SIXTH MEETING

Monday, 23 May 2011, at 09:15

Chairman: Dr M.T. VALENZUELA (Chile)
later: Mr Z. DUKPA (Bhutan)

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

Mr TUITAMA LEAO TUITAMA (Rapporteur) read out the draft third report of Committee B.

Mr LE GOFF (France) noted that the amendments, proposed by the delegates of Algeria and the Plurinational State of Bolivia to the draft resolution on drinking-water, sanitation and health and accepted during the course of the discussion,[1] did not appear in the version of the resolution reproduced in the Committee's draft third report. He sought assurances that they would be incorporated into the final text of the resolution.

The CHAIRMAN said that the Secretariat would ensure that all agreed amendments were included.

The report, as amended, was adopted.

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

Child injury prevention: Item 13.14 of the Agenda (Documents A64/23 and EB128/2011/REC/1, resolution EB128.R15) (continued from the fifth meeting, section 2)

The CHAIRMAN drew attention to a revision of the draft resolution contained in resolution EB128.R15 incorporating amendments proposed by several Member States, which read:

The Sixty-fourth World Health Assembly,

Recalling resolution WHA57.10 on road safety and health, which affirmed that road traffic injuries constitute a major public health problem that required coordinated international efforts;

Recalling also that the Health Assembly in resolution WHA57.10 accepted the invitation by the United Nations General Assembly for WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions;

Further recalling resolution WHA60.22 on health systems: emergency-care systems, which recognized that improved organization and planning for provision of trauma and emergency care is an essential part of integrated health-care delivery, and resolution WHA58.23 on disability, including prevention, management and rehabilitation, which urged Member States to take all necessary steps for the reduction of risk factors contributing to disabilities in childhood;

[1] See the summary record of the fifth meeting of Committee B, section 3.

Acknowledging the responsibilities to ensure safety in the care and protection of children affirmed in the Convention on the Rights of the Child (1989), in the International Labour Organization Convention 182 (1999) and in the International Labour Organization Convention 138 (1973), and further acknowledging the responsibilities to protect persons with disabilities set out in the Convention on the Rights of Persons with Disabilities (2006) particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;

Recognizing that child injuries are a major threat to child survival and health, that they are a neglected public health problem with significant consequences in terms of mortality, morbidity, quality of life, social and economic costs, and that in the absence of urgent action this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries, where there exists a significant burden of child injuries;

Recognizing that the leading causes of child death from unintentional injury include road traffic injury, drowning, fire-related burns, falls and poisoning. In some regions of the world, drowning is responsible for about half of total child injury deaths; context-specific preventive measures including safe environment, safety products, safety management and awareness raising are crucial [THAILAND];

Further recognizing that multisectoral approaches to preventing child injuries and limiting their consequences through implementation of evidence-based interventions have resulted in dramatic and sustained reductions in child injury in countries that have made concerted efforts;

Welcoming the joint WHO/UNICEF *World report on child injury prevention*[1] and its recommendations for public health policy and programming;

Considering that existing programmes on child survival and child health and development should introduce child injury prevention strategies, ensuring these are an integrated part of child health services, and that the success of child health programmes should not only be gauged by the use of traditional measures of infectious disease mortality but also by indicators of fatal and non-fatal injury,

1. URGES Member States:

(1) to prioritize the prevention of child injury among child issues and ensure that intersectoral coordination mechanisms necessary to prevent child injury are established or strengthened;

(2) to continue and, if necessary, to strengthen**, the fulfilment of their obligations** ~~their commitments~~ **[UNITED STATES OF AMERICA]** under the Convention on the Rights of the Child (1989) to respect, protect and fulfil the rights of children to the highest attainable standard of health and to take all appropriate legislative, administrative, social and educational measures to protect children from injury;

(3) to ensure that funding mechanisms for relevant programmes, including health programmes, cover child injury and prevention, emergency care, pre-hospital care, treatment and rehabilitation services;

(4) to implement, as appropriate, the recommendations of the WHO/UNICEF *World report on child injury prevention*, including, if not already in place, the assignation of a leadership role to a government agency or unit for child injury prevention and the appointment of a focal person for injury prevention, ensuring that such leadership facilitates collaboration between relevant sectors of government, communities and civil society; and, according to national needs, the key strategies identified in the *World report* as effective interventions for preventing child injury; and to monitor and evaluate the impact of these interventions;

[1] *World report on child injury prevention*, Geneva, World Health Organization, and New York, United Nations Children's Fund, 2008.

(5) to integrate child injury prevention in national child development programmes and in other relevant programmes, and to establish multisectoral coordination and collaboration mechanisms, in particular ensuring that prevention of child injury is accorded appropriate importance within programmes for child survival and health;

(6) to ensure that national data collection across relevant sectors or surveillance systems quantifies the demographic, socioeconomic and epidemiological profile of the burden of, risk factors for, and costs of child injury, and to **assure** ~~ensure~~ **[UNITED STATES OF AMERICA]** that the resources available are commensurate with the extent of the problem;

(7) to develop and implement a multisectoral policy and plan of action, where necessary, that contain realistic targets for child injury prevention and include promotion of standards and codes on the prevention of child labour, as well as on legal adolescent employment, product safety, school and play spaces, **transportation, [THAILAND]** construction regulations and laws, and that either stand alone, or are incorporated within the national child health policy or plan;

(8) to enforce and, if necessary, strengthen the existing laws and regulations relevant to the prevention of child injury;

(9) to strengthen emergency and rehabilitation services and capacities, including first-response teams, acute pre-hospital care, management at health facilities, and suitable rehabilitation programmes for injured or disabled children;

(10) to define priorities for research, taking into consideration the WHO/UNICEF *World report on child injury prevention*, and working closely with research and development communities, including relevant manufacturers and distributors of safety products;

(11) to raise awareness and health literacy, in particular on child safety among parents, children, employers and relevant professional groups, **as well as all members of the society, [THAILAND]** about risk factors for child injury, especially transport, including the use of "cell" phones and other such mobile devices while driving, workplace hazards, water and fire hazards, and lack of child supervision and protection of children, and to advocate dedicated child injury prevention programmes;

2. REQUESTS the Director-General:

(1) to collaborate with Member States in improving data collection and analysis systems for child injuries and in establishing science-based public health policies and programmes for preventing and mitigating the consequences of child injury;

(2) to collaborate with organizations of the United Nations system, international development partners and nongovernmental organizations ~~in order~~ to establish **an effective network to ensure effective coordination and implementation of activities for child injury prevention in low- and middle-income countries** ~~a mechanism for the communication and sharing of information on child injury and of child injury prevention activities, so as to guarantee the cooperation and coordination of all parties concerned~~**[CANADA]**;

(3) to encourage research that expands the evidence base for interventions to prevent child injuries and mitigate their consequences, and that evaluates the effectiveness of such interventions through collaborating centres and other partners, including translation into affordable safety products, policy interventions and effective implementation;

(4) to facilitate the adaptation and transfer of knowledge on measures and instruments to prevent child injury, from developed to developing settings;

(5) to support Member States in developing and implementing child injury prevention measures;

(6) to provide additional support to national injury prevention focal persons by organizing regular global and regional meetings and providing technical assistance;

(7) to provide technical support for strengthening systems and capacities for emergency and rehabilitation services;
(8) to collaborate with Member States, organizations in the United Nations system, and international development partners and nongovernmental organizations in order to mobilize resources and to augment the capacities needed to prevent child injury and undertake related rehabilitation programmes; to organize advocacy activities for governments of Member States; and to raise awareness that, in the absence of urgent action, this problem will hamper attainment of the Millennium Development Goals, particularly in developing, low- and middle-income countries where there exists a significant burden of child injuries;[1]
(9) to invest more in building institutional and individual capacities among Member States so that they are able to develop cost-effective interventions at national and subnational levels;
(10) to report progress made in implementing this resolution, through the Executive Board, to the Sixty-seventh 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]

Dr DAYRIT (Secretary) read out a revision proposed by the delegate of the United States of America to the amendment to subparagraph 1(2): after "to continue and, if necessary, to strengthen", "their" should be replaced by "the". In subparagraph 1(7) a comma should be inserted after the word "transportation".

Ms LAWLEY (Canada) suggested that in subparagraph 2(2) the word "effective" before "network" should be deleted.

The CHAIRMAN said that, in the absence of any objections, she would take it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.[3]

Youth and health risks: Item 13.16 of the Agenda (Document A64/25)

The CHAIRMAN drew attention to a draft resolution on youth and health risks proposed by the delegations of Finland, Hungary and Tunisia, which incorporated revisions proposed by an informal drafting group and read:

The Sixty-fourth World Health Assembly,

PP1 Having considered the report on youth and health risks,[4] which highlights the immediate and long-term effects of health risks on young people;

[1] Note from WHO Secretariat: The *World report on child injury prevention* provides the following data. Mortality for under 20 year-olds in the South-East Asia and African regions combined totalled 558 000 deaths out of the total of 950 366 deaths reported worldwide.

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

[3] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.27.

[4] Document A64/25.

PP2 Recalling the resolutions **that directly address young people:** WHA38.22 on maturity before childbearing and promotion of responsible parenthood; WHA42.41 on the health of youth; WHA56.21 on the strategy for child and adolescent health and development, WPR/RC39.R12 Rev.1 on adolescent health; EM/RC43/R.11 on health education of adolescents; AFR/RC51/R3 on adolescent health: a strategy for the African Region; EUR/RC55/R6 on the European strategy for child and adolescent health and development; and CD48.R5 on the Pan American regional strategy for improving adolescent and youth health;

PP3 Recalling ~~the fundamental right of adolescents and youth to the enjoyment of the highest attainable standard of health~~ **the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental** health, as set out in the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, which, inter alia, reaffirm the equality of young women and men and respect for diversity;

[Alternative text proposed by UNITED STATES OF AMERICA] PP3: Recalling the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental health, also recalling the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, and emphasizing the need to promote the equality of young women and men and respect for diversity;

PP4 Recognizing that health is not only the absence of disease or infirmity, but a state of complete physical, mental and social well-being as articulated in the Constitution of the World Health Organization;

PP5 Acknowledging the fact that the 1800 million young people globally – one quarter of all people living in the world are ~~under the age~~ **between the ages of 10 and 24** years – make up the largest cohort in history, thereby representing an extraordinary opportunity to shape the world's social, economic and health futures;

PP6 Recognizing that the 2.6 million annual deaths among young people are generally preventable and that their current health behaviours and conditions can compromise both their existing and future health as well as the health of future generations;

PP7 Mindful that heterogeneity of the youth population and their circumstances renders some young people, for example adolescent girls, more vulnerable than others to negative health outcomes;

PP8 Emphasizing the importance of promoting healthy lifestyles, such as participation in physical activity and sport, eating a healthy diet, and physical education, for young people;

PP9 Acknowledging the attention given to young people in **resolutions dealing with the population at large**: the WHO Framework Convention on Tobacco Control (resolution WHA56.1); the Global strategy to reduce the harmful use of alcohol (resolution WHA63.13); the Global strategy on diet, physical activity and health (resolution WHA57.17); the recommendations on the marketing of foods and non-alcoholic beverages to children (endorsed in resolution WHA63.14); the action plan for the global strategy for the prevention and control of noncommunicable diseases (resolution WHA61.14); the strategy on reproductive health (resolution WHA57.12), the UNAIDS strategy in HIV for 2011–2015; the

global strategy for the prevention and control of sexually transmitted infections (resolution WHA59.19); the global health sector strategy for HIV, 2011–2015; and the United Nations Decade of Action for Road Safety, 2011–2020; resolution WHA60.22 on health systems: emergency-care systems; and the recommendations contained in the *World report on violence and health* that were taken note of in resolution WHA56.24;

PP10 Recognizing the roles of the organizations **and programmes** in the United Nations system, such as ILO, UNESCO, UNICEF, UNHCR, UNFPA, and UNAIDS, and the International Organization for Migration, to address youth health risks and ~~in particular their comparative advantages~~ in influencing the determinants of youth health;

PP11 ~~Acknowledging~~ **Taking note of** the importance of addressing social determinants of youth health, social protection mechanisms that ensure the social inclusion, education and employment of youth, and the Guanajuato Declaration, resulting from the World Youth Conference (Leon, Guanajuato, Mexico, 25–27 August 2010) and which called for increased investments in policies and programmes across sectors and national development plans, with the meaningful participation of young people, following the World Programme of Action for Youth to the Year 2000 and beyond (United Nations General Assembly resolution 50/81);

PP12 Cognizant that the United Nations' World Programme for Action on Youth to the Year 2000 and beyond (United Nations General Assembly resolution 50/81) encourages *g*overnments to develop comprehensive sexual and reproductive health care services and provide young people with access to those services including, inter alia, education and services in family planning ~~consistent with the results of~~ **as set out in the programmes of action from** the International Conference on Population and Development (1994), the World Summit for Social Development (1995) and the Fourth World Conference on Women (1995)**; ensuring that adolescents have information about, access to and the choice of the widest possible range of safe, effective modern methods of family planning; and to provide adolescents with comprehensive education on human sexuality, on sexual and reproductive health and gender equality so as to enable them to deal in a positive and responsible way with their sexuality;**

PP13 Mindful that meeting indicators and targets related to young people ~~will be~~ **are** crucial for attaining six of the eight Millennium Development Goals (Goals 1, 2, 3, 4, 5 and 6), and that paying specific attention to young people ~~will~~ contribute**s** to achieving the aims of recent global health initiatives such as the United Nations Secretary General's Global Strategy for Women's and Children's Health and UNAIDS' Universal A**a**ccess to HIV**/AIDS** ~~P~~**p**revention, ~~T~~**t**reatment, ~~C~~**c**are and support;

PP14 Recognizing the opportunities to pay specific attention to the health needs of adolescents and youth during the forthcoming United Nations General Assembly high-level meetings on AIDS, on youth and ~~the planned United Nations General Assembly Special Session~~ on **the Prevention and Control of** Noncommunicable Diseases;

PP15 Acknowledging the ~~resource~~ **capacity** ~~that~~ **of** young people ~~represent for~~ **to participate and lead in** health and development and the leadership ~~that~~ they demonstrate in ~~developing and~~ using **and developing** innovative technologies to meet **global and** local ~~and global~~ challenges ~~and act as agent of change~~ **to their health and development;**,

1. ~~ENDORSES~~ **REAFFIRMS** WHO's strategies that address the major health risks facing youth and include specific interventions for this age group;

2. URGES Member States to accelerate action, as appropriate, and develop ~~a coherent national policy~~ **policies and plans to address** the main determinants of health ~~in~~ **affecting**

young people, including health-related behaviours and their impact on health at later stages in life **by**:

(1) ~~ensuring that~~ **adopting** national health policies and strategies **that** contain specific targets and indicators on relevant determinants including assets, and outcomes of youth health and well-being;

(2) reviewing and revising policies in health and other areas with a view to including measures to protect young people from harm (e.g. early childbearing, sexual exploitation and violence, use of illicit substances and tobacco, harmful **use of** alcohol ~~use~~, lack of physical activity, unhealthy diet and obesity, road traffic and other injuries, and mental **health** problems);

(2bis) reviewing and revising policies in health and other areas to eliminate all forms of discrimination experienced by youth;

(3) ~~ensuring that~~ **putting in place** systems for health management information and vital registration **that** provide up-to-date age- and sex-specific data, given the existing gap in the data regarding young people's health;

(4) ~~ensuring~~ **promoting** the responsiveness of the health system to adolescents' needs, including health workforce development and financing in order to remove barriers to access to youth-friendly health **care** services;

(5) ~~ensuring~~ **providing** access to contraception; **reproductive health** care ~~during pregnancy and childbirth~~ **services**; prevention, treatment **and** care of HIV**/AIDS** and sexually transmitted infections and associated support; mental health services; and trauma care;

(6) ~~ensuring~~ **promoting** access to accurate information and evidence-based approaches that promote healthy behaviour, for example health information on sexual and reproductive health;

(7) ~~applying~~ **promoting collaboration** ~~a~~ **a**cross sector~~al~~**s** ~~approach~~ **at all levels on** ~~to~~ young people's health ~~and~~ including aspects related to health in sectors such as education, social inclusion, **social and physical environments,** employment, and the media **and with** ~~including~~ civil society organizations **and the private sector, as appropriate;**

(8) involving different actors, such as families, ~~and~~ communities **and youth themselves,** in addressing determinants and health risks of young people, and mobilizing stakeholders in order to detect and help young people at risk or with a disadvantaged background;

(9) supporting the role of young people, with special attention to youth organizations, with a view to facilitating young people's empowerment and participation in influencing their immediate environments and shaping health public policy;

3. ~~CALLS on~~ **ENCOURAGES** multilateral and bilateral donors, ~~and~~ international financial institutions **and international development partners** to ~~direct~~ **support Member States to carry out these efforts including through the provision of** ~~specific~~ financial and technical ~~resources to the~~ support ~~of Member States in order to carry out these efforts~~**, as appropriate;**

4. REQUESTS the Director-General:

(1) to ensure ~~harmonized attention to addressing the health risks of adolescents and young people in the next Medium-term strategic plan across programmes and levels of the Organization in order to ensure provision of sufficient technical support to Member States;~~**appropriate Organizational priority, commitment, effective coordination and adequate resources in order to specify further and expand the implementation of existing strategies as they apply to young people and to regularly monitor the results for adolescents' health;**

(2) to ~~ensure appropriate oganizational priority, commitment, coordination and resources in order to specify further and expand the implementation of existing strategies as they apply to young people and to regularly monitor the results for adolescents' health~~ **address the health risks of adolescents and young people in the next Medium-term strategic plan across programmes and levels of the Organization in order to provide sufficient technical support to Member States;**

(3) to ~~encourage~~ **identify knowledge gaps** and ~~conduct~~ **facilitate** research that will strengthen the evidence base needed to establish, deliver and monitor effective and age- and gender-appropriate programmes for adolescents and youth;

(4) to ~~sustain current productive~~ **continue to collaborate, as appropriate, with** ~~bodies~~ **organizations** in the United Nations system and civil society ~~organizations as well as those in order~~, **and the private** sector~~s~~ that have a bearing on young people's health;

(5) to ~~support~~ strengthen~~ing~~ the **Organization's** capacity ~~of health ministries and~~ **to provide sufficient technical support on youth health to Member States, in particular health authorities, including strengthening capacity of** WHO ~~collaborating~~ centres ~~working to reduce risks to health~~ **such as the WHO Mediterranean Centre for Health Risk Reduction;**

(6) to ~~ensure~~ **promote** the participation and empowerment of young people as key stakeholders in health development, including in the ~~planned World Health Forum~~ **work of the Organization;**

(7) to ~~provide biennial progress reports, through the Executive Board,~~ **periodically report on the health of young people and the implementation of this resolution** to the World Health Assembly, ~~on the health of young people and progress in the implementation of this resolution~~ **through the Executive Board, with the first occasion being the Sixty-seventh World Health Assembly.**

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

1. Resolution Youth and health risks	
2. Linkage to programme budget	
Strategic objective:	Organization-wide expected result:
2. To combat HIV/AIDS, tuberculosis and malaria.	2.1. Guidelines, policy, strategy and other tools developed for prevention of, and treatment and care for patients with, HIV/AIDS, tuberculosis and malaria, including innovative approaches for increasing coverage of the interventions among poor people, and hard-to-reach and vulnerable populations.
3. To prevent and reduce disease, disability and premature death from chronic noncommunicable diseases, mental disorders, violence and injuries and visual impairment.	
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.	4.6. Technical support provided to Member States for the implementation of evidence-based policies and strategies on adolescent health and development, and for the scaling up of a package of prevention, treatment and care interventions in accordance with established standards.
6. To promote health and development, and prevent or reduce risk factors for health conditions associated with use of tobacco, alcohol, drugs and other psychoactive substances, unhealthy diets, physical inactivity and unsafe sex.	

7. To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches.

9. To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development.

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

This resolution links directly to indicator 4.6.1. In addition, it links to several of the indicators and targets for strategic objectives as set out in the Medium-term strategic plan 2008–2013 (Amended (Draft)) (revised version, April 2009).[1] The following indicators and targets are concerned: strategic objective 2, second point; strategic objective 3, all three points; strategic objective 6, all three points; strategic objective 7, first point; and strategic objective 9, third point.

3. Budgetary implications

(a) Total estimated cost for implementation over the life-cycle of the Secretariat's activities requested in the resolution (estimated to the nearest US$ 10 000, including staff and activities).

The lifetime of this resolution is estimated at 10 years (2011–2021). The estimated cost to the Secretariat for implementation of the resolution over this period at headquarters, the regional offices and country offices is US$ 105 million.

(b) Estimated cost for the biennium 2010–2011 (estimated to the nearest US$ 10 000 including staff and activities, and indicating at which levels of the Organization the costs will be incurred, identifying specific regions where relevant).

The estimated cost for the Secretariat at all levels during the remainder of the biennium would be US$ 5.3 million.

(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)?

Existing funds are insufficient to support all these costs. The estimated additional funds needed are US$ 530 000. The Secretariat will identify alternative sources of funding, to ensure sufficient funding levels to implement the resolution.

5. Administrative implications

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

Implementation in all regions and countries.

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

No.

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

Two additional regional staff are required at grade P4, one in each of the regional offices for Africa and the Western Pacific to ensure support for implementation of youth health in the region.

[1] Available online at http://apps.who.int/gb/ebwha/pdf_files/MTSP2009/MTSP3-en.pdf (accessed on 17 May 2011).

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

2011–2021.

Mr BEN AMMAR (Tunisia), introducing the draft resolution, observed that, in the 22 years since the Health Assembly had last discussed youth health, a generation had been born and grown up. Despite the heavy morbidity and mortality, with many deaths caused by road-traffic injuries and suicide, relatively little attention had been paid to the health of young people because it had been assumed that they were healthier than young children and older people; the sobering statistics in the report told a different story. Improving the health of young people was crucial to achieving Millennium Development Goals 5 (Improve maternal health) and 6 (Combat HIV/AIDS, malaria and other diseases) and to stemming the tide of noncommunicable diseases. The draft resolution was intended to encourage the development of national policies and strategies for young people's health and risk reduction, ensure that health systems were responsive to the needs of young people and provided them with adequate health-care services; and drew attention to the need for more effective coordination, monitoring and technical support in order to strengthen capacity and address the social determinants that affected young people's health.

The current generation of young people was a tribute to the health sector's success in ensuring child survival. Countries must continue to invest in the health and education of young people of both sexes, bearing in mind that they were the key to social and economic development. He urged Member States to support the draft resolution.

Dr AL HAJERI (Bahrain) said that young people represented a large proportion of her country's population. In general, they enjoyed good health, but they faced various health risks and economic, social and cultural challenges. In order to assist them in facing those challenges, her Government had implemented several high-level strategies, including a national youth strategy, launched in 2005, which was a key initiative for promoting young people's health. With WHO's support, Bahrain had undertaken several other initiatives, including introducing a national school health programme and plans covering tobacco control, HIV prevention and physical education. Those initiatives demonstrated her Government's commitment to the health of young people in order to promote lifelong health. She supported the draft resolution.

Mr VIEGAS (Brazil), expressing support for the draft resolution, said that most deaths of young people were preventable, being attributable to external causes such as violence and accidents. Young people's health was therefore very much a public health issue. Behaviours that often began in adolescence, including alcohol misuse, tobacco use, physical inactivity and inadequate nutrition, contributed to chronic noncommunicable diseases in adulthood and vulnerability to accidents and violence. Brazil was monitoring such health problems and their consequences. The statistics showed the importance of early public health intervention to promote, for example, healthy eating habits at school and at home. They also pointed to the importance of joint action between health and education authorities. Brazilian young people had participated in designing school-based programmes for the prevention of HIV and other sexually transmitted infections, which had been successful and which highlighted the importance of promoting the active participation and leadership of young people in youth health programmes.

Mr IBRAHIM (Egypt) suggested that in paragraph 2 of the draft resolution the phrase "in accordance with their respective national laws and regulations" should be added after "URGES Member States".

Dr NYONATOR (Ghana), speaking on behalf of the Member States of the African Region, said that interventions addressing young people's health risks were already on the health policy agenda in many countries of the African Region. Young people in the Region

contributed significantly to the economy and played an essential role in their families and communities. The adoption of policies and programmes promoting youth and adolescent health was therefore essential. A multisectoral approach involving the health, education, employment and other sectors was needed in order to address both health and non-health needs of young people and create an environment conducive to their development. Existing policies should be refined; new policies developed, including policies on the advertisement and sale of tobacco and alcohol; and institutional capacity for implementation and analysis should be increased.

Countries in the Region had adopted policy instruments and programmes to facilitate the development of national policies and strategies on sexual and reproductive health, HIV, mental health and promotion of healthy lifestyles. A regional framework for action designed to improve the health sector response to adolescent health needs had helped member countries to address nutrition, mental health, substance use and intentional and unintentional violence. He supported the draft resolution and endorsed the future directions outlined in the report. Other possible actions might include the strategic use of technology in order to reach young people and address their health needs, and the development and implementation of standards for young people's health and social services.

Mrs YAHAYA (Nigeria) said that adolescents and youth made up more than half the population of Nigeria and were confronted with major health challenges. Early onset of sexual activity and early marriage, which were prevalent, led to unwanted pregnancies, unsafe abortions and sexually transmitted infections, including HIV, and increased rates of maternal mortality and morbidity. More than half the unsafe abortions in Nigeria each year were performed on young women, who accounted for 40% of total maternal mortality. Lack of accurate information and limited access to adolescent-friendly health services contributed to the poor reproductive health of Nigerian young people.

Her Government had revised its adolescent health policy in 2008, and in 2009 had assessed the national response to young people's sexual and reproductive health needs. As a result, the clinical service protocol for youth-friendly health services had been revised and a training manual on adolescent health and development produced. Steps were being taken to expand the availability of youth-friendly health services, train health providers in providing youth-friendly services, refurbish and reorganize facilities to make them more attractive to young people, modify service hours and payment arrangements in order to facilitate young people's access to health services and increase funding for youth health and development programmes. She supported the draft resolution.

Dr MANSOOR (Iraq) suggested that the word "adolescents" should be added to the title of the report and resolution. Actions for the prevention, early detection and treatment of young people's health problems should be integrated into primary health care services and be an integral part of essential health services packages, which should include reproductive health services. Partnerships among sectors and stakeholders, including civil society, should be forged in order to compile data on health risks among adolescents and youth; raise awareness and educate young people about health risks, including HIV infection and noncommunicable diseases, and how to prevent them; transmit health messages to young people through school health programmes and through youth centres, Internet cafés and other places frequented by young people; provide psychological support to young people; harness the energies of young people and encourage them to develop their talents while discouraging bad habits; and train them to provide peer education.

Ms LAWLEY (Canada) supported the draft resolution and the health promotion and risk prevention approaches outlined in the report, which were in line with Canada's approach to youth health. Her Government was committed to enhancing the wellness of young people and reducing their health risks. It recognized that youth was a transitional period when life-long behaviours were established, setting the stage for future health outcomes, and that it was therefore a crucial period for promoting healthy living, including good nutrition and

maintenance of a healthy weight, physical activity and good mental health. Her Government was engaged in a range of information, education and programme interventions to address sexual health issues through a rights-based approach and prevention and treatment services.

Mr SUPRIYANTORO (Indonesia) welcomed the draft resolution, which addressed a critical issue with wide implications for development. In Indonesia young people represented almost one third of the population and were a valuable asset for the country's future. However, they faced significant health risks related to social economic, religious and cultural factors. Economic development, for example, had expanded the network of main roads, with rising mortality and disability due to road traffic injuries. The work to be undertaken on youth and health risks should be linked to that under the United Nations Secretary-General's Global Strategy for Women's and Children's Health in order to ensure that it contributed to progress towards Millennium Development Goals 4 and 5. Furthermore, the Secretariat should support Member States in providing health programmes and services for young people.

Mr McIFF (United States of America) said that the report could help to focus attention on the health of young people and encourage action at country level. It clearly identified the risk behaviours among young people that negatively affected their health and suggested appropriate interventions.

Welcoming the draft resolution, he said that the alternative text of the third preambular paragraph proposed by his delegation reflected the spirit of the original paragraph and cited the key instruments on which work with regard to youth and health risks was to be based, but did so in terms that were more accurate legally. He urged the Committee to support the amended version. He appreciated the amendment proposed by the delegate of Egypt on paragraph 2, but pointed out that the informal drafting group had agreed that the inclusion of the words "as appropriate" in that paragraph made a reference to national laws and regulations unnecessary. There remained hesitancy on the part of some delegations about some language in the draft resolution, particularly in relation to access to services and education, and with a view to reaching consensus he proposed that in the twelfth preambular paragraph, "for example, age-appropriate" be inserted before "access".

Dr LAHTINEN (Finland), welcoming the draft resolution, highlighted the importance of promoting sexual and reproductive health among young people. Despite investments made by countries and the international community, the proportion of young people who had adequate knowledge about how to protect themselves against HIV infection remained far below the 95% target set during the special session of the United Nations General Assembly on HIV/AIDS in 2001. Nevertheless, in some countries young people were leading the HIV prevention revolution by delaying sexual initiation, limiting the number of their sexual partners and consistently using condoms, thereby reducing unwanted and unsafe pregnancies among adolescents and contributing to progress on Millennium Development Goal 5. The draft resolution sent a clear message to Member States and to the Director-General on crucial action for youth health and he supported its adoption.

Mrs TZIMAS (Germany) stressed the importance of prevention and information in reducing health risks among young people. Previously agreed action plans and strategies, such as the Global strategy to reduce the harmful use of alcohol, the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases and the WHO Framework Convention on Tobacco Control, set out many effective prevention interventions, which had already yielded positive results in her country. For example, smoking rates among young people aged 12 to 17 years had fallen from 28% to 13% and the percentage of young people who had never smoked had increased from 41% to 68% between 2001 and 2011. The draft resolution encouraged due attention to health issues relevant to young people and she fully supported it.

Mr CHIRINCIUC (Republic of Moldova) said that his Government wished to sponsor the draft resolution.

Mr KOVALEVSKIY (Russian Federation) said that young people's health was one of the main components of his country's national development strategy. A national survey conducted among young people aged 14 to 17 years, however, had found that they were not especially concerned about health issues or leading a healthy lifestyle. Unhealthy habits in youth represented health risks and could lead to ill-health and disease in adulthood, and he therefore welcomed WHO's efforts to improve the health of young people and to support government policy-making on the matter. He endorsed the draft resolution.

Dr REN Minghui (China) supported the recommendations and interventions outlined in the report. Behaviours during youth had a long-term impact on health in adulthood and the health of future generations. A multisectoral approach was required to tackle health risks in young people. WHO had a key role to play in promoting youth health and in providing advice and technical support regarding the most suitable interventions at country level, in particular for developing countries. He supported the draft resolution, but asked why the Secretariat considered it necessary to mobilize additional human and financial resources for its implementation.

Dr RUSLI (Malaysia) highlighted the importance of young people for the health and future well-being of all countries. A multisectoral approach was being applied in Malaysia to tackle the main health risks among young people, which included tobacco, alcohol and illicit drug use, road traffic injuries and sexual activity. National campaigns against tobacco and alcohol use had reduced smoking and drinking among youth. A holistic, multisectoral, gender-sensitive approach was required to address the health issues affecting young people. Families, communities and young people themselves should be involved. She called on the Secretariat to continue to provide the necessary support to Member States in order to improve the health and well-being of young people.

Ms ARRINGTON AVIÑA (Mexico), echoing the comments made by previous speakers, said that a joint, multisectoral approach was necessary to tackle the social determinants and risk factors affecting youth health. Mexico had incorporated age- and gender-specific youth health strategies into its national health agenda, and had national programmes addressing the specific sexual and reproductive health and other health care needs of young people. Action had been taken to reduce road traffic injuries and deaths and to promote early detection of mental health disorders. In August 2010 Mexico had hosted the World Youth Conference, demonstrating the importance that it attached to youth health issues. She supported the draft resolution.

Mr LAHLOU (Morocco) said that social and economic determinants were key influences on youth development. The health sector should ensure the right of young people to live in a healthy physical and social environment. Measures implemented to tackle youth health risks should be coordinated across institutions and should ensure that young people were equipped with the knowledge to enable them to lead a healthy and productive life in the future. A multisectoral approach, involving government and the private sector, was essential for the reduction of health risks. Young people should be involved in youth health programmes and activities in order to ensure their success and sustainability. Young people's involvement in school health programmes was particularly important. He commended WHO's efforts to promote youth health and expressed support for the draft resolution.

Mr MELLAH (Algeria) firmly supported the draft resolution. His Government attached great importance to the health and well-being of young people, who made up a large proportion of the country's population. National youth health programmes had been implemented to tackle the health risks affecting young people, especially tobacco and illicit

drug use and violence. The Government had also introduced several initiatives to promote higher education and professional training and reduce unemployment among young people.

Ms CREELMAN (Australia), affirming her support for the draft resolution, suggested that "AIDS" in the fourteenth preambular paragraph should be replaced by "HIV/AIDS".

Ms NGARI (Kenya) observed that the physical and emotional changes of adolescence made youth especially vulnerable to health risks such as substance abuse and sexually transmitted infections, and that lack of access to relevant information meant that they were often not well equipped to cope with those changes. Kenya had implemented a range of youth-friendly policies and programmes to reduce health risks in young people, including a national school health policy and a national road safety action plan, and had enacted legislation to curb tobacco and alcohol use among youths. Youth-friendly centres had been established in all primary and secondary health facilities. Because the period of youth encompassed a wide age range, interventions must be targeted and age-appropriate. Multisectoral approaches were needed. She requested support to enable countries in the African Region to expand interventions aimed at ensuring that young people developed into healthy and productive adults, and voiced support for the draft resolution.

Dr ARANYA CHAOWALIT (Thailand) strongly supported the draft resolution. It would not be possible to reduce youth health risks without modifying the behaviour of adults, who served as models for young people. Moreover, adults had created a social environment that made young people vulnerable to health risks and adults ran the companies that aggressively marketed harmful products to youths. The implementation of global policies to regulate such marketing techniques was essential. Many global policies, recommendations and strategies, including the WHO Framework Convention on Tobacco Control and the Global strategy on diet, physical activity and health were already being implemented, but more effort was needed in order to ensure that those tools were being used effectively to address youth health risks. Young people should be empowered and their involvement in health and social development should be encouraged.

She welcomed the Director-General's commitment not to collaborate with the tobacco industry, but found it disappointing that she had not made a similar commitment in respect of manufacturers and marketers of unhealthy foods and beverages, especially alcohol. She requested information on the Secretariat's progress in implementing resolution WHA36.12, on alcohol consumption and alcohol-related problems, in particular with regard to selection of that topic as a theme for a future World Health Day. She and other delegations had repeatedly urged that alcohol-related problems be selected as the theme of World Health Day, but that had not yet happened.

Dr MOHAMMAD KHAMIS (United Arab Emirates) said that priority should be given to youth health issues and allocation of the necessary resources. Laws should be enacted to regulate risk factors and strengthen the protection of young people. More data on the health of young people were needed if effective, evidence-based youth health policies were to be developed. To that end, her Government had undertaken several school-based health surveys in order to identify the principal health risks to which young people were exposed and devise prevention strategies, targeting young adolescents in particular in order to halt unhealthy behaviours as early as possible. Recognizing the importance of youth for the future development of the country, her Government had implemented various policies and programmes aimed at improving the health of young people and discouraging unhealthy lifestyles. She underlined policy coordination and multisectoral, interministerial collaboration in order to identify and address youth health risks.

Dr AL-GHAFIRIYA (Oman) said that her Government attached great importance to youth health and had implemented programmes targeting young people, including programmes on school health, prevention of HIV infection, improvement of nutrition, and

mental health. In spite of those measures, many health risks remained, such as road traffic injuries and other physical and mental health risks. Stressing the need to involve civil society in tackling youth health risks, she expressed support for the draft resolution.

Mr MAULUDU (Papua New Guinea) supported the draft resolution. His country was experiencing rapid changes in lifestyle related to urbanization, which was creating new health risks for young people. Efforts were currently under way to collect the data needed in order to determine the extent of problems such as unintentional injuries and violence and mental and neurological disorders in the youth population. Programmes on sexual and reproductive health problems among young people had been implemented, and condoms had been made widely available, which had helped to reduce new cases of HIV infection. Additional measures sought to promote good nutrition and discourage alcohol and illicit drug use. He welcomed the technical support that WHO was providing to his country and others to address youth health risks and issues.

Mr WOJDA (Poland) said that, although his Government fully supported the efforts of the international community to reduce the health risks affecting young people, the provision of reproductive health-care services must be carried out in accordance with national legal frameworks.

Ms MATALAVEA (Samoa) welcomed the draft resolution, which would help to ensure that high priority was given to youth and health risks at the global, regional and national levels. Her Government attached great importance to the health of young people and recognized that actions aimed at reducing youth health risks would yield high returns in the future. If the country's main health problems were to be dealt with effectively, it was essential to address the specific health issues affecting youth, in particular the negative effects of globalization and urbanization on their health and behaviour. She fully supported the draft resolution and urged speedy consensus on the various proposed amendments.

Professor ARSLAN (Bangladesh) said that his country had made considerable progress towards the achievement of Millennium Development Goals 4 and 5, but further targeted action on youth health issues was necessary. The principal risks included early marriage and pregnancy, HIV and other sexually transmitted infections, undernutrition, anaemia, obesity, tobacco and alcohol use, suicide and unintentional injuries and violence. It was crucial to address those risks, given the long-term impact that behaviours in youth had on health in adulthood.

Many countries in the South-East Asia Region, including Bangladesh, were focusing on the provision of youth-friendly health care. In 2005, his Government had adopted national standards for the delivery of quality health services to young people. It had also committed to ensure that one third of primary health care centres were providing youth-friendly services by 2015. However, advocacy work was necessary to encourage young people to avail themselves of those services. He supported the draft resolution.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) said that her Government's approach to young people's health was in line with the approach advocated in the resolution, including targeting the most vulnerable groups, addressing risk behaviour, collecting and sharing evidence and coordinating activities across sectors. She supported the draft resolution.

Mr KESKINKILIÇ (Turkey) welcomed the report, although it had not given sufficient attention to the risks posed by the use of the Internet, and supported the draft resolution. Noting that the draft resolution requested the Director-General to collaborate with other bodies in the United Nations system, he urged her to work with ITU to promote Internet safety.

Ms BENJEDDI (International Federation of Medical Students Associations), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and its recognition of the role that young people could play in solving health problems and promoting healthy lifestyles. Social and economic factors, such as limited access to education and health care and unequal distribution of resources, had a negative impact on the health of young people, and it was to be hoped that those issues would be addressed at the forthcoming World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, 19-21 October 2011). Adolescent girls were a particularly vulnerable group, as they were at risk of unwanted pregnancy, violence, HIV infection, poor nutritional status and lack of access to education. Their health should be a priority. The health of young people could be improved by ensuring access to higher education and information through the use of social media and communication technologies, and her organization encouraged governments to make use of such resources in their national strategies on youth health. Peer education was also of great value in promoting health and reducing risks among young people. She expressed the hope that Member States would take advantage of the knowledge and resources that medical students could provide.

Mr Shin-Lan KOONG (Chinese Taipei) said that efforts to address health risks among young people should take account of culture-specific issues, such as the problem of betel quid consumption, which was common in Chinese Taipei and elsewhere. Surveillance was essential in order to identify and prioritize youth health risks, and Chinese Taipei regularly carried out youth behaviour surveys for that purpose. Preventing road traffic injuries was a priority in Chinese Taipei, which had introduced legislation requiring helmet and seat belt use.

Noncommunicable diseases in adulthood were related to behaviour adopted during adolescence, especially smoking, drinking and lack of physical activity. It was important for governments to invest in preventing risks and promoting healthy attitudes and to put in place regulations to ensure that youths under the age of 18 years could not gain access to tobacco, alcohol or other harmful substances. School-based programmes were effective, and Chinese Taipei had been focusing on health promotion in schools. It would welcome the opportunity to share its experiences with others.

Dr MASON (Child and Adolescent Health and Development) thanked the Government of Tunisia for proposing the inclusion of youth and health risks on the governing bodies' agendas. Young people were an important group from a public health standpoint, and insufficient attention had been paid to their health needs. The resolution would strengthen attention to those needs and therefore contribute to the attainment of Millennium Development Goals 4, 5 and 6, and would also serve as a reminder of the importance of young people's health to decision-makers in other forums, such as the forthcoming high-level meetings on noncommunicable disease and HIV/AIDS.

As had been emphasized by many delegates, it was important to empower young people to take responsibility for their own health and to involve them in decision-making about health programmes. Youth-friendly health services, which had also been mentioned, were vital to ensure better access to health care for young people. Road traffic injuries were a leading cause of death among young people, and it was essential, particularly at the start of the Decade of Action for Road Safety, to ensure that young people played an integral part in the actions to be undertaken.

Responding to the question raised by the delegate of China about resources, she explained that the cost of implementing the draft resolution could be largely covered using existing and expected resources; however, additional staff would be required at regional level to ensure provision of adequate support to Member States, and additional financial resources would therefore be needed.

Dr POZNYAK (Management of Substance Abuse), responding to the comments by the delegate of Thailand, said that the Secretariat's interaction with the alcohol industry was guided by resolutions and the mandates it received from the governing bodies and never took the form of collaboration or partnership. The Secretariat, together with Member States, had

done extensive work in recent years to draw attention to the health problems associated with alcohol consumption, culminating in 2010 in the adoption of the Global strategy to reduce the harmful use of alcohol, which was currently being implemented. Among other activities, the Global Information System on Alcohol and Health had been strengthened considerably, and the *Global status report on alcohol and health*[1] had been published in February 2011. The Secretariat was currently developing technical tools to support Member States' efforts to combat the harmful use of alcohol.

Dr DAYRIT (Secretary) read out the proposed amendments to the draft resolution. The delegate of the United States of America had proposed an alternative text for the third preambular paragraph, to read: "Recalling the right of everyone, including adolescents and youth, to the enjoyment of the highest attainable standard of physical and mental health, also recalling the International Covenant on Economic, Social and Cultural Rights, the United Nations Convention on the Rights of the Child, the United Nations Convention on the Elimination of All forms of Discrimination against Women and other international and regional human rights instruments, and emphasizing the need to promote the equality of young women and men and respect for diversity." The same delegate had proposed that in the twelfth preambular paragraph "provide young people with access" should be amended to read "provide young people with age-appropriate access" and that "ensuring that adolescents have information" should be amended to read "ensuring that adolescents have age-appropriate information". In the fourteenth preambular paragraph, the delegate of Australia had proposed that "AIDS" should be changed to "HIV/AIDS". In paragraph 2, the delegate of Egypt had proposed that "in accordance with their national laws and regulations" should be inserted after "Member States", but that proposal had not been supported by the delegate of the United States of America.

The CHAIRMAN asked whether the Committee wished to approve the draft resolution as amended.

Dr LAHTINEN (Finland) supported the proposed amendments to the third, fourth and twelfth preambular paragraphs. He recalled that the informal drafting group had inserted the phrase "as appropriate" in paragraph 2 in response to concerns raised by several delegates. He had consulted with the concerned parties and, in a spirit of compromise, proposed that the Committee accept the proposal by the delegate of Egypt and delete the phrase "as appropriate".

Dr EL SAYED (Egypt) agreed with the solution proposed by the delegate of Finland.

Ms ARRINGTON AVIÑA (Mexico) supported the proposed amendment to the third preambular paragraph. She suggested that in the twelfth preambular paragraph the word "ensuring" should be rendered "*garantizar*" in the Spanish-language version of the text.

Ms LAWLEY (Canada), supported by Dr LAHTINEN (Finland) and Mr McIFF (United States of America), pointed out that the phrase "as appropriate" in paragraph 2 referred to "accelerating action". That being the case, it should not be deleted.

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

[1] *Global status report on alcohol and health 2011*. Geneva, World Health Organization, 2011.

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

Mr Dukpa took the chair.

Progress reports: Item 13.17 of the Agenda (Document A64/26)

A. Poliomyelitis: mechanism for management of potential risks to eradication (resolution WHA61.1)

Dr PRASITCHAI MANGJIT (Thailand) said that the reported progress demonstrated the great effort and commitment by Member States to eradicating poliomyelitis. Certain concerns remained. The delay in the detection of outbreaks and re-establishment of polioviruses in certain countries indicated weak surveillance systems and the need to sustain a sufficiently high vaccination rate. Although the continuing gaps in vaccination coverage stemmed from operational problems, increasing community involvement, public acceptance of vaccination services and supplementary immunization activities could improve coverage. Given the persistent funding shortfalls, he called on the Secretariat to urge potential donors and Member States to make good those gaps, in order to achieve the global goal of a poliomyelitis-free world.

There had been no new case of poliomyelitis in Thailand since 1998 and his Government remained fully committed to the campaign to eradicate the disease.

Mr NABEEL (Pakistan) expressed appreciation of the Secretariat's collaboration with the Pakistani national authorities on the eradication of poliomyelitis. Since the launch of the Polio Eradication Initiative in his country in 1994, significant progress had been made, reducing the number of confirmed cases to 89 cases in 2009. Despite an increase in the number of cases in 2010, only 39 cases of poliomyelitis had been confirmed in the current year so far.

His Government had launched various initiatives to combat poliomyelitis, the latest being the National Emergency Action Plan 2011 for Polio Eradication, which included specific strategies to improve government oversight, address security issues, and reach migrant populations, with political commitment at the highest political level. National and provincial task forces had been created, and timelines set.

Although the fight against poliomyelitis continued to be an uphill struggle, compounded by security problems and serious flooding, no new case had been reported in the previous six months in the province of Punjab, home to 50% of the country's population, and no poliovirus type 3 had been detected during that time. The Government recognized the gravity of the situation. Planned measures included assisting those lowest administrative levels that had been identified as being at high risk, targeting migrant populations, improving the quality of vaccination campaigns by monitoring the more than 97 000 vaccination teams involved, and appealing for the continued support of international partners.

Dr KOBELA (Cameroon), speaking on behalf of the Member States of the African Region, recalled that by 2008 all but four Member States had interrupted the indigenous transmission of wild poliovirus. In 2010, 598 cases of poliomyelitis had been confirmed in 12 countries in the Region, 11% fewer than in 2009. However, a new outbreak had been confirmed in Congo in September 2010, with 382 reported cases. Moreover, there were concerns regarding the quality of monitoring at district level, for example the long chains of wild poliovirus transmission in Uganda had been linked to transmission in Kenya in February 2009. Furthermore, by mid-May 2011, 106 cases of wild poliovirus had been recorded in

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA64.28.

central Africa, including 52 in Chad, 48 in the Democratic Republic of the Congo, 4 in Angola, 1 in the Congo and 1 in Gabon.

One of the main objectives of the Strategic Plan of the Global Polio Eradication Initiative 2010-2012 was to stop all poliovirus transmission in at least two of the four countries with endemic poliomyelitis by the end of 2011. Angola, Chad and Nigeria had introduced emergency measures. In 2010, Nigeria had recorded only 21 cases of wild poliovirus, a drop of 95% in comparison with 2009. The other countries in the Region had remained vigilant in order to avoid re-transmission. Cameroon had introduced measures to strengthen political commitment to eradicating poliomyelitis, engaging local leaders and neighbouring States at risk of importing the virus, in order to ensure full acceptance of and participation in poliovirus vaccination campaigns. The results were encouraging. Three-dose vaccination coverage with oral poliomyelitis vaccine nationally had risen from 79.0% in 2009 to 83.2% in 2010. No wild poliovirus had been detected in 2010.

Challenges remained; the lack of financial resources, shortage of appropriate vaccines, and insufficient technical assistance could impede progress towards the goals of the Strategic Plan 2010–2012. It was also vital to maintain a high level of political engagement and improve the quality of prevention and eradication campaigns.

She thanked all the technical and financial partners for their support and expressed confidence that, if the relevant conditions were met, the countries in the Region would succeed in interrupting the transmission of poliovirus by 2012.

Dr DJIGUEMDE (Burkina Faso) thanked all the partners helping his country to interrupt the spread of wild polioviruses; it had been able to conduct several vaccination campaigns, step up routine vaccination and carry out surveillance at all levels. In 2010, no wild poliovirus had been detected. However, in view of his country's location and regional population movements, it would need further support to achieve eradication.

Professor ARSLAN (Bangladesh) said that it was evident that, despite successful efforts towards global eradication of poliomyelitis, attainment of the second milestone of the Strategic Plan 2010–2012 was at risk because of persistent transmission of poliovirus in some countries and that the third might not be reached owing to operational difficulties. Moreover, the international spread of wild polioviruses posed a substantial risk to achieving the goal of eradication. According to a recent study, completing eradication would result in total savings worldwide of US$ 42 000 million over the period 1988–2035 but it was important to stress the improvement to quality of life and the number of people benefiting. He expressed concerns that 38% of the US$ 1860 million budget of the Global Polio Eradication Initiative for 2011–2012 remained unfunded; it was to be hoped that the shortfall would be made up.

Most countries in the South-East Asia Region were poliomyelitis-free. Thanks to political commitment, strong vigilance and prompt action to interrupt transmission, there had been no case in Bangladesh since November 2006. All the global and regional strategies recommended by WHO to interrupt wild poliovirus circulation were being implemented and supplementary immunization activities were being continued; child vaccination coverage exceeded 99%; and acute flaccid paralysis surveillance was being maintained at international standards. The country's immunization programme consistently achieved high coverage rates. Preventing re-infection remained a challenge for all countries in the Region. Bangladesh would need assistance with maintaining a high level of immunity, ascertaining for how long it should conduct periodic risk assessment to determine the risk of re-infection and deciding whether to conduct immunization campaigns.

Dr SUGIURA (Japan), expressing appreciation of the report, welcomed the significant drop in the number of cases reported in India and Nigeria over the previous year and the declining incidence of wild poliovirus worldwide. He expressed concern, however, at the increased number of countries with re-established poliovirus transmission and the broader geographical spread. The importation of wild polioviruses and the emergence of countries

with re-established poliovirus transmission were matters of global public health interest, which was why Japan set great store by the Global Polio Eradication Initiative.

Although eradication of smallpox had raised hopes for the eradication of poliomyelitis, political momentum had to be maintained and further financing had to be found. A broader range of international stakeholders needed to make eradication a priority. Successful eradication programmes were grounded in strong political commitment and partnership. WHO must use its influence to convince politicians and religious leaders in countries with endemic poliovirus transmission of the importance of controlling the disease. The correct balance needed to be struck between routine vaccination and supplementary immunization. In particular, in the four remaining countries with endemic transmission and countries with re-established transmission, routine immunization programmes would have to be strengthened.

Dr MANSOOR (Iraq) said that combating poliomyelitis was important as it was closely linked to other primary health matters. Surveillance of acute flaccid paralysis should be regarded as a public safety issue. Eradication could be achieved only through adequate surveillance, high vaccination coverage rates and systematic immunization of children under the age of five years. Cooperation with neighbouring countries on all eradication-related activities, enhanced capacity building, and sharing of expertise between countries and regions were crucial. In Iraq, administration of a third dose of vaccine to children had improved results, despite practical difficulties caused by the security situation in the country. Recently, the detection rate of cases of acute flaccid paralysis had risen to 3 per 100 000 population (i.e. above the recommended rate of 2 per 100 000 population) under the age of 15 years. There had been no case of poliomyelitis in Iraq since January 2000.

Mrs YAHAYA (Nigeria) noted the report and confirmed that cases of poliomyelitis in her country had declined by 95% from 2009 to 2010. The reduction in transmission had been due to progress in improving programme quality, community commitment and child vaccination coverage. Despite the steep decline in transmission, all three serotypes of poliovirus persisted in Nigeria, owing to gaps in immunization, including the failure to vaccinate children in several high-risk areas, and poor surveillance. In 2011, Nigeria had so far confirmed eight cases of wild poliovirus (types 1 and 3). In April 2011, the Independent Monitoring Board of the Global Polio Eradication Initiative, which had been advised that Nigeria was at moderate risk of not interrupting transmission by the end of 2011, had commended Nigeria's progress towards eradication since 2009, but highlighted major gaps in vaccination and surveillance quality and the decline in political commitment during the election period. It acknowledged the Government's plans for action. The progress made could be attributed to greater political commitment since 2009, in particular among traditional leaders in the high-risk northern states. Lessons learnt from that partnership would be applied to secure sustained engagement among key religious leaders in the highest-risk states.

Nationwide rounds of vaccination had taken place, with funding from the Federal Government towards operational costs. The improvement of routine immunization had resulted in a national rate of coverage with three doses of oral poliomyelitis vaccine of 73.9%, significantly higher than the 37% coverage reported in 2006. A comprehensive emergency action plan for the high-risk areas had been drawn up and its implementation would be closely monitored by national coordination committees. A major challenge to implementing the Global Polio Eradication Initiative in Nigeria was inadequate funding: of the estimated US$ 275 million required for 2011–2012, there was a US$ 128 million shortfall. Furthermore, the decline in confirmed cases had led to complacency among political leaders and health workers. The emergency action plan was intended to reverse that attitude because even more progress would be needed to interrupt transmission by the end of 2011. She thanked WHO and all other partners for their support.

Dr RUSLI (Malaysia) expressed her country's appreciation of WHO's work on eradicating poliomyelitis and congratulated the European Region for its swift control of the 2010 outbreak. As wild poliovirus type 2 had been eradicated, and given the need for

countries to stockpile vaccines in order to respond to the importation of wild polioviruses, bivalent oral poliomyelitis vaccine should be mass produced, and WHO should examine mechanisms to ensure that those vaccines were affordable and accessible. She appreciated the commitments of countries with endemic poliovirus transmission to reduce or minimize the threat of spread, but she urged them to make a commitment to achieving eradication in the near future.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland), welcoming the progress made towards eradication of poliomyelitis, said that the decline in cases in India and Nigeria offered grounds for cautious optimism. Nevertheless, the outbreaks in the Democratic Republic of the Congo and Tajikistan and the situation in Pakistan were sober reminders of the fragile situation in Africa and Asia. The current year would reveal whether the progress made in 2010 was part of a cycle or the beginning of a sustained trend towards full eradication. That goal would be achieved with commitment to significantly stronger routine immunization and sustained worldwide political engagement, especially in the countries with endemic poliovirus transmission and those with re-established transmission. The funding shortfall was serious, but her Government had recently announced a doubling of its financial contribution to the Global Polio Eradication Initiative over the next two years, with a built-in challenge element designed to encourage other donors to contribute. All countries had an interest in helping to make up the existing budget shortfall in order to make eradication a reality.

Mr BLAIS (Canada) warned that the eradication of poliomyelitis could not be achieved without further funding. He urged all countries and other donors to increase their contributions towards the eradication of poliomyelitis, the goal set for the end of 2012. Political commitment to taking action at the national and international levels was vital.

Ms ZHANG Xiaobo (China) welcomed the remarkable progress made in 2010, in particular the significant decline in the number of wild poliovirus isolations reported in India and Nigeria. Nevertheless, WHO must be more proactive in meeting the challenges posed by countries with new outbreaks due to an imported poliovirus and those with re-established poliovirus transmission; the outbreak in Tajikistan was particularly alarming.

The international community must make eradication a priority and set aside more financial and other resources in order to meet the targets set in the Global Polio Eradication Initiative. WHO should provide more support to countries at risk of importing polioviruses. In her country, for example, transmission of the disease had been interrupted in 2000 but there was a risk of importation from neighbouring countries where the viruses had been endemic. She appealed to the Secretariat for help, in particular for country-specific immunization programmes.

Mr KOVALEVSKIY (Russian Federation) stressed the importance of eradication of poliomyelitis and the risk of importation of wild polioviruses in particular. He drew attention to inaccuracies in paragraph 5 of the progress report: there had been no outbreak of the disease in 2010 and no case of poliomyelitis in the Russian Federation in 2011; imported cases had been detected and isolated in good time. He asked for the text to be corrected.

Dr AL HAJERI (Bahrain) recalled that her country had made significant progress against communicable diseases, including poliomyelitis, from which it had been free since 1994. Its monitoring and surveillance programme had helped to prevent any case due to wild poliovirus. The national vaccination campaign conducted since 1981, with WHO's help, had been an important tool for combating the disease. In 2010 99.6% of the population had received three doses of poliomyelitis vaccine; the first oral dose had been replaced by an injection. Local, regional and international cooperation to eradicate the disease was essential. She was confident that Bahrain would remain poliomyelitis-free.

Dr KOUILLA (Gabon), congratulating the Secretariat on its coordination of the international fight to eradicate poliomyelitis, said that, although Gabon did not qualify for support for vaccination, it was committed to eradicating poliomyelitis by means of strict management in every health district. In 2010 there had been an outbreak of the disease in the neighbouring Congo, which had led the Government to plan and finance a three-stage preventive vaccination campaign. He requested support for the country's health system at the national and local levels, without which it would be unable to achieve eradication.

Ms DE MORA (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, welcomed the progress made in 2010 towards eradicating poliomyelitis, thanks to the priority accorded by governments and the global community. The fact that more than 80% of cases in 2010 had been in non-disease-endemic countries highlighted the vulnerability of the rest of the world. The outbreak in Tajikistan had been especially alarming but the country's Red Crescent Society had supported the emergency response. Similarly, the Congolese Red Cross had responded to the outbreak in Congo. Timely outbreak response operations had greatly improved, but routine immunization systems had to be strengthened in order to prevent outbreaks. Her Federation agreed with the Independent Monitoring Board that greater attention should be paid to the elements of social mobilization and communications in the Strategic Plan 2010–2012. In 2010 more than 20 000 volunteers from her Federation had assisted with vaccination rounds in Africa, Asia and Europe. The Federation would continue to support the Strategic Plan 2010–2012 in order to eradicate poliomyelitis.

Mr NICOSIA (Rotary International), speaking at the invitation of the CHAIRMAN, reiterated Rotary International's commitment to eradication of poliomyelitis. Rotary International had donated more than US$ 1000 million to support eradication in 122 countries over 20 years, in which time incidence had declined by 99%. It would continue to do all it could to achieve full eradication. In April 2011, the Independent Monitoring Board had identified the US$ 665 million shortfall in funding for global eradication as the major threat to achieving that goal. Rotary International was therefore fast-tracking a donation of US$ 80 million. He appealed to other donors to match that commitment and to all countries and partners to ensure that their poliomyelitis campaigns were well executed with surveillance of the highest quality. Money alone would not eradicate the disease; the remarkable progress made in India and Nigeria had been made thanks to full commitment at every political level. He urged Angola, Chad, the Democratic Republic of the Congo and Pakistan to intensify their district-specific efforts to achieve eradication of poliomyelitis.

Dr AYLWARD (Assistant Director-General) agreed that the Global Polio Eradication Initiative was at a pivotal point. Striking progress had been made towards eradication, with only 12 cases of wild poliovirus type 3 reported to date in 2011. According to the Independent Monitoring Board, eradication would be achieved in the near future, although possibly not by the end of 2012. Nevertheless, broad application of the best practices that had led to the remarkable success in India and Nigeria could result in complete eradication by the deadline of the current Strategic Plan.

Financing was indeed the major challenge. Despite generous contributions, there remained a budget shortfall of US$ 665 million, and some activities had already had to be cut. The Director-General had been personally involved in the outreach to existing partners, in particular the world's richest countries, and to a broader group of new stakeholders. That effort had been complemented by generous contributions by Rotary International and the Bill & Melinda Gates Foundation and key partners, such as the Government of the United Kingdom of Great Britain and Northern Ireland. Important new donors, such as the Crown Prince of Abu Dhabi, had made contributions. He thanked the delegate of Bangladesh for highlighting the new economic analysis indicating that the incremental net benefits of completing poliomyelitis eradication aggregated over the period 1988–2035 would be at least US$ 50 000 million.

The Strategic Plan 2010–2012 included pre-emptive campaigns to stop the international spread of the disease and rapid responses to new outbreaks. The Independent Monitoring Board had decided to monitor quarterly performance and risks. Those risks had been highlighted by the outbreaks in 2010 in Congo and Tajikistan. The main current threats to eradication were to be found in Pakistan and the countries with re-established poliovirus transmission. He agreed that the latter needed to be paid increased attention. The Director-General and WHO's partners would provide the countries where poliovirus transmission had been re-established with the same level of support as that given to countries with endemic poliovirus transmission in order to achieve the 2012 goal.

All partners recognized the need to strengthen routine immunization in order to secure a poliomyelitis-free world. India and Nigeria had recently reported that over the previous five years they had succeeded in carrying out aggressive eradication measures at the same time as stepping up their immunization programmes in the highest-risk areas. WHO had already begun cooperation with the GAVI Alliance to strengthen routine immunization. Significant progress had been made in 2010 on preparing for the post-eradication era, with the publication of studies outlining new strategies to reduce the cost of vaccination in low-income settings with inactivated poliovirus vaccine in the post-eradication era. Negotiations with UNICEF on a stockpile of monovalent vaccines were nearing completion, and new antiviral agents were in the pipeline.

He assured the delegate of the Russian Federation that any errors in the progress report would be corrected as appropriate.

The Director-General and key partners had agreed that they would meet on a quarterly basis to review the assessment of the Independent Monitoring Board in order to support all Member States with eradication through application of the best practices. Increasing emphasis would be laid on post-eradication issues, including cessation of the use of trivalent vaccines and introduction of bivalent vaccine in advance of stopping the use of oral vaccines and routine immunization programmes after eradication. WHO and its partners were fully committed to acting in accordance with the recommendations of the Independent Monitoring Board in order to meet the end-2012 deadline for eradication.

The meeting rose at 12:35.

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