EIGHTH MEETING

Friday, 20 May 2011, at 09:40

Chairman: Dr W. AMMAR (Lebanon)

1. THIRD REPORT OF COMMITTEE A (Document A64/57 (Draft))

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

The report was adopted.

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

Global immunization vision and strategy: Item 13.5 of the Agenda (Document A64/14) (continued from the seventh meeting)

Dr SJÖLIN-FORSBERG (Council for International Organizations of Medical Sciences), speaking at the invitation of the CHAIRMAN, said that the challenge of agreeing on critical aspects of essential tools for safety supervision had led to the establishment of the CIOMS/WHO Working Group on Vaccine Pharmacovigilance. The Working Group had agreed on several possible ways to strengthen the application of pharmacovigilance standards and terminology. Its future work could include harmonizing instruments in the toolkit for vaccine risk management, strengthening pre-licensure safety monitoring in clinical trials and globally harmonizing the assessment of benefits, risks and communication of safety and efficacy studies. The continuation of its work on the harmonization of tools would save time and money, stimulate global capacity-building and be in line with the conclusions of the Secretariat's report.

Mr BERMAN (MSF International), speaking at the invitation of the CHAIRMAN, stressed the need to concentrate concurrently on introducing new vaccines in developing countries and expanding coverage with basic vaccines. Outbreaks, such as those of measles in 28 African countries, were often the result of poor vaccination coverage and were likely to continue. Countries and global partners must therefore invest in outbreak response as well as prevention efforts. He urged the GAVI Alliance, whose work was commendable, to improve its performance in countries with limited health-care infrastructure and to increase its efforts to reduce vaccine prices by stimulating competition. Furthermore, vaccine-delivery strategies should be tailored to national conditions, with more focus on community mobilization in countries with low vaccine coverage, and priority given to the cold chain and the development of new technologies that eliminated the need for needles.

Mr WRIGHT (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, reminded Member States that the United Kingdom of Great Britain and Northern Ireland was to host the pledging conference for funding for the GAVI Alliance in June 2011, and urged donor countries to increase their donations. In addition, he stressed the vital role of civil society organizations in ensuring transparency and accountability with regard to access to vaccines. Three principles that should guide global approaches to immunization: equitable access for all, parallel work on building and strengthening health systems to ensure that qualified staff were available to administer vaccines, and the need to reduce the price of vaccines.

Mr DURISCH (Stichting Health Action International), speaking at the invitation of the CHAIRMAN and also on behalf of Health Action International, Knowledge Economy International, Third World Network, the Berne Declaration, People's Health Movement and the International Baby Food Action Network, expressed concerns about WHO's governance and management of conflict of interest issues. As a result of the complex relationship between commercial entities and WHO and other public health institutions, a clear approach and policies were needed to ensure that those with a conflict of interest were excluded from the policy or norm-setting decision-making process. The proposals for the governance of the Decade of Vaccines did not adequately address the management of conflict of interest and he urged Member States to ensure that any changes to the governance structure successfully dealt with conflict of interest and guarded against initiatives that would give the private sector a greater role in WHO's governance. He urged Member States to oppose the proposed governance of the Decade of Vaccines and the proposed reforms of WHO.

Dr AHUN (GAVI Alliance), speaking at the invitation of the CHAIRMAN, thanked those Member States that had voiced their support for the Alliance. Since the report by the Secretariat had been written, there had been continued significant progress in introducing new vaccines, such as the introduction of pneumococcal vaccines in the Democratic Republic of the Congo, Guyana, Kenya, Mali, Nicaragua, Sierra Leone and Yemen. The GAVI Alliance had committed itself to support the introduction of pneumococcal vaccine in 19 further countries by 2012, and, if sufficient support were received from donors, that number would increase to 40 countries. Welcoming the consistent support received from WHO, she reminded Member States of the pledging conference due to take place in the United Kingdom in June 2011 and expressed appreciation of the Director-General's stated intention to attend.

Dr OKWO-BELE (Immunization, Vaccines and Biologicals) thanked Member States for their comments and support. Their guidance in the preparation of the global vaccination action plan would be welcome. He applauded the success of Member States in implementing the Global immunization vision and strategy. The lessons learnt from the implementation would be used to ensure even greater coverage in future. Highlighting the success of the regional vaccination weeks that had been held in five out of six WHO regions, he looked forward to working with Member States on implementing Global Vaccination Week.

With regard to the high prices of new vaccines, additional government resources had been secured through dedicated budget line items, but in most cases that had not sufficed to reduce costs. That issue was also being addressed through various mechanisms, including full procurement, such as the PAHO Revolving Fund for Vaccine Procurement, and the establishment of advance market commitments and other forms of innovative financing. Discussion of other possible methods was also vital, with UNICEF playing a leading role, for example by providing support for work towards the GAVI Alliance's goal of shaping vaccine markets. He acknowledged the positive comments on the Secretariat's approach to technology transfer, and observed that several candidate vaccines from manufacturers in developing countries were in clinical trials. The Secretariat provided support for technology transfer initiatives at all stages, including the strengthening of national regulatory authorities to ensure the safety and efficacy of vaccines.

The aim of the global vaccination action plan was to expand the framework of the Global immunization vision and strategy, notably by extending the time frame from 2016 to 2020. A further aim was to foster engagement with additional stakeholders in order to reach the goal of equitable access to vaccines for all. A clear balance had to be struck between accelerated disease-control initiatives, introduction of new vaccines and routine vaccination, and that should form the basis for the development of the global vaccination action plan. With regard to measles, the Strategic Advisory Group of Experts on immunization had confirmed the view of the Ad-Hoc Expert Working Group on Measles that the disease could be eradicated. The target date for the eradication of measles should be

brought forward in view of the progress that had already been made towards the goal set by the Health Assembly in May 2010 for reduction of measles mortality. [1]

The Committee noted the report.

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, EB128.11 and EB128.R12) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R8, on sustainable health financing structures and universal coverage, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;[2]

PP2 Having considered *The world health report 2010*,[3] which received strong support from the Ministerial Conference on Health Systems Financing – Key to Universal Coverage (Berlin, November 2010);

PP3 Recalling resolution WHA58.33 on sustainable health financing, universal coverage and social health insurance;

PP4 Recalling Article 25.1 of the Universal Declaration of Human Rights, which states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control;

PP5 Recognizing that effective health systems delivering comprehensive health services, including preventive services, are of utmost importance for health, economic development and well-being and that these systems need to be based on equitable and sustainable financing as mentioned in the Tallinn Charter: Health Systems for Health and Wealth (2008);

PP6 Underlining the valuable contribution made by fair and sustainable financing structures towards achieving health-related Millennium Development Goal 4 (Reduce child mortality); Goal 5 (Improve maternal health); and Goal 6 (Combat HIV/AIDS, malaria and other diseases); as well as Goal 1 (Eradicate extreme poverty and hunger);

PP7 Having considered *The world health report 2008*[4] and resolution WHA62.12, that highlighted universal coverage as one of the four key pillars of primary health care and services through patient-centred care, inclusive leadership and health in all policies;

PP8 Noting that health-financing structures in many countries need to be further developed and supported in order to expand access to necessary health care and services for all while preventing and providing protection against disastrous financial risks;

PP9 Accepting that, irrespective of the source of financing for the health system selected, equitable prepayment and pooling at population level, and the avoidance, at the point of delivery, of

[1] See document A63/18 paragraph 29.

[2] Documents **A64/12 and A64/13.**

[3] *The world health report 2010. Health systems financing: the path to universal coverage*. Geneva, World Health Organization, 2010.

[4] *The world health report 2008. Primary health care: now more than ever.* Geneva, World Health Organization, 2008.

direct payments that result in financial catastrophe and impoverishment, are basic principles for achieving universal health coverage;

PP10 Considering that the choice of a health-financing system should be made within the particular context of each country, and that it is important to regulate and maintain the core functions of risk pooling, purchasing, and delivery of basic services;

PP11 Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, and a financing mix of contribution-based and tax-financed inputs;

PP12 Recognizing the important role of State legislative and executive bodies, with the support of civil society, in further reform of health-financing systems with a view to achieving universal coverage,

1. URGES Member States:[1]

(1) to consider proposing an agenda item on universal health coverage to be discussed by the forthcoming United Nations General Assembly; [Thailand]

(~~1~~**2**) to ensure that health-financing systems evolve so as to avoid significant direct payments at the point of delivery and include a method for prepayment of financial contributions for health care and services as well as a mechanism to pool risks among the population in order to avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking the care needed;

(~~2~~**3**) to aim for affordable universal coverage and access for all citizens on the basis of equity and solidarity, so as to provide an adequate scope of health care and services and level of costs covered, as well as comprehensive and affordable preventive services through strengthening of equitable and sustainable financial resource budgeting;

(~~3~~**4**) to continue, as appropriate, to invest in and strengthen the health-delivery systems, in particular primary health care and services, and adequate human resources for health and health information systems, in order to ensure that all citizens have equitable access to health care and services;

(~~4~~**5**) to ensure that external funds for specific health interventions do not distort the attention given to health priorities in the country, that they increasingly ~~comply with~~ **implement [USA]** the principles of aid effectiveness, and that they contribute in a predictable way to the sustainability of financing;

(~~5~~**6**) to plan the transition of their health systems to universal coverage, while continuing to safeguard the quality of services and to meet the needs of the population in order to reduce poverty and to attain internationally agreed development goals, including the Millennium Development Goals;

(~~6~~**7**) to recognize that, when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, macroeconomic, sociocultural and political context of each country;

(~~7~~**8**) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government-inclusive stewardship;

(~~8~~**9**) to promote the efficiency, transparency and accountability of health-financing governing systems;

(~~9~~**10**) to ensure that overall resource allocation strikes an appropriate balance between health promotion, disease prevention, rehabilitation and health-care provision;

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

(~~10~~**11**) to share experiences and important lessons learnt at the international level for encouraging country efforts, supporting decision-makers, and boosting reform processes;
(~~11~~**12**) to establish and strengthen institutional capacity in order to generate country-level evidence and effective, evidence-based policy decision-making on the design of universal health coverage systems**, including tracking the flows of health expenditures through the application of standard accounting frameworks**; **[Thailand]**

2. REQUESTS the Director-General:
(1) 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; [Thailand]
(~~1~~**2**) to provide a report on measures taken and progress made in the implementation of resolution WHA58.33, especially in regard to equitable and sustainable health financing and social protection of health in Member States;
(~~2~~**3**) to work closely with other United Nations organizations, international development partners, foundations, academia and civil society organizations, in fostering efforts towards achieving universal coverage;
(~~3~~**4**) to prepare a plan of action for WHO to support Member States in realizing universal coverage as envisaged by resolution WHA62.12 and *The world health report 2010*;[1]
(~~4~~**5**) to prepare an estimate of the number of people covered by a basic health insurance that provides access to basic health care and services, that estimate being broken down by country and WHO region;
(~~5~~**6**) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly equitable prepayment schemes, with a view to achieving universal coverage by providing comprehensive health care and services for all**, including strengthening capacity in tracking resource flows through the application of standard accounting frameworks**; **[Thailand]**
(~~6~~**7**) to facilitate within existing forums the continuous sharing of experiences and lessons learnt on social health protection and universal coverage;
(~~7~~**8**) to report to the Sixty-fifth World Health Assembly and thereafter every three years, through the Executive Board, on the implementation of this resolution, including on outstanding issues raised by Member States during the Sixty-fourth World Health Assembly.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.[2]

Ms WISEMAN (Canada) asked for clarification on the objectives and expected outcomes of the proposed discussion by the United Nations General Assembly on universal health coverage. WHO was the more appropriate venue for discussion of global health issues and challenges, including that of universal health coverage.

Dr JADEJ THAMMATACHAREE (Thailand) explained that, with regard to universal health coverage, increased awareness was needed of the issues and initiatives taken by different entities within the governments of the Member States and other parties, as the issue would affect departments

[1] *The world health report 2010. Health systems financing: the path to universal coverag*e. Geneva, World Health Organization, 2010.

[2] See document EB128/2011/REC/1, Annex 4.

such as the ministries of finance, labour and development, as well as trade unions and the private sector.

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed that the word "forthcoming" should be removed from subparagraph 1(1), as the current proposed agenda for the next meeting of the United Nations General Assembly was already full and adding universal health coverage to the debate risked detracting from the discussion on noncommunicable diseases.

With regard to subparagraph 2(1), it was premature to request the Director-General to act immediately; asking the Director-General to propose the inclusion of the agenda item would both weaken the request contained in subparagraph 1(1) and deprive Member States of their role in proposing agenda items for discussion at the General Assembly. She therefore proposed that subparagraph 2(1) be deleted.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) agreed with the proposed change to subparagraph 1(1). He suggested that in subparagraph 2(1) the word "insert" should be replaced by "propose" and the phrase "in the context of social protection" be inserted after "universal health coverage".

Mr HOHMAN (United States of America) said that he was not in a position to accept either subparagraph 1(1) or 2(1) as proposed by the delegate of Thailand; both subparagraphs should be deleted.

Ms BENNETT (Australia) supported the statement made by the delegate of Hungary.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) expressed concern at the proposal by the delegate of the United States of America and asked why deleting the two subparagraphs would be necessary.

The DIRECTOR-GENERAL thanked Member States for their views and suggested that subparagraph 1(1) should be retained, subject to amendment on the wording. With regard to subparagraph 2(1), she agreed that the authority of Member States should not be usurped by the Director-General; therefore, if the language in subparagraph 1(1) could be amended acceptably to incorporate some of the aspects of subparagraph 2(1), it would make the latter redundant, so allowing its deletion.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) argued that, if one subparagraph were to be deleted, it should be subparagraph 1(1) not subparagraph 2(1). He agreed that it was the prerogative of Member States to propose agenda items for the United Nations General Assembly, and therefore accepted that subparagraph 1(1) was too strongly worded. However, advocacy of universal health coverage at the global level would serve to increase awareness of the issue. Therefore, it would be more productive for the Health Assembly to request the Director-General to communicate to the United Nations Secretary-General the wish for a discussion of the subject at the General Assembly. Noncommunicable diseases were already on the agenda for discussion by that body, meaning that there would be no chance that universal health coverage might detract from discussion of that issue.

Mr HOHMAN (United States of America) affirmed the prerogative of Member States to propose items for discussion at the General Assembly, and welcomed Thailand's receptivity to the deletion of subparagraph 1(1). However, he voiced concern at the willingness of the Health Assembly to adopt such language at that point, as well as at the continued efforts to move the discussion of important health issues to the United Nations.

Ms WISEMAN (Canada), supporting the comments by the previous speaker, stressed that any message communicated by the Director-General to the United Nations Secretary-General would be for information purposes only, as items for discussion could be proposed only by Member States.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) disagreed with the view that health issues, particularly universal health coverage, should not be discussed at the United Nations General Assembly, as that crucial measure required input from numerous sectors and thus warranted discussion by the General Assembly.

The DIRECTOR-GENERAL, thanking the delegate from Thailand for his comments, said that, although there was agreement about the Member States' prerogative to propose items for discussion at both the Health Assembly and the United Nations General Assembly, it was unclear whether Member States collectively wished to request her to communicate a message to the United Nations Secretary-General. Even if she did so, that would not guarantee the inclusion of the issue on the provisional agenda of the General Assembly. She emphasized the importance of providing health care for all and acknowledged the challenges faced by Member States. Although debate of the issue at the General Assembly might not cause substantive changes, it would serve to bring the issue to the attention of important ministries and, most importantly, Heads of State.

Dr VIROJ TANGCHAROENSATHIEN (Thailand), seconded by Mr BUSS (Brazil), proposed that discussion of the draft resolution be temporarily suspended to permit informal discussions between the interested delegations.

It was so agreed.

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

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R9 on health workforce strengthening, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;[1]

PP2 Recalling resolution WHA57.19 on challenges posed by the international migration of health personnel, which, inter alia, urged Member States to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems, and to frame and implement policies that could enhance effective retention of health personnel;

PP3 Recalling also resolution WHA59.23 on rapid scaling up of health workforce production, which, inter alia, recognized that shortages of health workers are interfering with efforts to achieve the internationally agreed health-related development goals, including those contained in the Millennium Declaration, and those of WHO's priority programmes;

PP4 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel,[2] which, inter alia, recognized that an adequate and accessible health workforce is fundamental to an integrated and effective health system and for the provision of health services, and that Member States should take measures to meet their own health personnel needs, i.e. take measures

[1] Documents **A64/12 and A64/13**.

[2] Adopted in resolution WHA63.16.

to educate, retain and sustain a health workforce that is appropriate for the specific conditions of each country;

PP5 Acknowledging the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education, which is related to the increase in quantity, quality and relevance of the skill-mix of the health workforce in an equitable and efficient manner;

PP5bis Recognizing that, for the transformative scaling up of faculty members in health professional training institutions, quantity, quality and attitude are prerequisites for sustainable transformative scaling up of health professionals; [Thailand]

PP6 Recognizing that recruiters and employers are key stakeholders who may contribute to success in the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel;

PP7 Noting with approval recent international calls to action regarding the importance of ensuring scale-up and an equitable distribution of the health workforce globally, regionally and within countries;[1]

PP8 Recognizing the centrality of human resources for health for the effective operation of health systems as highlighted in *The world health report 2006,*[2] and that the health workforce shortages and inefficiencies are also seriously hampering effective implementation of primary health care, as stated in *The world health report 2008*,[3] and expansion of health service coverage, as described in *The world health report 2010*;[4]

PP9 Deeply concerned that shortages and inadequate distribution of appropriately trained and motivated health workers, and inefficiencies in the ways in which the health workforce is managed and utilized, remain major impediments to the effective functioning of health systems and constitute one of the main bottlenecks to achieving the health-related Millennium Development Goals;

PP10 Realizing that increased production and improved retention of health workers, in particular in rural areas, is reliant on various factors including a sufficient and sustainable health financing system, which is to some extent determined by decisions made outside the confines of the health sector, including in international organizations;

PP11 Observing that insufficient evidence of the effectiveness of health workforce policies and a lack of comprehensive, reliable and up-to-date data, including analytical tools, constitute significant challenges for Member States trying to achieve or maintain a sufficient, sustainable and effective health workforce;

PP12 Concerned that many Member States, particularly those with critical shortages or imbalances of health workers, also lack the governance, technical and managerial capacity to design and implement efficient and effective policy interventions related to scaling up and retaining the health workforce;

PP13 Realizing that a sufficient, efficient and sustainable health workforce is at the heart of robust health systems and a prerequisite for sustainable health improvement;

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[1] Including, but not limited to, the *Kampala Declaration and Agenda for Global Action of March 2008*, the G8 Communiqué of July 2008; *Closing the gap in a generation: health equity through action on the social determinants of health: Final Report of the Commission on Social Determinants of Health.* Geneva, World Health Organization, 2008; the High-level Taskforce on Innovative International Financing for Health Systems, 2009; and the *Venice concluding statement on maximizing positive synergies between health systems and global health initiatives,* 2009.

[2] *The world health report 2006 – working together for health*. Geneva, World Health Organization, 2006.

[3] *The world health report 2008. Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

[4] *The world health report 2010. Health systems financing: the path to universal coverage.* Geneva, World Health Organization, 2010.

PP14 Recognizing the division of health responsibilities between national and subnational levels of government that is unique to federated states,

1. URGES Member States:[1]

(1) to implement the voluntary WHO Global Code of Practice on the International Recruitment of Health Personnel in order that both source and destination countries may derive benefits from the international migration of health personnel and in order to mitigate the negative effects of health worker migration on health systems, particularly in countries with critical health worker shortages;

(2) to prioritize, in the context of global economic conditions, public sector spending on health, as appropriate, to ensure that sufficient financial resources are available for the implementation of policies and strategies to scale-up and retain the health workforce, particularly in developing countries, and to recognize it as an investment in the health of the population that contributes to social and economic development;

(3) to consider developing or maintaining a national health workforce plan as an integral part of a validated national health plan, in accordance with national and subnational responsibilities with increased efforts towards effective implementation and monitoring, as appropriate in the national context;

(4) to use and implement evidence-based findings and strategies, including those from the Global Health Workforce Alliance Taskforce on Scaling Up Education and Training, for the successful scaling-up of health worker education and training;

(5) to participate actively in the ongoing work on the WHO policy guidelines on transformative scale-up of health professional education in order to increase the workforce numbers and relevant skill-mix in response to country health needs and health systems context;

(5)bis 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; [Thailand]

(6) to develop strategies and policies to increase the availability of motivated and skilled health workers in remote and rural areas, with reference to WHO global policy recommendations on increasing access to health workers in remote and rural areas through improved retention of the health workforce;

(7) to implement the relevant recommendations for increased retention of health workers in rural areas, including: improved living conditions; safe and supportive working environment; outreach support; career development and advancement programmes; supporting professional networks; and social recognition of dedicated health personnel;

(8) to develop or strengthen in-country capacity for health workforce information systems in order to guide, accelerate and improve country action including the collection, processing and disseminating of information on their health workforce, covering, but not limited to, stock, education and training capacity, distribution, migration and expenditures;

(9) to work with other sectors to generate evidence and introduce effective policy interventions in order to address other factors that affect the availability of health workers in rural or remote areas, such as socioeconomic deprivation, geographical barriers and distance, transport and the acceptability of services;

2. URGES nongovernmental organizations, international organizations, international donor agencies, financial and development institutions and other relevant organizations working in developing countries:

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

(1) to align and harmonize, in line with the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, their education, training, recruitment and employment practices with those of the countries in which they are based, in particular national health plans, where available, in order to create ~~synergies~~ **coherence and coordination [USA]** and support Member States' efforts in building a sustainable health workforce, strengthening health systems and improving health outcomes;
(2) to support national long-term strategies and interventions to build and sustain a sufficient and efficient health workforce, including investment in the future health workforce;

3. REQUESTS the Director-General:
(1) to continue the implementation of the Global Code of Practice on the International Recruitment of Health Personnel, including, upon request, provision of technical support to Member States in implementing the Global Code;
(2) to provide leadership at global and regional levels by generating evidence and recommending effective interventions to address factors that hinder access to health workers; to work closely with partner agencies in the multilateral system on appropriate measures to support Member States' efforts to maintain or achieve a sufficient, sustainable and effective workforce; and to advocate for this topic to be placed high on global development and research agendas;
(3) to provide technical support to Member States, upon request, for their efforts to scale-up education and training and improve the retention of the health workforce; including identifying efficient and effective health workforce policies and developing and implementing national health workforce plans;
(4) to support Member States, upon request, in strengthening their capacity for coordination on health workforce issues between ministries of health, other ministries and other relevant stakeholders;
(5) to encourage and support Member States in developing and maintaining a framework for health workforce information systems, in order to accommodate the collection, processing and dissemination of information on their health workforce, including stock, migration, education and training capacity, skill mix, distribution, expenditures, positions and determinants of change;
(6) to encourage Member States to support the ongoing development of the WHO policy guidelines on transformative scale-up of health professional education in order to increase the quantity, quality and relevance of the health workforce, and towards addressing shortages in human resources for health in an equitable and efficient manner;
(7) to promote research relevant for both developing and developed countries on efficient and effective policies and interventions to improve scale-up and retention of the health workforce, with the aim of establishing and maintaining an accessible global evidence base for best practice, and efficient and effective health workforce policies and interventions, including supporting the strengthening of knowledge centres with the purpose of accommodating translation of evidence and best practice into context-specific policy solutions;
(8) to strengthen capacity within the Secretariat with the purpose of giving sufficient priority to relevant tasks related to the Organization's wider efforts in addressing the global health workforce crisis;
(9) to report on progress in implementing this resolution to the World Health Assembly through the Executive Board, in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.[1]

Dr PÁVA (Hungary), speaking on behalf of the European Union, disagreed with the introduction of the fifth preambular paragraph bis, as the potential implications of the amendment on the education and training of health workers in the scope of national education systems were unclear. In addition, she did not support the inclusion of the word "attitude" in that preambular paragraph and asked what was that meaning of "faculty members" in both the fifth preambular paragraph bis and in subparagraph 1(5)bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the term "faculty members" referred to teachers and professors; it could be replaced by "teachers" in both the fifth preambular paragraph bis and subparagraph 1(5)bis. The reason for including the word "attitude" in the relevant paragraphs was that, in order change education systems and scale up health professionals, it was necessary to change attitudes.

Mr PRAZ (Switzerland) shared the concern about inclusion of the word "attitude". He suggested that, as the language in subparagraph 1(5)bis was fairly strong, the phrase "according to needs" or "when appropriate" be inserted after "health professionals".

Mr HOHMAN (United States of America) observed that the amendments proposed by the delegate of Thailand were aimed at solving an important issue, as increasing the quality and quantity of medical school teachers was a vital tool for strengthening of the health workforce. He echoed the concerns expressed about the use of the word "attitude"; the problems with the two outstanding paragraphs were perhaps simply linguistic ones. It might be possible to amend the fifth preambular paragraph to incorporate the provisions of the fifth preambular paragraph bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) proposed that in both the fifth preambular paragraph bis and subparagraph 1(5)bis the words "and attitudes" be deleted.

Dr PÁVA (Hungary) and Mr PRAZ (Switzerland) accepted the amendments proposed by the delegate of Thailand.

Mr HOHMAN (United States of America) commented that the discussions were moving in the right direction. However, he had further concerns about the reference to reorienting teachers of health professionals in subparagraph 1(5)bis.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the term "reorient" referred to the reorientation of the curriculum and training activities in order to be explicit that, in future, it would be the prerogative of Member States to intervene and reorient the curriculum.

Mr HOHMAN (United States of America) pointed out that subparagraph 1(5)bis referred to reorienting teachers rather than the curriculum. The language should be either amended or deleted.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) said that the term "reorient" was vital and should be retained. He noted the United States' President's Emergency Plan for AIDS Relief was currently working with the Secretariat on the reorientation of the medical education system. He

[1] See document EB128/2011/REC/1, Annex 4.

proposed that the first line of subparagraph 1(5)bis be amended to read: "to expand, strengthen and reorient curricula, training methods and teachers...". He urged Member States and the Secretariat not to allow a linguistic issue to thwart the wish of a Member State to convey a strong intention for the work of WHO.

Dr DOLEA (Assistant Secretary) read out the proposed text of the first line of subparagraph 1(5)bis, which took account of the amendments proposed by the delegate of Thailand: "to reorient curricula and training methods, and to expand and strengthen teachers of health professional institutions..."

Ms BENNETT (Australia) expressed concern at the use of the word "expand" in conjunction with "teachers". She proposed that the first line of subparagraph 1(5)bis be amended to read: "to expand, strengthen and reorient, as appropriate, health professional training, in terms of...".

Dr ISSA MOUSSA (Niger) said that the proposed wording read out by the Secretary did not link well with subparagraph 1(5), which referred to health professional education-related human resources and the rationale behind subparagraph 1(5)bis was to strengthen that first paragraph. The word "involve" should be used in place of "reorient" in order to facilitate having a critical mass of human resources involved in health-related activities.

Dr DOLEA (Assistant Secretary) said that another possible formulation could read: "to reorient curricula and training methods and to scale up and strengthen teachers of health professional training institutions...".

Mr HOHMAN (United States of America) proposed an alternative formulation, which read: "to expand, strengthen and orient health professional training institutions, in terms of quantity, quality and skill-mix to the implementation of the transformative scaling up of health professionals".

Dr VIROJ TANGCHAROENSATHIEN (Thailand) accepted the proposal by the delegate from the United States of America, but requested that "relevant" be reinserted after "skill-mix".

Dr DOLEA (Assistant Secretary) read out the revised version of subparagraph 1(5)bis: "to expand, strengthen and orient health professional training institutions, in terms of quantity, quality and skill-mix relevant to the implementation of the transformative scaling up of health professionals".

Mr HOHMAN (United States of America) proposed that "to be" should be inserted before "relevant to".

The CHAIRMAN took it that the Committee agreed to all those proposed amendments and that it wished to approve the draft resolution as amended.

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

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R10 on strengthening national health emergency and disaster management capacities and

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.6.

resilience of health systems, which incorporated amendments during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Recalling resolutions WHA58.1 on health action in relation to crises and disasters, and WHA59.22 on emergency preparedness and response, resolution WHA61.19 on climate change and health, and other World Health Assembly and Regional Committee resolutions and action plans, inter alia, on health security and the International Health Regulations (2005), as well as on pandemic preparedness, safe hospitals and other matters related to emergencies and disasters at local, subnational and national levels;

PP2 Recalling United Nations' General Assembly resolution 60/195, which endorsed the Hyogo Declaration and the Hyogo Framework for Action 2005–2015: Building the Resilience of Nations and Communities to Disasters, as well as resolutions 61/198, 62/192, 63/216, 64/200 and 64/251, which, inter alia, called upon Member States to increase efforts to implement the Hyogo Framework, to strengthen risk-reduction and emergency preparedness measures at all levels, and to encourage the international community and relevant United Nations' entities to support national efforts aimed at strengthening capacity to prepare for and respond to disasters;

PP3 Reaffirming that countries **should ensure the protection of** ~~have responsibility for ensuring the protection of~~ **[USA]** the health, safety and welfare of their people and ~~for ensuring~~ **should ensure [USA]** the resilience and self-reliance of the health system, which is critical for minimizing health hazards and vulnerabilities and delivering effective response and recovery in emergencies and disasters;

PP4 Regretting the tragic and enormous loss of life, injuries, disease and disabilities resulting from emergencies, disasters and crises of all descriptions;

PP5 Mindful that emergencies and disasters also result in damage and destruction of hospitals and other health infrastructure, weakened ability of health systems to deliver health services; and setbacks for health development and the achievement of the Millennium Development Goals;

PP6 Expressing deep concern that continuing poverty, increasing urbanization and climate change are expected to increase the health risks and impacts of emergencies and disasters on many countries and communities;

PP7 Acknowledging that most actions to manage the risks to health from natural, biological, technological and societal hazards, including the immediate emergency response, are provided by local- and country-level actors across all health disciplines, including mass casualty management, mental health and noncommunicable diseases, communicable diseases, environmental health, maternal and newborn health, reproductive health, and nutrition and other cross-cutting health issues;

PP8 Recognizing the contribution of other sectors and disciplines to the health and well-being of people at risk from emergencies and disasters, including local government, planners, architects, engineers, emergency services and civil protection, and academia;

PP9 Concerned that country and community capacities to manage major emergencies and disasters are often overwhelmed, and that coordination, communications and logistics are often revealed as the weakest aspects of health emergency management;

PP10 Appreciating that some countries, including those with low-income or emerging country development status, have reduced mortality and morbidity in disaster situations through their investment in emergency and disaster risk-reduction measures, with the support of local, regional and global partners;

PP11 Recognizing that WHO plays an important role as a member of the International Strategy for Disaster Reduction system and as the health cluster lead in the framework of humanitarian reform, and works closely with other members of the international community, such as the United Nations Secretariat of the International Strategy for Disaster Reduction, UNDP, UNICEF, the United Nations Office for the Coordination of Humanitarian Affairs, the International Red Cross and Red Crescent Movement, and other nongovernmental organizations, on supporting country capacity development

and developing institutional capacities for multisectoral emergency and disaster risk-management, which includes disaster risk-reduction;

PP12 Building on the International Strategy for Disaster Reduction, the 2008–2009 World Disaster Reduction Campaign on Hospitals Safe from Disasters, the 2010–2011 Campaign on Disaster Resilient Cities, World Health Day 2008 on Climate Change and Health, World Health Day 2009 on Hospitals Safe in Emergencies, and World Health Day 2010 on Urban Health Matters, which have resulted in local, subnational, national and global actions on reducing risks to health from emergencies and disasters;

PP13 Recognizing that improved health outcomes from emergencies and disasters require urgent additional action at country, regional and global levels to ensure that the local, subnational and national health risk-reduction and overall response in emergencies and disasters are timely and effective and that health services remain operational when they are most needed, in this respect bearing in mind that emergencies and disasters affect men and women differently,

1. URGES Member States:[1]

(1) to strengthen all-hazards health emergency and disaster risk-management programmes (including disaster risk**-**reduction, emergency preparedness and response)[2] as part of national and subnational health systems, supported by, **and with effective enforcement of, [Thailand]** legislation, regulations and other measures, to improve health outcomes, reduce mortality and morbidity, protect ~~investment in~~ **[Thailand]** health infrastructure and strengthen the resilience of the health system and society at large, and mainstream a gender perspective into all phases of these programmes;

(2) to integrate all-hazards health emergency and disaster risk-management programmes (including disaster risk-reduction) into national or subnational health plans and institutionalize capacities for coordinated health and multisectoral action to assess risks, proactively reduce risks, and prepare for, respond to, and recover from, emergencies, disasters and other crises;

(2bis) to establish inventories of types and quantities of chemical hazards at sites and in transportation, and to make this information accessible to concerned government and other related agencies, and to stakeholders in order to support effective health emergency and disaster risk-management for chemical hazards; [Thailand]

(3) to develop programmes on safe and prepared hospitals that ensure: that new hospitals and health facilities are located and built safely so as to withstand local hazards; that the safety of existing facilities is assessed and remedial action is taken; and that all health facilities are prepared to respond to internal and external emergencies;

(4) to **establish, [Thailand]** promote **and foster [Thailand]** regional and subregional collaboration, **not limited to WHO regional structures, [Thailand]** including sharing of experience and expertise for capacity development, in risk-reduction, response and recovery;

(5) to strengthen the role of the local health workforce in the health emergency management system**,** ~~in order~~ **[Thailand]** to provide local leadership and health services, through enhanced planning, training~~,~~ **for all health-care workers, [Thailand]** and access to other resources;

~~3.~~**2. [Thailand]** CALLS UPON Member States, donors and development cooperation partners to allocate sufficient resources for health emergency and disaster risk-management programmes and partners through international cooperation for development, humanitarian appeals, and support for

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

[2] Health emergency and disaster risk-management includes all measures to assess risks, proactively reduce risks, prepare for, respond to, and recover from, emergencies, disasters and other crises.

WHO's role in ~~all international health related matters.~~ **health emergency and disaster risk-management matters; [Thailand]**

~~2.~~**3.** **[Thailand]** REQUESTS the Director-General:

(1) to ensure that WHO at all levels has enhanced capacity and resources, and optimizes its expertise across all disciplines in the Organization, in order to provide the necessary technical guidance and support to Member States and partners for developing health emergency and disaster risk-management programmes at national**,** subnational and local levels;

(2) to strengthen collaboration with and ensure coherence and complementarity of actions with those of relevant entities, including those in the public, private, nongovernmental and academic sectors, in order to support country and community health emergency and disaster risk- management, which includes disaster risk**-**reduction, as well as ongoing efforts by Member States to implement the International Health Regulations (2005);

(3) to strengthen the evidence base for health emergency and disaster risk-management including operational research and economic assessments;

(4) to support national and subnational assessments of risks and capacities for health emergency and disaster risk-management, as a basis for catalysing action and strengthening national and subnational health emergency and disaster risk-management capacities, including disaster risk**-**reduction;

(5) to report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session, on progress made in implementing this resolution;

(5bis) to support regional and subregional networks, including those outside the WHO regional structures, in order to strengthen their collaboration on health emergency and disaster risk management. [Thailand]

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.[1]

Dr PÁVA (Hungary), speaking on behalf of the European Union, did not support the insertion of a new subparagraph 1(2)bis which related more to preparations to comply with the International Health Regulations (2005). Moreover, there was no information available on the potential financial implications for Member States. In addition, she expressed a reservation about the reference to making information available "to concerned government and other related agencies, and to stakeholders", which could have security implications. She could not support the proposed amendments to subparagraphs 1(4) and 3(5)bis; the proposed support outside WHO's regional structures was too broad and vague. It needed further clarification of whether engagement was meant instead of support.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) stated that there was no link to the International Health Regulations (2005) in the proposed subparagraph 1(2)bis. Information was badly needed on the type and quantity of chemical hazards in order to allow timely and appropriate responses to, and management of, chemical hazards by emergency management and disaster management teams. Creating an inventory had no significant cost implications for Member States. With regard to subparagraph 3(5)bis, "including those outside the" could be replaced by "not limited to".

Dr PÁVA (Hungary) reiterated her concern about the insertion of the proposed subparagraph 1(2)bis and proposed that it be deleted.

[1] See document EB128/2011/REC/1, Annex 4.

The DIRECTOR-GENERAL suggested that the discussion of the draft resolution should be suspended to permit further informal discussion by interested parties and to allow time to understand the rationale behind the proposed amendment.

It was so agreed.

The CHAIRMAN drew attention to a revised version of the draft resolution in resolution EB128.R11 on strengthening nursing and midwifery, which incorporated amendments made during the discussions of the informal working group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the reports on health system strengthening;[1]

PP2 Recognizing the need to build sustainable national health systems and to strengthen national capacities to achieve the goal of reduced health inequities;

PP3 Recognizing the crucial contribution of the nursing and midwifery professions to strengthening health systems, to increasing access to comprehensive health services for the people they serve, and to the efforts to achieve the internationally agreed health-related development goals, including the Millennium Development Goals and those of the World Health Organization's programmes;

PP4 Concerned at the continuing shortage and maldistribution of nurses and midwives in many countries and the impact of this on health care and more widely;

PP5 Acknowledging resolution WHA62.12 on primary health care, including health system strengthening, which called, inter alia, for the renewal and strengthening of primary health care, as well as urging Member States to train and retain adequate numbers of health workers, with appropriate skill mix, including primary care nurses and midwives, in order to redress current shortages of health workers to respond effectively to people's health needs;

PP6 Acknowledging the ongoing WHO initiatives on the scaling up of transformative health professional education and training in order to increase the workforce numbers and the relevant skill-mix in response to the country health needs and health systems context;

PP7 Recognizing the global policy recommendations by WHO on increasing access to health workers in remote and rural areas through improved retention[2] as an evidence platform for developing effective country policies for rural retention of nursing and midwifery personnel;

PP8 Taking note of the WHO Global Code of Practice on the International Recruitment of Health Personnel;[3]

PP9 Reaffirming the call for governments and civil society to strengthen capacity to address the urgent need for skilled health workers, particularly midwives, made in the WHO UNFPA UNICEF World Bank Joint Statement on Maternal and Newborn Health;

PP10 Noting the importance of multidisciplinary involvement, including that of nurses and midwives, in high-quality research that grounds health and health systems policy in the best scientific knowledge and evidence, as elaborated in WHO's strategy on research for health, endorsed in resolution WHA63.21;

PP11 Noting that nurses and midwives form the majority of the workforce in many countries' health systems, and recognizing that the provision of knowledge-based and skilled health services

[1] Documents A64/12 and A64/13.

[2] *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* Geneva, World Health Organization, 2010.

[3] Adopted in resolution WHA63.16.

maximizes the physical, psychological, emotional and social well-being of individuals, families and societies;

PP12 Recognizing the fragmentation of health systems, the shortage of human resources for health and the need to improve collaboration in education and practice, and primary health care services;

PP13 Having considered the reports on progress in the implementation of resolution WHA59.27 on strengthening nursing and midwifery;[1]

PP14 Mindful of previous resolutions to strengthen nursing and midwifery (WHA42.27, WHA45.5, WHA47.9, WHA48.8, WHA49.1, WHA54.12 and WHA59.27) and the new strategic directions for nursing and midwifery services in place for the period 2011–2015;[2]

PP15 Recognizing the need to improve the education of nurses and midwives,

1. URGES Member States: ~~demonstrate their commitment to strengthening nursing and midwifery by~~: **[Thailand]**

(1) **to** develop~~ing~~ targets and action plans for the development of nursing and midwifery, as an integral part of national or subnational health plans, that are reviewed regularly in order to respond to population-health needs and health system priorities as appropriate;

(2) **to** forg**e**~~eing~~ strong, interdisciplinary health teams to address health and health system priorities, recognizing the distinct contribution of nursing and midwifery knowledge and expertise;

(3) **to** participat**e**~~eing~~ in the ongoing work of WHO's initiatives on scaling up transformative education and training in nursing and midwifery in order to increase the workforce numbers and the mix of skills that respond to the country's health needs and are appropriate to the health system context;

(4) **to** collaborat**e**~~eing~~ within their regions and with the nursing and midwifery professions in the strengthening of national or subnational legislation and regulatory processes that govern those professions, including the development of ~~entry-level~~ **[Zimbabwe]** competencies for the educational and technical preparation of nurses and midwives~~;~~, **and systems for sustaining those competencies [Thailand]; and** consideration ~~must~~ **should [USA]** be given to the development of the continuum of education that is necessary for attaining the required level of expertise of nurse and midwifery researchers, **educators and administrators**; **[Thailand]**

(5) **to** harness~~ing~~ the knowledge and expertise of nursing and midwifery researchers in order to contribute evidence for health system innovation and effectiveness;

(6) **to engage** actively ~~engaging~~ the expertise of nurses and midwives in the planning, development, implementation and evaluation of health and health system policy and programming;

(7) **to** implement~~ing~~ strategies for enhancement of interprofessional education and collaborative practice including community health nursing services as part of people-centred care;

(8) **to** includ**e**~~eing~~ nurses and midwives in the development and planning of human resource programmes that support incentives for recruitment, retention and strategies for improving workforce issues, such as remuneration, condition~~s~~ of employment**, career development and advancement, [Thailand]** and development of positive work environments;

(9) ~~introducing~~ **to establish national mechanism in order to develop an infrastructure that supports [Thailand]** the effective interventions proposed in the global policy

[1] See documents A61/17 and A63/27.

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

recommendations on increasing access to health workers in remote and rural areas through improved retention;[1]

(10) **to** implement~~ing~~ the WHO Global Code of Practice on the International Recruitment of Health Personnel, given the national impact of the loss of trained nursing staff**, and to implement effective rural retention policies and interventions**; **[Thailand]**

2. REQUESTS the Director-General:

(1) to strengthen WHO's capacity for development and implementation of effective nursing and midwifery policies and programmes through continued investment and appointment of professional nurses and midwives to specialist posts in the Secretariat both at headquarters and in regions;

(2) to engage actively the knowledge and expertise of the Global Advisory Group on Nursing and Midwifery in key policies and programmes that pertain to health systems, the social determinants of health, human resources for health and the Millennium Development Goals;

(3) to provide technical support and evidence for the development and implementation of policies, strategies and programmes on interprofessional education and collaborative practice, and on community health nursing services;

(4) to provide support to Member States in optimizing the contributions of nursing and midwifery to implementing national health policies and achieving the internationally agreed health-related development goals, including those contained in the Millennium Declaration;

(5) to encourage the involvement of nurses and midwives in the integrated planning of human resources for health, particularly with respect to strategies for maintaining adequate numbers of competent nurses and midwives;

(5bis) to strengthen the dataset on nurses and midwives as an integral part of the national health workforce information systems and maximize use of this information for evidence-based policy decisions; [Thailand]

(6) to report on progress in implementing this resolution to the Sixty-fifth and Sixty-seventh World Health Assembli**es**~~y~~ **and thereafter every three years**, **[Zimbabwe**] through the Executive Board.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.[2]

Dr PÁVA (Hungary), speaking on behalf of the European Union, questioned the wisdom of deleting the phrase "demonstrate their commitment to strengthening nursing and midwifery by:" from the introductory text of paragraph 1. In addition, in subparagraph 1(9) she suggested replacing the verb "establish" by "promote". The proposed amendment to subparagraph 1(10) was acceptable, provided that the following text were added at the end: "as appropriate at national and local levels". The proposed insertion of subparagraph 2(5)bis was redundant, as resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel had contained a similar provision. In subparagraph 2(6) she proposed that the same wording from subparagraph 3(9) of WHA64.6 should be used.

[1] *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations.* Geneva, World Health Organization, 2010.

[2] See document EB128/2011/REC/1, Annex 4.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) explained that the deletion of “demonstrate their commitment to strengthening nursing and midwifery by:” had been proposed as it was considered that the phrase weakened the subparagraphs contained in paragraph 1. Member States should be urged to take action rather than merely to demonstrate their commitment, which did not guarantee action.

Ms WISEMAN (Canada), referring to subparagraph 1(9), proposed the insertion of “and subnational” after “national” and the deletion of “infrastructure”, in order to reflect the division of responsibility that existed within federated states. In addition, the proposed amendment to subparagraph 1(10) should be deleted as there was no clear link between rural retention policies and international migration and, furthermore, subparagraph 1(9) already called for efforts to increase “access to health workers in remote and rural areas through improved retention”. The text of the proposed subparagraph 2(5)bis should be moved to become subparagraph 1(4)bis, as the collection of national and subnational data was the responsibility of Member States. In addition, in the same paragraph, she proposed the insertion of “and subnational” after the word "national". She welcomed proposal by the delegate of Hungary to amend subparagraph 2(6), as reporting requirements clearly needed streamlining.

Ms BENNETT (Australia) expressed support for the amendments to subparagraph 1(9) proposed by the delegates of Hungary and Canada. The proposed subparagraph 2(5)bis should, she agreed, be moved to paragraph 1, as the activities mentioned were aimed at the Member States. She supported the comments by the delegate of Canada regarding the proposed amendments to subparagraph 1(10).

Dr VIROJ TANGCHAROENSATHIEN (Thailand) would accept changes to subparagraph 1(9) if the text were to read: "to promote establishment of national and subnational mechanisms in order to develop and support …". With regard to subparagraph 1(10), he concurred with the comments of the delegates of Australia and Canada; he stressed that the WHO Global Code of Practice was a comprehensive instrument that covered rural retention but agreed that, because of the mention of health workers in remote and rural areas in subparagraph 1(9), the proposed amendment could be deleted. He welcomed Canada’s proposed amendments to subparagraph 2(5)bis but did not agree with the delegate of Hungary that the subparagraph was redundant.

Ms CHASOKELA (Zimbabwe) endorsed the proposals of the delegates of Hungary and Australia to retain the reporting process and format.

Dr DOLEA (Assistant Secretary) read out the amended texts. Operative paragraph 1 would read: “URGES Member States to translate into action their commitment to strengthen nursing and midwifery by...”. Subparagraph 1(9) would read: “to promote the establishment of national and subnational mechanisms in order to develop and support the effective interventions proposed...”. Subparagraph 1(10) would read: “to implement the WHO Global Code of Practice on the International Recruitment of Health Personnel, given the national impact of the loss of trained nursing staff as appropriate at national and local levels”. Subparagraph 2(5)bis would read: “to strengthen the dataset on nurses and midwives as an integral part of the national and subnational health workforce information systems...” and the paragraph would be moved to operative paragraph 1, to become subparagraph 1(4)bis. Subparagraph 2(6) should be replaced with the following text: “to report on progress in implementing this resolution to the World Health Assembly through the Executive Board in a manner integrated with the reporting on resolution WHA63.16 on the WHO Global Code of Practice on the International Recruitment of Health Personnel.”

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

The CHAIRMAN drew attention to the revised version of the draft resolution contained in resolution EB128.R12 on strengthening national policy dialogue to build more robust health policies, strategies and plans, which incorporated proposed amendments and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on health system strengthening: improving support to policy dialogue around national health policies, strategies and plans~~;~~;[2]

PP2 Having considered the importance of policy directions suggested by the world health reports for 2008 and 2010;[3] resolution WHA62.12 on primary health care, including health system strengthening; resolutions EUR/RC60/R5 on addressing key public health and health policy challenges in Europe: moving forwards in the quest for better health in the WHO European Region; WPR/RC61.R2 on the Western Pacific Regional Strategy for health systems based on the values of primary health care; AFR/RC60/R1 on a strategy for addressing key determinants of health in the African Region and documents AFR/RC60/7 on health systems strengthening: improving district health service delivery, and community ownership and participation and SEA/RC63/9 on the development of national health plans and strategies;

PP3 Recognizing that robust and realistic national health policies, strategies and plans are essential for strengthening health systems based on primary health care;

PP4 Underlining the importance of coherent and balanced policies, strategies and plans under ministries of health with respect to efforts to achieve the Millennium Development Goals;

PP5 Acknowledging that many Member States have made efforts to ensure that their national health policies, strategies and plans respond better to growing expectations for improved health and better services;

PP6 Noting that an inclusive policy dialogue with a comprehensive range of stakeholders, within and beyond government, **including civil society organizations, the private sector, and health professionals and academics, [Thailand]** within the health and other sectors, is critical to increasing the likelihood that national policies, strategies and plans will be appropriately designed and implemented and will yield the expected results,

1. URGES Member States:[4]

(1) to show effective leadership and ownership of the process of establishing robust national or subnational health policies and strategies, basing that process on broad and continuous consultation and engagement of all relevant stakeholders;

(2) to base their national or subnational health policies, strategies and plans on the overarching goals of universal coverage, people-centred primary care and health in all policies, as well as on a comprehensive, balanced and evidence-based assessment of the country's health and its health system challenges;

(3) to ensure that national or subnational health policies, strategies and plans are ambitious but realistic with respect to available resources and the capacities of staff and institutions, and

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.7.

[2] Document **A64/12**.

[3] *The world health report 2008. Primary health care (now more than ever).* Geneva, World Health Organization, 2008. *The world health report 2010. Health systems financing: the path to universal coverage.* Geneva, World Health Organization, 2010.

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

that they address the entire health sector, public as well as private, and the social determinants of health;

(4) to ensure that national health policies, strategies and plans are integrated with subnational operational plans, disease or life-cycle programmes, and are linked to the country's overall development and political agenda;

(5) to regularly monitor, review and adjust their national or subnational health policies, strategies and plans with a view to ~~adjusting them to respond to~~ **developing evidence-based responses to [Thailand]** evolving challenges and opportunities, and to involve all relevant stakeholders;

(6) to strengthen their institutional capacity, as appropriate, in harmonizing and aligning donor programmes with the national policies, strategies, priorities and plans;

(6bis) to empower civil society and communities, the private sector, health professionals and academics, to participate actively and efficiently in policy dialogue and the evaluation and monitoring process, as well as to be actively involved in reviewing the performance of national policies, strategies and plans; [Thailand]

2. CALLS upon development agencies and other partners to strengthen adherence to the principles of the Paris Declaration on Aid Effectiveness, of ownership, harmonization, alignment, **managing for [Thailand]** results, and mutual accountability, encouraging efforts through mechanisms such as the International Health Partnership;

3. REQUESTS the Director-General:

(1) to renew the Organization's role at country level as a facilitator of inclusive policy dialogue around national health policies, strategies and plans, to reflect this across the Organization's workplans and operations, and to provide technical inputs for conducting the planning process, as appropriate;

(2) to promote the principles of the Paris Declaration on Aid Effectiveness, of ownership, harmonization, alignment, results, and mutual accountability, based on priorities set out in the national health policies, strategies and plans;

(3) to support Member States in their efforts to ensure the ownership, quality and coordination of the technical support they receive, and to foster cross-country and regional learning and cooperation;

(4) to strengthen the Organization's capacity at all levels for enhanced and integrated support to national policy dialogue around national health policies, strategies and plans;

(5) to report to the Sixty-fifth World Health Assembly, through the Executive Board, on progress made, obstacles faced and results obtained in enhancing support provided to Member States for national policy dialogue around national health policies, strategies and plans.

The financial and administrative implications of the adoption of the resolution for the Secretariat were unchanged from those provided to the Board at its 128th session.[1]

Dr PÁVA (Hungary), speaking on behalf of the European Union, proposed that, in order to give more flexibility to Member States, in subparagraph 1(6)bis the following new text should be added: "URGES Member States to promote engagement and empowerment for all stakeholders including civil society and communities, the private sector, health professionals and academics to participate actively and efficiently in policy dialogue concerning the performance of national policies, strategies and plans".

Dr VIROJ TANGCHAROENSATHIEN (Thailand) expressed support for the amendments.

[1] See document EB128/2011/REC/1, Annex 4.

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

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

Draft WHO HIV/AIDS strategy 2011–2015. Item 13.6 of the Agenda (Document A64/15)

The CHAIRMAN drew attention to a draft resolution proposed by the delegations of Angola, Argentina, Brazil, Cape Verde, Panama, Paraguay, Timor-Leste and United States of America, which read:

The Sixty-fourth World Health Assembly,

Recalling resolution WHA63.19 which requested the Director-General inter alia to develop a WHO HIV/AIDS strategy for 2011–2015 that builds on previous WHO HIV**/AIDS** strategies and plans endorsed by several Health Assemblies, including resolutions WHA53.14, WHA56.30, WHA59.12 and WHA59.19;

Having considered the draft WHO HIV**/AIDS** strategy 2011–2015,[2]

1. ENDORSES the global health sector strategy on HIV**/AIDS**, 2011–2015;

2. AFFIRMS the vision and strategic directions of the global health sector strategy on HIV**/AIDS**, 2011–2015 and that the global strategy aims to guide the health sector's response to HIV**/AIDS**, including recommended actions at country and global levels as well as contributions to be made by WHO;

3. WELCOMES the alignment of the global health sector strategy on HIV**/AIDS**, 2011–2015 with other strategies addressing related public health issues, including the UNAIDS strategy for 2011–2015;[3]

4. URGES Member States:

(1) to adopt and implement the global health sector strategy on HIV**/AIDS**, 2011–2015;

(2) ~~to adapt~~ **to implement according to the national context** the strategy, on the basis of the most current strategic information on the nature of the HIV**/AIDS** epidemic and the preparedness of the health system and community systems to respond, and to reach those populations most vulnerable to, and at risk of, HIV**/AIDS** infection;

5. REQUESTS the Director-General:

(1) to give adequate support to implementation of the global health sector strategy on HIV**/AIDS**, 2011–2015, including provision of support to Member States for country implementation and annual reporting on progress on the health sector response to HIV**/AIDS**;

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.8.

[2] Document A64/15.

[3] *Getting to zero:UNAIDS strategy 2011–2015*. Geneva, UNAIDS, 2010.

(2) to monitor progress in implementing the global health sector strategy on HIV/**AIDS**, 2011–2015 and to report progress, through the Executive Board, to the Sixty-sixth World Health Assembly and every two years thereafter.

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

1. Resolution Draft global health sector strategy on HIV, 2011–2015

2. Linkage to programme budget

Strategic objective:	Organization-wide expected result:
2. To combat HIV/AIDS, tuberculosis and malaria.	All expected results.
4. To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence, and improve sexual and reproductive health and promote active and healthy ageing for all individuals.	All expected results.
The HIV strategy also links with strategic objectives 6, 7 and 11.	

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

The goals of the strategy are consistent with the UNAIDS Strategy 2011–2015 and reaffirm existing internationally agreed goals:

- to achieve universal access to comprehensive HIV prevention, treatment and care
- to contribute to achieving Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases) and other health-related Goals (3, 4, 5 and 8) and associated targets.

The HIV strategy's four targets for 2015 build on the indicators and targets of the Medium-term strategic plan 2008–2013. The targets are as follows:

- reduce new infections: reduce by 50% the percentage of young people aged 15–24 years who are infected (compared with a 2009 baseline)
- eliminate new HIV infections in children: reduce new HIV infections in children by 90% (compared with a 2009 baseline)
- reduce HIV-related mortality: reduce HIV-related deaths by 25% (compared with a 2009 baseline)
- reduce tuberculosis-related mortality: reduce tuberculosis deaths by 50% (compared with a 2004 baseline).

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$ 515 million for the five-year period 2011–2015.

(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$ 73 million, of which more than two thirds is expected to be incurred at regional and country levels.

(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)?

Funding sources include: assessed contributions; core voluntary contributions; core funding of the UNAIDS Unified Budget, Results and Accountability Framework; and direct voluntary contributions from Member States and foundations.

5. Administrative implications

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

The Secretariat will provide support to implementation of the strategy at all levels of the Organization and in all regions. A detailed draft operational plan for the next biennium has been developed, indicating specific outputs at each organizational level and for each region. Particular attention will be given to ensuring that the Organization has adequate capacity at country level to support strategy implementation.

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

WHO's HIV programme is currently undergoing a realignment process that aims to identify the necessary competencies, skills and staffing structure for implementing the strategy. The realignment is focusing on improving efficiencies within the programme throughout the Secretariat, including defining a clear division of labour across the three levels of the Organization. The outcome of the realignment process should be implemented by July 2011 and it is anticipated that the staffing levels will be sufficient to support implementation of the strategy. It is anticipated that there may need to be some adjustments in staffing over the five-year period to meet changing demands.

(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).

Not applicable.

(c) Time frames (indicate broad time frames for implementation of activities)

The strategy will be implemented over a five-year time period. Detailed operational plans will be developed for each biennium.

Dr TAKEI (Japan) fully supported the new draft strategy, which had been based on extensive consultations and maintained consistency with the existing guidelines and technical framework. In particular, he welcomed the following improvements to the version submitted to the Executive Board in January: the clearer and more specific description of monitoring; the broadening of the strategy, in response to the expectations from Member States and recognition of the need for health systems strengthening, to target all the health-related Millennium Development Goals; greater consistency and

coherence with existing policy documents such as the UNAIDS strategy; and the consideration of WHO's complementary role and collaboration with other organizations in the United Nations system.

In cooperation with international organizations and the Global Fund to Fight AIDS, Tuberculosis and Malaria, Japan would continue to provide assistance globally in order to have an impact on HIV/AIDS.

Ms ESCOREL DE MORAES (Brazil), speaking on behalf of the sponsors of the draft resolution, said that much had changed since the adoption in 2006 of the WHO HIV/AIDS Universal Access Plan 2006–2010, which had been based on the target adopted in 2006 by the United Nations of universal access to HIV prevention, treatment and care. There had been an increased recognition of the importance of integrating HIV into the broader public health and development agendas and of putting human rights at the centre of the response. Evidence had demonstrated that linking the HIV response to the attainment of the Millennium Development Goals and to the renewed primary health care agenda was the most effective overall approach to strengthening health systems.

WHO needed a new strategy to guide its work towards the targets of the 2015 Millennium Development Goal. She commended the Secretariat's wide and transparent consultative process for drafting a strategy for 2011–2015 that was in line with the broader United Nations and UNAIDS frameworks.

She further proposed two amendments to the draft resolution. In subparagraph 4(2), the text should begin: “to implement the strategy according to their epidemic situation …” and in subparagraph 5(1) the word “annual” should be deleted.

Dr HWOAL (Iraq) said that, even though the incidence of HIV infection was not high in Iraq, the Government had been working to keep the prevalence low since starting an HIV/AIDS programme in 1982. Partnerships with all stakeholders, from intergovernmental organizations to civil society, were needed in order to build capacity for diagnosis, treatment and prevention and to raise awareness about HIV/AIDS. In general, knowledge and health education needed to be strengthened through the media and better school health education programmes. Social and medical support was provided to people living with HIV. Couples should be tested for HIV before marriage. HIV services and programmes needed to be integrated into all primary health care and it was important to ensure screening programmes in all provinces of the country, including blood testing in regions where there was a high prevalence of HIV. World AIDS Day provided an incentive to take stock of the situation in order to review implementation indicators.

Strong partnerships were also needed to counter malaria and tuberculosis, with engagement of all stakeholders and follow-up.

Dr RUSLI (Malaysia) applauded the draft global health sector strategy on HIV, 2011–2015 and endorsed its recommendations. She welcomed its alignment with the UNAIDS strategy 2011–2015 and its focus on priority areas. Malaysia had prepared a national strategic plan on HIV/AIDS 2011–2015, which was in line with the WHO and UNAIDS strategies and the Millennium Development Goal targets.

Dr KAPATA (Zambia) expressed satisfaction with the revised draft strategy and thanked the Secretariat for ensuring that Member States' comments had been incorporated. Zambia had participated in the consultation process for developing the strategy with key stakeholders, including representatives of government institutions, donors, civil society, nongovernmental organizaitons, universities, media, bilateral and multilateral agencies and experts in HIV and related programmes. The strategy developed was expected to build on WHO's "3 by 5" initiative and the WHO HIV/AIDS Universal Access Plan and guide countries like Zambia in strategically prioritizing HIV in the context of global commitments and targets.

Like many countries in sub-Saharan Africa, Zambia had a heavy burden of HIV/AIDS and related illnesses such as tuberculosis and he asked the Secretariat to continue its support through guidance in adapting strategies to suit countries' individual scenarios. He appealed to all interested partners and stakeholders to support the implementation of the strategy fully.

Professor AHMED (Bangladesh) said that Bangladesh wished to build on the achievements and experiences of the "3 by 5" initiative and the five strategic directions of the WHO HIV/AIDS Universal Access Plan 2006–2010. He urged WHO to provide guidance to countries on how to prioritize their HIV and health investments.

As Bangladesh had a low prevalence of HIV (less than 1% seropositivity rate), it needed relevant indicators and activities. He asked the Secretariat to provide a framework for concerted action at the global, regional and country levels and within the Organization.

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, Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The European Union welcomed the simplified structure of the revised strategy and the stronger focus on the need to tailor interventions to each country and key populations, in which civil society's participation was crucial. It recognized the need to monitor and evaluate the strategy on a regular basis. The Secretariat should ensure coordination with other international organizations and existing HIV/AIDS reporting mechanisms and she strongly recommended streamlining the monitoring activities of other agencies and choosing validated indicators. Responses would benefit from focus on regionally relevant issues.

The strategy was ambitious, but financing was limited. Was the estimated US$ 221 million for 2012–2013 covered by the budget and how did the Secretariat allocate the respective resources?

She urged a clear division of labour at the three levels of the Organization and within UNAIDS for the effective implementation of the strategy. WHO should concentrate on normative work, in particular on models of integrated, decentralized service delivery; strategic technical support; collaboration with all national stakeholders; and, collaboration — in Europe— with the relevant institutions of the European Union, and with UNAIDS, especially during and after the United Nations General Assembly High-Level Meeting on AIDS (New York, 8–10 June 2011).

The European Union would continue to support WHO's role and activities. She supported the draft resolution and endorsement of the global health sector strategy.

Mr PRAZ (Switzerland) endorsed the draft strategy. He welcomed the special consideration of gender and HIV-related stigmatization and discrimination in accessing services as well as the health systems approach in national HIV interventions recommendations. He had two specific comments on strategic direction 1, Optimize HIV prevention, diagnostic, treatment and care. First, in paragraphs 35, 44 and 50, the word "counselling" should appear before "testing" and the strategy should not encourage general screening but should focus on prevention and counselling. Secondly, he strongly supported paragraph 60, Ensure access to comprehensive services for sex workers, men having sex with men and transgendered people, and paragraph 61, Provide harm reduction services for people who use drugs. The French version of harm reduction should be rendered "*reduction des risques*".

The division of labour between WHO headquarters and field offices was welcome and he supported the close collaboration with national partners to strengthen local capacities in defining and implementing the HIV/AIDS response. He also supported a periodic monitoring review that was based on the burden of disease in each region and country. An indicator could be added under strategic direction 1 for a greater link to other sexually transmitted infections and sexual and reproductive health prevention programmes.

Dr TAAL (Gambia) recalled that the draft strategy had been circulated in July 2010 to Member States in the African Region for comment and suggestions together with a support document to guide them in the consultative meeting with stakeholders. At the end of the review process, 31 (68%) of the 46 countries in the African Region had organized country consultations using the guidelines provided. The major challenge had been the limited time offered to Member States for organizing in-country consultations and providing feedback. There had been competing demands, among which were the preparation of proposals for Round 10 of applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria; preparations and negotiations for projects and reviews under the United States' President's Emergency Plan for AIDS Relief; and revision of national HIV/AIDS strategic plans.

Aligning WHO's strategic guidance to the overall national strategic planning or the health sector strategic planning for HIV/AIDS for countries in the mid-term planning cycle could be problematic or cause delays in the adaptation and implementation of the new global strategy by Member States. Nevertheless, he recommended that the strategy be endorsed.

Mr CHANDRAMOULI (India) noted the revised draft strategy with appreciation. WHO should take the lead on HIV treatment and care and on HIV/tuberculosis co-infection and share responsibility with UNICEF, UNAIDS and other organizations in the United Nations system for the prevention of mother-to-child transmission of HIV. It should collaborate with other UNAIDS cosponsors in supporting actions in all other priority areas.

In order to control the spread of HIV/AIDS, his Government was implementing the National AIDS Control Programme as a 100% centrally-sponsored scheme. The scheme had been launched in July 2007 and phase 3 of the programme, 2007–2012, had planned to halt and reverse the epidemic over a five-year period by integrating programmes for prevention, care, support and treatment.

According to recent estimates, since the launch of the scheme, the number of newly detected cases of HIV had more than halved. His country would take into account WHO's proposed strategy when drafting phase 4 of its national AIDS control programme.

Professor TJANDRA YOGA ADITAMA (Indonesia) supported the draft HIV/AIDS strategy 2011–2015 including the four strategic directions. Her country intended to expand its HIV/AIDS programme with health education programmes in collaboration with health professionals, community and religious leaders. It also planned to increase the number of hospitals and clinics that could provide care, support and treatment to patients and implement the integrated tuberculosis and HIV/AIDS programme in several provinces. She called for a patient-oriented approach rather than a disease-oriented approach to combat HIV/AIDS.

Dr GOUYA (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that, to be effective in reaching universal access, a combination of increased and predictable funding and an effective response to diverse and evolving epidemics in a changing environment was needed. The Member States recommended endorsement of the global health sector strategy for HIV. In order to implement the strategy effectively, they recommended that the Secretariat should provide country-level support in various ways. National HIV prevention and control strategies should be reviewed and revised in order to prioritize interventions in line with global and regional strategies, according to the local epidemic context; the capacity of government institutions and civil society organizations should be built; HIV surveillance systems should be set up with special attention to adolescents and adults engaging in high-risk sexual activity and injecting drugs; investment should be made in programme monitoring and evaluation so as to enable responsive HIV programme management; and costed operational plans for health sector response to HIV should be drafted with an adequate proportion of spending on health allocated to the implementation of those plans.

Dr HUYA RIMVALTANGUGUYON (Thailand) said that she could not accept the new indicators tabulated in the draft strategy. There was no need to establish a new set of indicators which would lead to an unnecessary administrative burden on countries. WHO should and must apply the existing indicators contained in the United Nations General Assembly's Declaration of Commitment on HIV/AIDS, with which Member States were already familiar.

The Secretariat should support Member States in improving the quality, reliability and comparability of datasets at the country level and support evidence-based policy decisions. Also, it seemed that an increasing proportion of resources went to treatment, at the expense of prevention, although prevention of new HIV cases was more important than treatment. The new $CD4^+$ count-based guideline for early initiation of antiretroviral treatment should be carefully implemented in line with countries' health systems and policies. Priority should be given to early enrolment of patients in therapy programmes.

She proposed the following amendments to the draft resolution: subparagraphs 4(1) and 4(2) should be deleted and replaced with a new subparagraph that read: "to adapt, apply and implement, according to the national context, the global health sector strategy on HIV/AIDS 2011–2015 according to the status of the HIV epidemic, the readiness of health and community systems in response to and reaching the most at risk populations". A new subparagraph 4(2)bis should be inserted, to read: "to strengthen primary health care with an adequate number and skill-mix of health workforces, supply of diagnostics, medicines and other essential medical supplies as a platform for the effective implementation of the strategy". In subparagraph 5(1), the word "annual" should be changed to "biennial", as annual reporting would be an ambitious undertaking.

In view of the biennial report required by the United Nations General Assembly special session on AIDS, it would be unnecessary to report to the Health Assembly every two years after the Sixty-sixth World Health Assembly. She proposed reporting in 2014 at the same time as the report to the General Assembly. Subparagraph 5(2) should therefore read: "to evaluate the outcomes and challenges in implementing the global health sector strategy on HIV, 2011–2015 and formulate the next phase of strategy through the Executive Board to the Sixty-seventh World Health Assembly in 2014".

Ms NYANDORO (Zimbabwe) welcomed the draft strategy, and called on the Director-General to allocate adequate finance, human resources and technical assistance to Member States for the effective implementation of the strategy. Such allocation of resources should be guided by the greatest needs at regional and country levels. HIV/AIDS remained a major health challenge for Africa, especially southern Africa; WHO and the Global Fund to Fight AIDS Tuberculosis and Malaria should provide the resources with a focus on women, children and adolescents, but she expressed concern at the reduction in the budget for HIV/AIDS at both the headquarters and regional levels. WHO had a leadership role to play in the fight against AIDS and could not afford to abrogate its responsibilities to other partners.

The strategy should be revised to identify more specifically those at risk and key populations, and the definitions should be linked to the circumstances pertaining to countries and regions.

Dr FENG Yong (China) supported the draft strategy. WHO should not only provide technical support but also play a coordinating role and provide specific tactics, such as: allocation of prevention resources for prevention; coordination with pharmaceutical companies in various countries to lower the costs of antiviral medicines; testing of reagents; and exploring and promoting effective means of prevention and control to help countries to solve their problems with regard to prevention and treatment. His Government would refer to the draft strategy in formulating its prevention and treatment objectives and plans and work with international communities to stop the global spread of disease.

He proposed two amendments to the draft resolution. Paragraph 4 duplicated information in its two subparagraphs; he proposed removing "and implement" in subparagraph 4(1), leaving reference

only to "adopt". He endorsed the proposal by the delegate of Brazil for subparagraph 4(2), which should begin: “to implement the strategy, according to the epidemic situation and national context, …”.

Dr ZAINAL (Brunei Darussalam) fully supported the revised draft strategy. He greatly appreciated its approach, which incorporated existing good practices, valuable evidence on the effectiveness of HIV-related approaches, interventions in the health sector, and the broad consultative process to its development. He welcomed the efforts made in aligning the draft strategy with the UNAIDS strategy for 2011–2015. The four strategic directions and core elements were tightly focused and would be of great value in guiding country level actions and in monitoring progress.

Mrs GŁAŻEWSKA (Poland) said that Poland, as Vice-Chair of the UNAIDS Programme Coordinating Board, welcomed the revised draft strategy and supported WHO's efforts to align its strategy with that of UNAIDS. There was a need to strengthen interventions that focused on regions especially affected by the HIV/AIDS epidemic and where the number of HIV infections was on the increase, particularly eastern Europe, which was the only region where the prevalence had tripled in the past decade. She emphasized his country’s support for the participation of civil society in the fight against HIV/AIDS.

Dr CHISTYAKOVA (Russian Federation) noted that the revised draft strategy was clear and comprehensive, with defined goals, objectives and directions. In particular, he noted the attention given to the rational use of existing financial and human resources, and to increasing the effectiveness of procurement and supply. Given that so far progress had been fragile and uneven, it was important to analyse in more detail the deficiencies in the implementation of previous initiatives, especially the "3 by 5" initiative and expanding access to care. Her Government was fulfilling the obligations it took on in the Declaration of Commitment on HIV/AIDS adopted by the United Nations General Assembly and, in line with WHO recommendations and its national programmes, was expanding screening, prevention and access to care.

Some elements of the draft strategy would need further analysis and amendment, in the light of differences in culture, religion and national practices. In particular, the recommended country action on harm-reduction services (paragraph 61 of the draft strategy) should be revised to read: “A package of services should be provided that includes a complex of measures on prevention, treatment and care of people with HIV”.

She supported the draft resolution as amended by the delegates of Thailand and China.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) welcomed the revised draft strategy, emphasizing that work on HIV should continue to be grounded in evidence, for which WHO's technical leadership was crucial. It was gratifying that, in its revision, the draft strategy had been aligned with the UNAIDS strategy for 2011–2015 and that that was reflected in the draft resolution, which she supported.

Dr DLAMINI (South Africa) congratulated the Director-General on the revised draft strategy. Her country's HIV counselling and testing campaign had to date reached 11.9 million out of the targeted 15 million and had resulted in 1.5 million people receiving antiretroviral treatment. The Government's budget allowed for increasing treatment coverage to two million people, reflecting the fact that the prices of antiretroviral medicines had more than halved. Further price reduction would enable even greater coverage. She supported Treatment 2.0 as the next phase towards universal access, but agreement had to be reached on the $CD4^+$-cell count threshold for initiating treatment. WHO should support countries with implementation and increasing responsiveness of the health system.

The draft resolution should reflect the setting of realistic targets that were measurable. She agreed with the delegate of Thailand that the texts in paragraph 4 should be merged and reflect the

national context, and with the delegate of China regarding the financial implications. A footnote should be added to subparagraph 4(2) to define vulnerable populations, while recognizing that HIV/AIDS remained a generalized heterosexual epidemic in high-burden countries. Reporting requirements (subparagraph 5(2)) should be aligned across the organizations in the United Nations system.

Ms MÅRENG (Norway) congratulated the Secretariat on its work to revise and elaborate the draft strategy, with its clear links to and complementarity with the UNAIDS strategy and definition of WHO's specific roles and tasks. It was important for WHO to ensure sufficient capacity and resources to implement and monitor the bold and ambitious strategy. She highlighted the areas of gender and harm-reduction, stressing that WHO needed courage with regard to the latter to promote what was best for health. Norway had positive experiences with harm-reduction measures: needle-exchange programmes and low-threshold health services had resulted in only limited spread of HIV among injecting drug users. She endorsed the draft resolution as amended.

Ms KHUMALO (Swaziland) said that Swaziland had the highest HIV prevalence in the world, with 26% of the adult population infected. The pandemic was generalized in the population and not confined to certain population groups.

She urged the Secretariat to continue its leadership, giving HIV/AIDS the highest priority and ensuring allocation of adequate resources, even in times of austerity. The African Region had the highest burden and must receive support. She supported the draft resolution as amended.

Dr JUNG Sung-hoon (Republic of Korea) acknowledged the contributions of all parties that had led to the success of the "3 by 5" initiative and the 2006–2010 WHO HIV/AIDS Universal Access Plan. He welcomed the revision of the draft strategy for 2011–2015, which was clearer; it also better defined national and Secretariat actions. It was to be hoped that the strategy would produce synergy in work towards achieving both the UNAIDS strategy and the Millennium Development Goals.

His Government's three proposed strategic directions for HIV/AIDS response were: strengthening prevention among high-risk groups; enhancing early diagnosis and compliance with antiretroviral therapy; and preventing prejudice and discrimination. It would continue to support WHO's strategy on the response to HIV.

Dr KABUAYI (Democratic Republic of the Congo) supported the objective of WHO's global health sector strategy on HIV, 2011–2015, namely universal access to HIV prevention, treatment and care. He thanked WHO for the consultative process and for taking into account his country's recommendations for improving the draft text. In particular, he welcomed the strategies proposed for the effective integration of HIV/AIDS control and WHO's commitment to mobilize further resources for implementation of the strategy.

He urged the inclusion of an indicator for the third strategic direction on building strong and sustainable systems in terms of a percentage of teaching and health-personnel training institutions that included HIV in their curricula, as his country had called for during the consultation process.

Dr DeCOCK (United States of America) commended WHO's leadership in the response to HIV/AIDS. His Government had been pleased to have collaborated with WHO through the President's Emergency Plan for AIDS Relief. The revised draft strategy rightly continued to emphasize the Secretariat's role in supporting countries and reaffirmed internationally agreed commitments on HIV and alignment with the UNAIDS Strategy for 2011–2015. His Government supported its global goals and strategic directions. WHO should work closely with UNAIDS to estimate the investment needed to achieve those goals, through development and use of tools to cost national plans and work with development partners to increase efficiency in the application of development assistance funds. Costs

should be based on country-specific empirical costing and cost-effectiveness data and should take into account coverage rates of current programmes.

Recognizing the pressure of budgetary constraints, he called on the Secretariat to continue to work closely with Member States and other partners in implementing the strategy so as to ensure that activities were prioritized and scarce resources used effectively. The relative strengths of different parties for implementing aspects of the strategy should be identified; WHO's strength in HIV/AIDS lay in its convening authority, normative work and policy guidance. In view of recent scientific advances, a priority for WHO should be the provision of guidance on how best to use antiretroviral medicines for prevention as well as treatment. With regard to human rights, WHO should recognize that UNAIDS and other cosponsors were more experienced in advocacy, and better resourced for it. Efforts must be made to avoid duplication.

The draft strategy made several references to the need to foster an open competitive market for antiretroviral medicines in order to contain costs, and to the importance of voluntary mechanisms to promote access to medicines, such as voluntary licences and patent pools. The licence from the United States National Institutes of Health within the Medicines Patent Pool was an important first step but it was crucial to provide more rights holders with incentives to voluntarily explore such mechanisms on agreed terms and conditions. Meaningful and transparent engagement among all relevant stakeholders, including owners of intellectual property rights, to address public health challenges while maintaining an incentive system that promoted investment, research and innovation was critical for much-needed new HIV treatments.

He asked to see the proposed amendments in writing, and agreed on the need for achieving clarity in subparagraph 5(2) with regard to harmonizing the reporting requirements and their conclusion - possibly at the Seventieth World Health Assembly.

The meeting rose at 13:05.

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