph 1(6)bis should be inserted, reading: "to empower civil society and communities, the private sector, health professionals and academia to actively and efficiently participate in the policy dialogue and the evaluation and monitoring process, as well as to be actively involved in reviewing the performance of the national policies, strategies and plans;". Furthermore, given the importance of emphasizing each country's autonomy and specificity in the implementation of national plans, as well as the need to recognize the role of development agencies and donor countries, the words "and specificity," should be inserted after "country ownership" in the third line of paragraph 2.

Emphasis should be placed on inclusiveness in the policy dialogue at the Health Assembly, which at present permitted the equal participation only of governments and not other partners. Some countries had included representatives of local civil society organizations, academia, professional bodies and even the private sector in their delegations. Others should be encouraged to follow suit as a sign of their inclusiveness. It was to be hoped that WHO reform would lead to a reform of the

governing bodies that would enable all partners to participate on an equal footing in meetings of the Health Assembly and the Executive Board.

The CHAIRMAN suggested that the Secretariat should prepare and circulate a paper containing all the proposed amendments to the draft resolution, and that the Committee's consideration of the agenda item should be suspended and resumed later in the week.

It was so agreed.

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

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: Item 13.1 of the Agenda (Documents A64/8, A64/8 Corr.1 and A64/8 Add.1)

The CHAIRMAN invited the Committee to consider the draft resolution contained in document A64/8, attachment 3.

Ms HALTON (Australia) recalled that the Sixtieth World Health Assembly in 2007 had considered the serious concerns about the largely informal system of sharing influenza viruses, on which health security greatly depended in the event of a pandemic. Many Member States had expressed doubts about the system's fairness, especially with regard to sharing benefits, and had called for it to be formalized. The Health Assembly had decided to begin intergovernmental negotiations to establish a framework providing for governance, transparency and the equitable sharing of viruses and benefits. Those negotiations had been intense and had lasted for four years. The Open-Ended Working Group of Member States on Pandemic Influenza Preparedness had recently submitted its report. It was particularly satisfying that all the issues causing such concern in 2007 had been fully debated, and she thanked Mexico and Norway, the Co-Chairs of the Group, for having brought the negotiations to an historic conclusion. The most recent discussions, in April 2011, had resulted in the excellent Pandemic Influenza Preparedness Framework, and Australia had accepted a mandate to carry out further informal work on the unresolved issue concerning the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization. In its report, the Working Group had strongly recommended that the Health Assembly should consider the options presented in square brackets in the draft resolution. It would be extremely difficult to reach a consensus on either of the options or on any other wording, yet it would be a major failure if the Health Assembly postponed adoption of the Framework until 2012. She therefore proposed deleting the whole of the fifth preambular paragraph of the draft resolution. Reaffirming the need for governance, transparency and fairness in a system that provided all countries with the necessary protection from an influenza pandemic, she urged the Health Assembly to adopt the draft resolution as amended.

Mr BARBOSA (Brazil) welcomed the historic agreement reached on the Pandemic Influenza Preparedness Framework, and the accompanying Standard Material Transfer Agreements as a result of the negotations called for by Member States in 2007. The negotiating process had highlighted the critical importance of WHO's intergovernmental mechanisms. Although Member-driven, the process had brought in other parties, including civil society and industry, proving that greater participation in decision-making resulted in agreement on a more institutional, predictable, inclusive and democratic mechanism.

Crucial agreements had moved the process in the right direction. Thanks to the adoption of the two Standard Material Transfer Agreements, one on the relationship within the network and the other on that among vaccine manufacturers, a legal regime had been established for WHO, influenza laboratories and interested manufacturers. The mechanism encouraged contributions by the pharmaceutical industry and other bodies, whose access through the WHO network to viruses of pandemic potential enabled them to produce vaccines. Preparedness for an influenza pandemic was essential and would depend on long-term commitments and substantial financial contributions by all concerned, in particular those able to contribute more. Each recipient country should be treated differently, with income levels being taken into account.

The Health Assembly would have to ensure that the Framework and the accompanying Standard Material Transfer Agreements were implemented in a way that met countries' expectations for improving the system. That included the provision of a reasonable level of benefits for developing countries. Similarly, intellectual property rights would play a central role in the new system. Although those with the technology should profit from their investments, in times of a pandemic they should share that technology through solidarity. It was crucial to provide developing countries with access to the processes and technologies to produce vaccines and other products by granting non-exclusive licences with no or affordable royalties.

Thanks to the Framework, the system would become more predictable, provided that all players met their obligations. Throughout the process everyone had shown flexibility but in the future, predictable – albeit not legally binding – rules would create moral and ethical obligations. It was for governments, the industry and the Secretariat jointly to monitor the fair, efficient and transparent implementation of the Framework while meeting their respective obligations. In particular, the industry's contribution was long overdue. An intergovernmental mechanism should be established to oversee the functioning of the Framework. The Advisory Group would play a central role in ensuring that it was properly implemented and that the agreed rules were observed. The Framework would ultimately be judged by the number of lives saved in the event of a pandemic, by its ability to provide for a universal response and, moreover, by an increase in – and a geographical diversification of – the global capacity to produce vaccines to deal with pandemics. The in-built review clause was another important instrument, provided that it resulted in timely improvements to the Framework rather than in its undoing. Once adopted by the Health Assembly, it would serve to strengthen cooperation among Member States but it should be balanced, effective and transparent, helping those unable to respond unaided to the outbreak of an influenza pandemic.

Mr SOAKAI (Nauru) said that, in his country vaccination against pandemic influenza A (H1N1) 2009 virus had been conducted in two phases, with the aim of immunizing 90% of the population, which in 2010 had been estimated at 9550 people. Phase I had targeted WHO's recommended at-risk groups, and by March 2010, 10% of the population had been vaccinated. By the end of Phase II, in January 2011, 96% of the population had been vaccinated, a figure above the initial target. The exercise had been coordinated by a multisectoral pandemic taskforce, which had met every month and had led the response in surveillance and reporting, infection control, medicine stockpiling, clinical services, media awareness, health promotion and education, screening at the border and providing travellers with health education. WHO and Chinese Taipei had provided 9800 vaccine doses for the campaign.

Important lessons had been learnt, including the need to obtain enough political and community support for a campaign on such a scale to succeed. Furthermore, specific and targeted media and awareness-raising campaigns before and during the exercise had proved vital. It had been found necessary to have a communication network and a call-back or referral focal point to answer the public's queries. The multisectoral approach had given ownership to the stakeholders. According to hospital-based surveillance, no case of infection with pandemic (H1N1) 2009 virus had been indentified in Nauru since October 2010, apparently indicating that the vaccination exercise had been

successful. He thanked WHO and partners for their support. He endorsed the amendment to the draft resolution proposed by the delegate of Australia.

Dr SEDYANINGSIH (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, fully endorsed the proposal by the delegate of Australia to delete the fifth preambular paragraph of the draft resolution. The finalized Pandemic Influenza Preparedness Framework provided a coherent and unified international approach aimed at ensuring the availability of influenza viruses to WHO and the sharing of such benefits as equitable access to vaccines, antiviral agents, diagnostic kits and intellectual property licences, while strengthening national surveillance systems. Member States had been actively involved in the intense negotiations of the previous four years. Under the astute leadership of the Co-Chairs of the Open-Ended Working Group, and with the support of the Director-General, all stakeholders, including the pharmaceutical industry and civil society, had pulled together successfully in a collective effort to design a reliable and transparent pandemic influenza preparedness and response system. The contributions of the pharmaceutical industry in particular, together with the legally binding provisions of the Standard Material Transfer Agreements, would be the key to the system's credibility and success. All parties should focus on its immediate implementation, with its functioning coordinated by the oversight mechanism described in paragraph 7.1.2 of document A64/8. With the new Framework in place and drawing on the lessons learnt from the recent outbreaks of influenza A (H1N1 and H5N1), the world would be better prepared to respond to a future pandemic. Her Region was committed to making it a success for the good of global public health security.

Dr MHLANGA (Zimbabwe), speaking on behalf of the Member States of the African Region, paid tribute to the Co-Chairs of the Open-Ended Working Group for their tireless efforts in steering the arduous negotiations on the Pandemic Influenza Preparedness Framework to a successful conclusion, giving the international community the means for a stronger response to a future pandemic by ensuring that the roles and responsibilities of the key players were more clearly defined. It was a significant victory for public health and a milestone in the work of WHO. The outbreak and rapid spread of pandemic (H1N1) 2009 virus between June 2009 and August 2010 had made clear the challenges facing the developing countries in the African Region because they had lacked affordable access to – and the capacity to manufacture – vaccines, as well as adequate risk assessment and surveillance systems. Since the pandemic (H1N1) 2009 virus would continue to circulate for the foreseeable future, a better-organized response was crucial. Hence the importance of implementing the Framework and institutionalizing a legal regime in order to promote a coherent global approach for making viruses available to WHO and ensuring equitable access to essential vaccines, antiviral agents, diagnostic kits and scientific information, in particular for low-income countries. He therefore requested the Director-General to work with Member States and other stakeholders such as the pharmaceutical industry, whose support for the preparedness effort at the national level had been invaluable, to ensure the swift implementation of the Framework and the development of a pan-African laboratory capacity-building programme, for example. To that end, he supported the proposal to delete the fifth preambular paragraph of the draft resolution.

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, Bosnia and Herzegovina, Serbia, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. Welcoming the outcome of the last meeting of the Open-Ended Working Group, she commended the Co-Chairs, and all parties involved, on the commitment, flexibility and support that had made it possible, after four years of hard and challenging negotiations, to reach an agreement that clarified roles and responsibilities within the WHO system, and which had established a groundbreaking partnership with the pharmaceutical industry. It had done much to ensure

that the world was better prepared for a future pandemic. The European Union endorsed the proposal to delete the preambular paragraph of the draft resolution containing language that had failed to secure a consensus. All Member States must accept the Pandemic Influenza Preparedness Framework as the instrument for governing access and benefit-sharing with respect to biological materials, and must agree to implement it accordingly. It would be a major step forward in ensuring that virus samples were made available to WHO with a view to safeguarding health security for all.

Mr JAZAÏRY (Algeria) joined previous speakers in commending the Co-Chairs and members of the Open-Ended Working Group on the quality and results of their work; in outlining the advantages of the coherent and unified approach provided by the much-needed Pandemic Influenza Preparedness Framework; and in calling on the Director-General and Secretariat to continue working closely with Member States, stakeholders and especially the pharmaceutical industry, on the implementation of the WHO global pandemic influenza action plan.

It was crucial to understand the exact nature of a virus in order to monitor the spread of disease, to establish its potential to develop into a pandemic, and to produce the necessary vaccines. Yet developing and especially least developed countries often lacked adequate access to – and the capacity to manufacture – vaccines and antiviral agents, and global supplies could be diminished by a sudden increase in demand that led to soaring and unaffordable prices. In order to prevent intellectual property rights from undermining efforts to tackle that problem, the holders should grant a non-exclusive licence to WHO, which could, in turn, grant a sublicence to those rights to interested developing countries. Member States should help to establish a multilateral system for equitable benefit-sharing, and ensure the transfer of technologies, skills and expertise required for capacity-building in terms of laboratories, surveillance and risk assessment systems, and the production of diagnostic kits and medicines. Lessons must be learnt from past experience in dealing with the pandemic (H1N1) 2009, which had exposed the inadequacy of funding provided by Member States, international organizations, development banks, the private sector and others; and WHO had come up with a number of commendable options for reliable and sustainable funding mechanisms to underpin the benefit-sharing system. He welcomed the report and draft resolution.

Mr BROU (Côte d'Ivoire) applauded the finalization of the Pandemic Influenza Preparedness Framework and called on WHO to take the necessary steps to ensure its effective implementation so as to give African populations better access to vaccines. Particular attention should go to virus traceability.

Ms RENDÓN CARDENÁS (Mexico) said that the successful conclusion to the negotiations on the Pandemic Influenza Preparedness Framework had shown what could be achieved with diplomacy, responsibility and the political will for the benefit of humankind. The international community had become better equipped to meet the health challenges of influenza pandemics in a coherent and coordinated manner. The Framework provided a flexible system for sharing not only the viruses and biological materials required for the swift and safe production of vaccines, but also the resulting benefits. It had set a precedent for future WHO negotiations. Given the importance of adopting the draft resolution contained in document A64/8 at the present session, Mexico endorsed the amendment proposed by Australia and reaffirmed its commitment to building a safer world for one and all.

The meeting rose at 17:30.

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