FOURTH MEETING

Friday, 20 May 2011, at 09:50

Chairman: Dr M.T. VALENZUELA (Chile)
later: Dr A.-Z.GOLEM (Croatia)

1. SECOND REPORT OF COMMITTEE B: (Document A64/58 (Draft))

Mr TUITAMA LEAO TUITAMA (Samoa), Rapporteur, read out the draft second report of Committee B.

The report was adopted.

2. STAFFING MATTERS: Item 18 of the Agenda

Human resources: annual report: Item 18.1 of the Agenda (Document A64/36)

Dr GULLY (Canada) noted with appreciation WHO's progress with respect to gender balance, and encouraged continued efforts to achieve parity within the coming decade. The Secretariat needed also to remain vigilant so that the gains made in gender equality, and within the Organization, were maintained and indeed furthered. WHO had other challenges to face, among them the unequal distribution of professional and higher-category posts between developed and developing countries, and an ageing workforce.

Noting the significant reduction between 31 July and 31 December 2010 in the number of temporary staff largely due to budgetary constraints, he asked for clarification about the extent to which WHO's core business, including standard-setting work and technical cooperation, was being strategically modified to adapt to those reductions.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) observed that there was general recognition of the significant human resources difficulties that the Organization faced, as had been outlined in the documents on the future of financing and the human resources strategy introduced the previous year. A key element of the strategy was to embed human resources thinking and strategies within the organizational culture, rather than letting that aspect remain a separate management issue. A progress report should be provided on some key performance targets, now that the strategy had been in force for a year.

He welcomed the significant efforts and resources invested in ensuring that the Global Management System would help the Organization to target better its resources for decision- and policy-making in the human resources area. However, he highlighted the wider corporate risks attaching to the System, notably the manufacturer's cessation of support for the current software in 2013, which would pose substantial difficulties for the Organization, particularly financial problems. How did the Organization plan to respond?

Member States and the Secretariat had to have a set of strategic objectives that were specific, measurable, achievable, realistic and timely, and which would be applied throughout the Organization, from top-level corporate strategic objectives down to individuals' objectives, with clear synchronization of those objectives.

As the documents on the future of financing for WHO made clear, there was currently a mismatch within the Organization's staffing model, in terms both of short- and long-term contracts and of the related mix of skills and experience. The Organization must have a staffing model that was fit for purpose.

Many Member States had not taken due account early enough of the important role played by the International Civil Service Commission in making recommendations on human resource issues, with the result that, once those recommendations had been endorsed by the United Nations General Assembly, they had become a *de facto* reality for all organizations in the United Nations system, imposing constraints on the Organization that made it difficult to implement flexible policies. He sought information on the level of the Secretariat's engagement with that Commission in terms of influencing the discussions before it made recommendations.

Ms ALTMAIER (Human Resources Management) said that she appreciated the support expressed for the progress in achieving gender balance. Headquarters was working closely with the regions, and the Secretariat had just launched a new web site and an outreach activity toolkit that should make it possible to close the gender gap, especially in the higher categories, in less time than the 10 years mentioned in the report.

With regard to staffing levels, the process of decreasing staff numbers was continuing, with a further 300 people affected across the Organization (144 of them in headquarters) since the beginning of the year as a result of the mismatch between funding and staffing levels.

The Secretariat had already implemented 28 standard operating procedures for human resources. The implementation of the "make and check process", effective from 1 June 2011, under which all transactions with payroll implications would have to be signed off by a National Professional Officer or professional staff member would help to mitigate the risk. Those standard operating procedures had been aligned with WHO's rules and regulations in order to achieve consistent and harmonized processes across the Organization. The next stage would be to undertake an exercise, in collaboration with the Global Service Centre, to determine the cost of each transaction. A major project to clean up the data, which had involved examining all the personnel assignment details in the Global Management System, was drawing to its close. More than 10 000 data fields that had been identified as erroneous or empty had been rectified or completed, and a policy had been instituted to prevent data corruption and attain further data quality in future. The Secretariat could now fully rely on the data in the System, which was a major step forward. Further work was in hand to automate human resource reports.

With regard to performance management, the compliance rate had increased from 55% two years earlier to 77% at the present time; the target remained 100%. The Organization was investing heavily in training in performance management and evaluation. Objectives were being refined and an Organization-wide workplan was being prepared. Further, over the past two years, the recruitment time had been reduced from nine to five months; the goal was four months, but that would need greater availability of recruitment panel members. As another step towards more rapid deployment, several rosters had been or were being developed for specific categories of personnel, including potential WHO Representatives, administrative officers, and epidemiologists. She would be able to submit further information to the Executive Board at its 130th session in January 2012, including data on some main performance indicators, as baselines were established against which progress could be measured.

Specific, measurable, achievable, realistic and timely objectives for human resources staff had been disseminated widely so that all offices could increase their efficiency and effectiveness and improve results. In the area of skill mix, work had to be completed on a fully functioning performance management system that would detect competency gaps and

enable the Secretariat to determine how to close them through training and learning focused on the strategic priorities.

Funding and staffing were mismatched. In January 2012 a new staffing model would be submitted to the Board, one that not only differentiated between ongoing and project-based functions but also defined the allocation of contract types. That would help in the identification of what changes in contracts and contracting might subsequently be needed. The revised staffing model would also link functions and funding more closely, with clear descriptions of all posts so that projects could be readily expanded or shrunk depending on Member States' strategic needs.

Overall, a holistic approach was being taken to human resources management, in order to foster the creation and establishment of a high-performance culture. Islands of high-performance culture already existed, but that concept was not yet uniformly distributed throughout the Organization. Only when that culture was fully in place would it be possible to impose accountability, and apply a policy of rewards and sanctions which was currently being developed with the countries and regions.

With regard to the involvement of the International Civil Service Commission in human resources policy-making, it was true that the Organization felt somewhat isolated and neglected, with decisions all being taken in New York, and the needs of the outlying specialized agencies not apparently being taken seriously. WHO was working with the United Nations system on performance management, classification, organizational design and policies for streamlining and implementation. However, with more support and guidance from Member States, WHO could be more effective in shaping the agenda and improving policies.

Mr CHATELUS (France) stressed his country's readiness to help the Organization in any way possible in its dealings with the United Nations Secretariat, in particular through a dialogue in which the Members States could participate. Human resources issues and questions of contract types were crucial for WHO, in the context of its search for a more balanced funding model and above all for a staffing model that would both be in harmony with the Organization's mission and allow the staff to be fully associated with the universally supported reform of the United Nations system.

Ms ALTMAIER replied that it was in the Organization's interest to have as much information exchange as possible. She welcomed such exchanges, and would be organizing round-table meetings in order to share information with all Member States. As part of the Organization's reform, a task force would be established comprising staff from the regions and headquarters to review all the Staff Rules and, by January, to come up with a comprehensive package of what needed to be changed in the light of the revised staffing model to be presented. That process would require dialogue and exchange with all Member States.

The Committee noted the report.

Report of the International Civil Service Commission: Item 18.2 of the Agenda (Document A64/37)

The Committee noted the report.

Amendments to the Staff Regulations and Staff Rules: Item 18.3 of the Agenda (Documents A64/38 and EB128/2011/REC/1, resolution EB128.R5)

The CHAIRMAN invited the Committee to consider the draft resolution recommended by the Executive Board in resolution EB128.R5.

The draft resolution was approved.[1]

Report of the United Nations Joint Staff Pension Board: Item 18.4 of the Agenda (Document A64/39)

The Committee noted the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 18.5 of the Agenda (Document A64/40)

The CHAIRMAN proposed the nomination of Dr Ebenezer Appiah-Denkira (Ghana) as a member and Mrs Palanitina Tupuimatagi Toelupe (Samoa) as an alternate member of the WHO Staff Pension Committee for a three-year term until May 2014.

Dr DAHN (Liberia), speaking on behalf of the Member States of the African Region, supported that proposal.

The CHAIRMAN proposed the nomination of Dr Viroj Tangcharoensathien (Thailand) as a member of the WHO Staff Pension Committee to complete the remainder of the term of office of Dr A.A. Yoosuf (Maldives), namely until May 2013.

Mr PRASAD (India), speaking on behalf of the Member States of the WHO South-East Asia Region, supported that proposal.

It was so decided.[2]

Interim progress report of the Working Group on the Election of the Director-General of the World Health Organization: Item 18.6 of the Agenda (Document A64/41)

Ms QUACOE (Côte d'Ivoire) speaking on behalf of the Member States of the African Region, observed that the agenda item concerning the election of the Director-General raised issues of improving the procedures for doing so. The matter had been under examination since 2006, and was one of considerable importance for the African Region.

Since the creation of WHO, its Directors-General had come only from three of its six regions. With a view to ensuring equality of opportunity to all the regions, the countries of the African Region requested that the World Health Assembly incorporate the principle of balanced geographical representation into the criteria for nominations to the post of Director-

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA64.25.

[2] Decision WHA64(8).

General set forth in resolution EB97.R10. Improving the rules for selecting the Director-General would involve increasing the participation of all Member States in the process and enhancing the role of the World Health Assembly by proposing more than one candidate for its consideration. There was also a need to define more objective selection criteria in the interests of transparency, given that certain of the criteria contained in resolution EB97.R10, such as "sensitiveness to cultural, social and political differences" or "a strong commitment to the work of WHO" seemed difficult to measure.

Ms BLACKWOOD (United States of America) expressed appreciation for the constructive spirit shown by the members of the working group at its first meeting. The United States welcomed the challenge by the chair of the working group, to both sides, to take the discussion beyond its past boundaries in a spirit of flexibility and openness. The efforts of the working group had to lead to durable solutions that would strengthen the Organization. The role of the Director-General, whether in overseeing response to pandemic outbreak, promoting best practices among Member States, or managing a global organization, had never been more crucial to all of WHO's Member States.

The Committee noted the report.

3. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 19 of the Agenda (Document A64/42)

Mr QUINTANILLA (Cuba) drew attention to the Organization's collaboration with the United Nations in the preparation, in particular, of the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals, of September 2010, and the forthcoming high-level meeting on the prevention and control of noncommunicable diseases, to be held in September 2011.

Despite such successful collaboration, however, much remained to be done. The United Nations system's operational activities for development must be universal, voluntary, neutral and multilateral, responding flexibly to the development needs of the countries in which they were carried out. They must be implemented for the benefit of the recipient countries, at their request and in line with their development policies and priorities.

Ms CHAVANICHKUL (Thailand) commented that the report seemed to be a "business-as-usual" type of document, which merely outlined the collaborative process between WHO and other agencies and organizations but failed to highlight the benefits and challenges of those various collaborations, especially the implications for health of the United Nations reform agenda. She hoped that the Secretariat would be able to provide a more analytical report, one that would include mechanisms for efficient business operations among United Nations and other intergovernmental agencies.

Ms DJANGANI (Equatorial Guinea), speaking on behalf of the Member States of the African Group, said that 18 countries in the African Region had received joint technical assistance from United Nations bodies, which had enabled them, inter alia, to prepare medium-term expenditure frameworks, mobilize donors and draw up health plans. Within that framework, the WHO Regional Office for Africa was working with the African Union in various areas of common interest, including implementation of the Africa Health Strategy

2007–2015, prevention and treatment of HIV/AIDS, preparation and administration of traditional medicines and reduction of maternal mortality.

Despite such positive undertakings, challenges remained. They included the high transaction costs of collaborative efforts, the need for harmonization of working methods, the differing areas of competency and different programmes of the various organizations involved, the search for new sources of funding in emerging countries, the fragmentary nature of development assistance at national level and the major efforts that would be needed nationally and internationally to achieve the Millennium Development Goals by the target date of 2015.

Mr CHATELUS (France) considered that in the present period of reform and transition, it was no great drawback that the report was not very detailed and might be considered a "business-as-usual" document. The matter of collaboration within the United Nations system was key to WHO's reform and its future financing system. It should therefore be developed further and incorporated into all aspects of the reform process, for which it would act as a key indicator.

Dr MANSOOR (Iraq) said that the report should be more detailed, in its description both of collaborative efforts and of the outcomes that such efforts were intended to achieve. He stressed the need for coordination among the different organizations of the United Nations system and for harmonization of plans and programmes. A framework for coordination among the regional offices should be established, and national resources needed to be developed to further cooperation among the various organizations.

Mr SAMIEI (International Atomic Energy Agency) said that the Agency was pleased to be a partner in the WHO-IAEA Joint Programme on Cancer Control established in March 2009. Nuclear and radiation techniques were often the sole means of diagnosing and treating many diseases, especially cancers and heart diseases. The Agency had more than 40 years of field experience in assisting Member States to develop the use of radiation techniques for health and medicine. Capacity-building and training provided by the Agency had enabled some 115 low- and middle-income Member States to establish basic nuclear medicine clinics to provide radiation therapy to at least a portion of their cancer patients. However, existing resources were much too small to address the enormous and growing needs in such countries, which had led the Agency in 2005 to launch its Programme of Action for Cancer Therapy (PACT), which targeted developing countries and in which WHO was a key partner. A joint IAEA/WHO programme, launched in 2008, was aimed at assessing cancer control infrastructures and developing national cancer control plans in low- and middle-income countries.

The IAEA and WHO had also initiated several joint country projects on cancer control to demonstrate the synergies that could be achieved by international and national partners in cancer capacity-building. The IAEA was honoured to have contributed its expertise to WHO's global efforts against cancer.

Dr WORNING (Executive Director, Office of the Director-General) took note of the wish of Member States to have a more detailed report and of the suggestion that collaboration within the United Nations system and with other intergovernmental organizations should become an integral part of the broad reform agenda proposed by the Director-General.

Harmonization of efforts, alignment with national priorities, and national ownership were key features of the Organization's intervention strategy at country level and she hoped the strategy would ensure that the health priorities of all the countries concerned were recognized and supported within the United Nations system as a whole.

The increasing prominence of health matters in the debates within the United Nations General Assembly represented an enormous opportunity, but had also necessitated some changes in WHO's way of working. For example, headquarters and the regional offices had needed to devise a seamless methodology to draw as much attention as possible to the topic of noncommunicable diseases.

The Committee noted the report.

4. INTERNATIONAL AGENCY FOR RESEARCH ON CANCER: AMENDMENTS TO STATUTE: Item 20 of the Agenda (Document A64/43)

The CHAIRMAN invited the Committee to consider the draft resolution in document A64/43.

The draft resolution was approved. [1]

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

Infant and young child nutrition: implementation plan: Item 13.13 of the Agenda (Document A64/22)

Dr RUBERU (Sri Lanka), speaking on behalf of the Member States of the WHO South-East Asia Region, observed that the Region accounted for over 70% of the world's malnourished children. The rate of exclusive breastfeeding up to the age of six months varied widely from country to country, but averaged out at no more than 25%. All the countries in the Region had adopted the global strategy for infant and young child feeding, although to differing extents, and funding was often a constraint on implementation. Application of the International Code of Marketing of Breast-milk Substitutes needed to be strengthened in most of the countries, which would entail training of health staff and enforcement of legislation.

The countries of the Region were tackling the question of infant and young child nutrition with a common approach. The four main areas of attention were low birth weight, reduction of anaemia prevalence, management of severe acute malnutrition and childhood obesity. In reducing low birth weight, the focus was on adolescent and pre-pregnancy nutrition, and pregnancy weight gain was used as an indicator. In addition, attention was focused on care for low-birth-weight children.

Fortification of food was one strategy used to combat anaemia, but most fortification was based on wheat flour, which did not meet the needs of the large number of countries of the Region where the staple food was rice. Rice fortification needed to be given priority, or else suitable alternative foods needed to be found for each country. In the area of complementary feeding, the countries promoted therapeutic feeding using indigenous, locally available and culturally acceptable foods, rather than ready-to-use therapeutic foods, wherever possible.

Management of severe acute malnutrition was centred on community-based programmes that also included developing locally produced therapeutic foods. Recent surveys had revealed the rapidly increasing prevalence of child obesity. To raise the profile of that health problem at the global level, the countries of the Region urged Member States, and

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA64.26.

requested the Director-General, to collaborate in initiating a global programme to tackle obesity.

Mr PRASAD (India) said that the Government of India had consistently promoted exclusive breastfeeding for the first six months and introduction of complementary foods thereafter, with continued breastfeeding up to two years. National guidelines on infant and young child feeding had been prepared to foster that approach. In 2004 the Indian Government had revised its legislation to extend the age of exclusive breastfeeding to six months and to place infant foods on a par with infant milk substitutes in the areas of advertising and promotion. India now had one of the strongest laws to protect breastfeeding from commercial influence, with the ultimate aim of eliminating all forms of commercial promotion of complementary foods as being suitable for children under two years of age. Ready-to-use therapeutic foods were not accepted by the Government of India, which instead promoted therapeutic feeding with indigenous, locally available and culturally acceptable foods.

Under its strategic plan for child survival, the Government had set a number of goals, the implementation of which was expected to contribute to the achievement of the health-related Millennium Development Goals. The overarching aim was to provide universal access to basic quality care while taking into account the social determinants of health.

Dr AL HAJERI (Bahrain) said that her country was implementing a range of measures to promote maternal, infant and young child nutrition. It had developed guidelines based on the International Code of Marketing of Breast-milk Substitutes, and implemented the global strategy for infant and young child feeding. It was also monitoring iron levels in infants, young children, pregnant women and breastfeeding mothers in order to prevent iron deficiency anaemia. A committee had been established to monitor the marketing of breast-milk substitutes and foods designed specifically for infants and young children, and to ensure compliance with relevant WHO resolutions. In 2010, the Ministry of Health had launched a programme that used different health indicators to prevent diseases caused by malnutrition among infants, adolescents and breastfeeding mothers.

Professor ARSLAN (Bangladesh) said that the first section of the comprehensive implementation plan might be divided into three subsections: maternal, infant and young child nutritional status; the scope of the nutritional issues to be tackled by governments and development partners; and progress in the implementation of policies to reduce maternal, infant and young child malnutrition. The second section of the implementation plan might set out a universal strategy to implement maternal, infant and young child nutrition policies, which each Member State could adapt in accordance with its nutritional status and concerns. The third section might provide guidelines for the development of action plans for individual countries, setting out objectives, indicators, targets, activities, time frames, and monitoring and evaluation strategies.

Dr WARUNEE PUNPANICH VANDEPITTE (Thailand) urged the Director General and Member States to support the enactment of new laws and strengthen existing measures to ensure that the marketing of breast-milk substitutes complied with the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions. Thailand strongly supported the fifth action contained in the second section of the implementation plan concerning monitoring and evaluation of the implementation of policies and programmes, which should include indicators on adoption and implementation of the Code.

In Thailand, the prevalence of overweight children was rapidly increasing, and a national obesity tracking strategy had been formulated. She hoped that WHO would collaborate with others in launching a global programme to tackle obesity. Iodine deficiency remained problematic, particularly among pregnant women and breast-feeding mothers in impoverished areas, and salt iodization remained a significant technical challenge. WHO must work closely with its partners to make developing countries aware of the importance of universal salt iodization and folate supplementation and to provide them with technical support in those areas.

Ms BLACKWOOD (United States of America) said that the United States supported the recommendations to develop further the issues relating to overnutrition and to increase the references to maternal nutrition in the implementation plan. The plan should also differentiate more clearly between optimal maternal feeding practices and the interventions necessary to promote those practices. More supporting evidence should be provided in the background papers to demonstrate the impact of national nutrition policies, and countries should be advised that the implementation of nutritional interventions would require prioritization and need to be tailored to the national context. The implementation plan should include a section clarifying paragraph 1.4 of resolution WHA63.23, which urged Member States "to end inappropriate promotion of food for infants and young children, and to ensure that nutrition and health claims shall not be permitted for foods for infants and young children, except where specifically provided for in relevant Codex Alimentarius standards or national legislation". There were few such relevant Codex standards, and many Member States lacked legislation regulating the labelling and use of foods for older infants and young children. The implementation plan provided an opportunity to clarify guidelines on the promotion of foods for infants and young children, in particular concerning complementary feeding between six and 24 months. A reference to foods in national policies, rather than in national legislation, would give governments more flexibility to meet changing public health priorities.

Dr AYDINLI (Turkey) said that the WHO Child Growth Standards were an important tool in reducing malnutrition and helping to control the obesity epidemic. Food safety and nutrition programmes were essential, as was collaboration between civil society and the private sector.

Turkey had achieved considerable success in the area of maternal, infant and young child nutrition, and implemented a number of programmes at the national and regional level including the promotion of breastfeeding and complementary feeding; iron and vitamin D supplementation for infants and pregnant women; the promotion of iodized salt programmes; ensuring access to and availability of healthier foods, including fruit and vegetables; and the provision of primary education for girls, all of which contributed significantly to reducing obesity.

Ms SHI Qi (China) said that China attached particular importance to maternal, infant and young child nutrition, and had incorporated a number of nutrition indicators in its national plan for economic and social development. It was establishing a number of baby-friendly hospitals and providing folate supplementation for pregnant women and mothers. China would welcome increased international cooperation and the sharing of experience and results in the area of maternal and young child nutrition. It hoped that WHO would continue to play an active role in that field, including by providing financial and technical support and working with Member States to select the strategy best adapted to their national circumstances.

Dr MOMAH (Nigeria) said that, following from her country's firm commitment to address the urgent problem of undernutrition, its strategic plan to ensure optimum feeding of

infants and young children, including those with HIV/AIDS, had been mainstreamed into the national strategic health development plan for 2010–2015. Nigeria had enacted into law the International Code of Marketing of Breast-milk Substitutes. It had also adopted the ILO Maternity Protection Convention C183, and legislation was in place to extend maternity leave to 14 weeks. Her country was taking various steps to promote infant and young child nutrition, including building capacity for training infant and young child feeding counsellors; updating the nutrition information surveillance system; producing individual child health record cards incorporating the new WHO Child Growth Standards; and holding a maternal and newborn child health week twice a year.

In 2008, an assessment of infant and young child feeding in Nigeria had been undertaken using WHO tools. Challenges remained, including support for scaling up interventions at every level, inadequate human resources, and low levels of support from partners for nutrition activities. Plans to establish a nutrition council in Nigeria had received attention at the highest level.

Dr DIXON (Jamaica) welcomed the proposed objective of the implementation plan to address the double burden of malnutrition in children from the earliest stages of development. She agreed with the suggested five-year period for short-term assessments and ten-year period for long-term assessments; milestones might however be included to mark progress over shorter time periods.

With regard to the priority interventions, sectoral policies and indicators listed in the appendix to the implementation plan, she said that vitamin A supplementation was not needed in Jamaica as vitamin A deficiency was not prevalent. An additional survey would have to be carried out in order to ascertain the prevalence of anaemia among under-five-year-olds and whether supplementation was indicated. The policy of using salt as a vehicle for iodine and fluoridation might have to be revised in the light of her Government's efforts to reduce the consumption of sodium.

Jamaica recognized the importance of exclusive breastfeeding in the first six months of life and of continued breastfeeding for two years or more. A national breastfeeding week was held every September, the Baby-friendly Hospital Initiative was implemented across the island, and a good network of international agencies and local food industries was in place. However, available data showed that while the majority of mothers were aware of the benefits of breastfeeding, few reported sustained exclusive breastfeeding after the first six weeks of life.

Dr GULLY (Canada) said that Canada welcomed WHO's development of a comprehensive implementation plan for infant and young child nutrition, and supported the recent expansion of its scope to include maternal nutrition. Canada continued to support resolution WHA63.23, which urged Member States to expedite, strengthen and expand implementation of the global strategy for infant and young child feeding, and underscored the need for flexibility to meet the unique needs and circumstances of each Member State in that regard. Canada also supported the International Code of Marketing of Breast-milk Substitutes, which should be adapted by countries to suit their specific political, economic and social conditions.

Canada was concerned about the fiscal vulnerability of WHO's Department of Nutrition for Health and Development. The equivalent of 1% of the total budget for the biennium had been allocated to strategic objective 9 (To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development), and Canada wondered whether that amount would be sufficient to meet the existing requirements of the Department as well as the activities included in the implementation plan.

Dr MANSOOR (Iraq), speaking on behalf of the Member States of the WHO Eastern Mediterranean Region, expressed support for the Director General's efforts in the area of maternal, infant and young child nutrition. Statistics published by UNICEF showed that some 30% of under-five-year-olds in the Region, in particular in heavily populated areas, suffered from poor growth as a result of malnutrition. The situation had deteriorated further in a number of countries following the global financial crisis. With support from WHO, 17 countries from the Region had so far implemented relevant international standards and strategies, and he hoped all other countries of the Region would have done so by the end of the year. The global strategy for infant and young child feeding formed the basis for nutrition efforts in his own country.

Efforts to promote maternal, infant and young child nutrition in the Region, although essential, were limited and should be evaluated and strengthened. Steps should be taken to strengthen breastfeeding and complementary feeding programmes. Monitoring and follow-up activities should be undertaken, and technical assistance provided to facilitate the implementation of measures to combat undernutrition and malnutrition. Efforts should also be made to establish partnerships with stakeholders from other sectors to facilitate the further development of nutrition programmes.

Dr KOSHY (Malaysia) commended WHO's efforts to develop a comprehensive implementation plan. Her country had succeeded in improving maternal, infant and young child nutrition using a multifaceted approach spearheaded by the Ministry of Health. The National Nutrition Policy of Malaysia and the National Plan of Action for Nutrition of Malaysia for 2006–2015 had provided the strategic framework; implementation of the Baby-friendly Hospital Initiative had also had a positive impact.

Malaysia agreed in principle with the comprehensive implementation plan, which addressed both undernutrition and obesity. Examples of initiatives and interventions should be included in the plan as lessons to be learnt. As some of the proposed interventions might overlap with those under the 2008–2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, good coordination and careful planning were required at the national level to ensure the optimum use of all available resources.

Dr AILLON (Plurinational State of Bolivia) recalled that the International Code of Marketing of Breast-milk Substitutes had been adopted 30 years earlier in response to the marketing practices of certain international companies which used aggressive publicity campaigns to promote breast-milk substitutes, endangering the health of breastfeeding mothers and infants all over the world. The Latin American region had made much progress in implementing the Code, although the extent varied from country to country. As a result of the zero malnutrition programme in Bolivia, chronic malnutrition had been significantly reduced in less than five years. As part of that programme, mother and baby-friendly hospitals had been established, where breastfeeding support groups had been set up and the promotion of breast-milk substitutes was prohibited. In 2006, Bolivia had enacted legislation intended to encourage exclusive breastfeeding for the first six months of life, extend the breastfeeding period for up two years, and regulate the promotion, distribution, marketing and sale of breast-milk substitutes. His country would continue its efforts to ensure that the International Code of Marketing of Breast-milk Substitutes was implemented fully.

Dr MPONDA (United Republic of Tanzania), speaking on behalf of the Member States of the WHO African Region, said that vitamin A, iodine and iron deficiencies were major underlying factors in over 50% of the cases of morbidity and mortality among children under five years of age and pregnant women in Africa. Owing to the limited use of exclusive

breastfeeding and inappropriate feeding practices, more than 43% of children in Africa suffered from stunted growth and 23% were underweight. Malnutrition in all its forms, which threatened lives, health, growth and development, and was linked to the rise in noncommunicable diseases, was slowing Africa's progress in achieving economic growth and reducing poverty.

The African Region welcomed the decision to include maternal nutrition — a factor critical to both maternal and child survival — in the implementation plan and suggested that it should also include a focus on adolescent girls. The Region was pleased to note that the double burden of malnutrition was being addressed. It welcomed the decision to begin consultations in the African and South-East Asia Regions, where the burden of malnutrition was high, and trusted that, as the plan was developed further, there would be adequate consultation to ensure relevant inputs from countries. The plan should give priority to interventions to strengthen breastfeeding, including implementation of the International Code of Marketing of Breast-milk Substitutes. It should also provide guidance on strengthening growth monitoring, using the new WHO Growth Standards, and on improving the management of severe acute malnutrition at health centre and community levels.

The African Region welcomed the fact that one of the five actions envisaged under the plan concerned the provision of sufficient human resources. The plan should also include cost-effective approaches to improving the skills and knowledge of service providers and other frontline workers involved in maternal, young child and infant nutrition. The Region welcomed the inclusion in the plan of non-health interventions that had an impact on nutrition. The plan should provide specific guidance to Member States on strengthening multisectoral coordination and implementation, which remained a challenge in many countries of the Region. The African Region was grateful for all the assistance it had received in support of its efforts to improve the well-being of women and children.

Ms CREELMAN (Australia) outlined some of Australia's recent achievements in the area of maternal, infant and young child nutrition, including the agreement reached by health ministers on the Australian national breastfeeding strategy 2010–2015 and the establishment of a national breastfeeding committee composed of senior government officials. Among the items on Australia's current agenda were: reporting on a 2010 national infant feeding survey, finalizing a set of core national breastfeeding indicators, revising infant feeding guidelines, and reviewing its response to the International Code of Marketing of Breast-milk Substitutes.

It was important that the implementation plan met international development needs while taking into account the different contexts that existed in various countries. Australia would welcome more information on the time frames and procedures for developing and finalizing the background papers and implementation plan, and on their relation to a global multisectoral nutrition framework. It also sought clarification on the timing and coordination of the proposed regional and national stakeholder consultations.

Mr GARCIA DE ZUÑIGA (Paraguay) welcomed the holistic approach being taken with respect to nutrition, and noted that an intersectoral approach involving civil society was also important to ensure success. Precise indicators for monitoring the implementation of policies, plans and programmes were needed in order to measure impact and ensure that the substantial investment of financial and human resources was justified. It would be useful to develop measurement indices and health interventions for women of reproductive age, so that nutritional deficits, low weight or anaemia could be detected and prevented before pregnancy when such interventions would be the most effective.

If further progress was to be made in the area of nutrition, steps had to be taken to improve information generation and monitoring, empower local human resources and implement basic strategies such as the promotion of breastfeeding. The main challenge was to

ensure that nutrition was regarded as an inalienable right that encompassed not only the provision of foodstuffs but also the establishment of basic conditions that enabled all human beings to realize their potential from the very beginning of life.

Dr AL HAMAD (Kuwait) said that the implementation plan must be sufficiently flexible to respond to the cultural, political and social context of each country. A mechanism should be devised to monitor the implementation of the plan in all countries.

Dr BOKENGE (Democratic Republic of the Congo) said his country shared the Organization's concerns about the continuing decline in the resources available to the developing countries, and sub-Saharan Africa in particular, for tackling problems linked to nutrition, including vitamin A and iron deficiency, obesity, diabetes and cardiovascular disease. He called on WHO to intensify its efforts to mobilize funds and promote local foods, and urged it to appoint a nutrition counsellor in its regional offices.

Mr LAHLOU (Morocco) said that malnutrition could have an adverse impact on a country's economic and social development. The causes of malnutrition should be identified and the quality of services enhanced, including obesity prevention.

The Moroccan Government had developed a strategy for 2012–2019 to improve the health of its citizens. The strategy was consistent with the content of the implementation plan and sought, inter alia, to encourage breastfeeding, promote the marketing of good quality and healthy products, and increase awareness of the importance of nutrition.

Dr KAZIHISE (Burundi) said that his Government attached great significance to maternal, infant and young child nutrition and was implementing a programme to combat malnutrition, which was a reality for many people in Burundi. With heightened awareness and a commitment to tackle the issue of nutrition at the global level, more tangible and rapid results could surely be achieved. He welcomed the support provided to his country by its financial and technical partners.

Dr MINAROO (Indonesia) said that, in accordance with its national development plan, Indonesia had launched a food nutrition action plan every five years. The plan addressed five areas, namely ensuring sustainable access to food; infant and young child feeding; food safety; healthy lifestyles; and capacity building, and was used to guide the development of nutrition programmes. In line with the WHO Child Growth Standards, Indonesia had enacted health legislation in 2009 that promoted exclusive breastfeeding for the first six months. It was also undertaking various priority activities, including integrated counselling on breastfeeding, complementary feeding and growth, and case management of severe acute malnutrition. Reductions in the prevalence of vitamin A deficiency, iron deficiency anaemia and iodine disease disorders confirmed that the nutritional status of infants and young children in Indonesia continued to improve.

Dr Shin-Lan KOONG (Chinese Taipei), welcomed the preparatory process used in the development of the comprehensive implementation plan. Chinese Taipei welcomed in particular the inclusion in the plan of actions aimed at establishing a supportive environment and fostering the implementation of non-health interventions. Breastfeeding rates had increased in Chinese Taipei following the introduction of the Baby-friendly Hospital Initiative. However, obesity was a growing problem. To tackle it, legislation relating to the content of television, radio and satellite broadcasting had recently been amended and a law was being drafted that would place restrictions on the advertising of foods linked to obesity and hypertension. She hoped that statutory regulations on the marketing of foods, non-

alcoholic beverages and breast-milk substitutes would be established in her country in the near future.

Ms ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, welcomed the fact that the implementation plan would also address maternal nutrition, which was intrinsically linked to the health of mother and child. The plan raised one concern: a focus on nutrition might result in less attention being paid to breastfeeding and maternity protection. The positive impact on health and poverty reduction of interventions related to improved early, exclusive and continued breastfeeding, as well as their cost-effectiveness, had been repeatedly underscored in medical journals. Moreover, the effects of breastfeeding on child survival, growth, health and development were not limited to settings where resources were scarce.

The many resolutions on infant and young child nutrition passed by the Health Assembly over the past 30 years provided clear guidance with respect to the basic elements of the implementation plan, which should include the International Code of Marketing of Breast-milk Substitutes, the Baby-friendly Hospital Initiative, complementary feeding after six months and training of health professionals. The rules concerning the obligations and responsibilities of commercial enterprises, as set out in the global strategy for infant and young child feeding, should be applied during consultations on the implementation plan.

She sought reassurance from the Secretariat that the biannual reporting on the global strategy for infant and young child feeding, the Baby-friendly Hospital Initiative and the International Code of Marketing of Breast-milk Substitutes would be maintained.

Ms ALLAIN (Consumers International), speaking at the invitation of the CHAIRMAN, commended the Secretariat's work on the implementation plan. However, as a result of the shift in focus towards nutrition in general, the importance of protection, promotion and support for breastfeeding and complementary feeding might be minimized. It was vital that the plan be developed within the framework of human rights, social justice and the principles of the Alma-Ata Declaration.

Although important progress in achieving optimal infant and young child feeding had been made over the past 30 years, much remained to be done. For example, the International Code on the Marketing of Breast-milk Substitutes had yet to be implemented fully: only 33 countries had enacted all of its provisions into law, and some 500 violations by 22 companies in 46 countries had recently been reported.

The participation of industry in regional and national consultations on the implementation plan was a matter of great concern as no provision appeared to have been made for managing conflicts of interest. The effectiveness of recommendations for policy and programme implementation would be compromised at all levels if the role of industry was expanded to include policy setting.

Ms GIULIANI (Churches' Action for Health), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, said that both undernutrition and obesity were linked to the increasing dependence of poor countries on high-income countries for food security. Nutrition strategies should therefore address the complex socioeconomic and political determinants of malnutrition, and governments and international bodies like WHO must advocate regulation of the trade and marketing of unhealthy foodstuffs to protect consumers against aggressive corporate influence.

It was alarming that WHO had shifted its focus to nutrition in general, to the detriment of breastfeeding and complementary feeding. Breastfeeding was a major safeguard against early childhood malnutrition and should be protected, promoted and supported as part of comprehensive primary health care. Reports of ongoing violations of the International Code of

Marketing of Breast-milk Substitutes made it clear that much remained to be done to protect breastfeeding.

In order to prevent inadequate nutrition in early childhood, regulations controlling marketing practices should be strictly enforced, particularly in schools. Binding regulations were crucial, as voluntary agreements by corporations were inadequate and often disregarded, particularly in the South.

The plan to allow industry to participate in the development of the implementation plan, in the absence of any guidance on the prevention and management of conflicts of interest, was a matter of concern. Any consultation process should be made transparent through the publication on a website of all submissions and the clear identification and disclosure of any conflicts of interest.

To make nutritional interventions sustainable in local contexts, the implementation plan must be aligned with primary health-care systems, with strong community participation. Ready-to-use therapeutic foods should be restricted to the treatment of severe acute malnutrition, and local production of such foods should be accelerated and information provided on their basic ingredients.

The definitive elimination of malnutrition in the long-term depended on coherent efforts to tackle its structural determinants. WHO must insist on the fact that food security and sovereignty were essential for good nutrition; the measures taken to promote them must be supported by other sectors and institutions.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that the active engagement of stakeholders, particularly those in official relations with WHO, was critical to the success of the implementation plan. The International Special Dietary Foods Industries were well positioned to provide expertise on the development of new products delivering nutrient-rich foods for infants and young children and on the deployment of products in accordance with national and international guidelines, and to offer educational support to families on appropriate complementary feeding practices.

Inappropriate complementary feeding remained a challenge. Country data showed that even where breastfeeding rates had improved, stunting and wasting at two years of age remained a problem, and that after six months of age, children were at increased risk of malnutrition because of suboptimal feeding practices and the fact that complementary foods did not always fully meet their nutritional needs. Positive nutrition and health outcomes for infants and young children could be achieved by incorporating evidence-based policies on complementary feeding in the implementation plan. She recommended that consideration be given to providing nutrition counselling to all women during pregnancy and lactation.

Dr ALWAN (Assistant Director-General) said that he had taken note of the comments of the delegate of Thailand regarding the need to accord greater priority to strengthening the implementation of the International Code of Marketing of Breast-milk Substitutes and to achieve universal iodization. Efforts to monitor overweight and obesity trends at the global level were considered a priority within WHO's programmes on nutrition and noncommunicable diseases. The Global status report on noncommunicable diseases 2010 contained specific estimates of overweight and obesity for the 193 Member States of WHO, which would serve as the baseline for future monitoring of overweight and obesity and other noncommunicable disease trends.

Noting that several Member States had called for the scaling up of technical support to countries, he pointed out that technical collaboration was a key strategic direction under WHO’s nutrition programmes.

Responding to the comment from the delegate of Australia regarding the time frame and process for development of the implementation plan, he said that working papers had already been drafted and had been posted on the WHO web site. A draft of the comprehensive

implementation plan would be prepared by August 2011, circulated to members for comment in September, and submitted to the Executive Board for consideration in January 2012. A regional consultation had already taken place in Harare and consultations would be held in Burkina Faso in July and Sri Lanka in August. Consideration was also being given to holding a regional consultation in the Region of the Americas.

Replying to the question from Canada regarding the budgetary allocation, he said that the approved programme budget for 2012–2013 contained the possibility of scaling up the resources for strategic objective 9 by 23% as compared to expenditure in the 2008–2009 biennium. Action was being taken to restructure the Department of Nutrition for Health and Development and to strengthen coordination between headquarters and country and regional offices.

He wished to assure the delegate of the United States that WHO had invested considerable resources in updating the evidence base for nutrition programmes. Several guidelines on micronutrients had also been recently updated. Additional efforts had been made to define adaptation methodologies to guide Member States in choosing priority interventions.

Turning to the comments from civil society, he said that WHO would continue to apply the guidelines concerning interaction with commercial enterprises during the consultations on the implementation plan and in other areas of work. Biannual reporting on the global strategy for infant and young child feeding and the International Code on the Marketing of Breast-milk Substitutes would continue.

He thanked Member States for their guidance and excellent input, which would assist in the finalization of the implementation plan, and looked forward to receiving further comments on the plan later in the year.

Dr Golem (Croatia) took the Chair.

The Committee noted the report .

The meeting rose at 12:45.

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