



WORLD HEALTH ORGANIZATION

SIXTY-FIFTH WORLD HEALTH ASSEMBLY

GENEVA, 21–26 MAY 2012

SUMMARY RECORDS OF COMMITTEES

REPORTS OF COMMITTEES

LIST OF PARTICIPANTS

GENEVA
2012

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

| | | | |
|-------|---|--------|--|
| ACHR | – Advisory Committee on Health Research | OIE | – <i>Office International des Epizooties</i> |
| ASEAN | – Association of Southeast Asian Nations | PAHO | – Pan American Health Organization |
| CEB | – United Nations System Chief Executives Board for Coordination | UNAIDS | – Joint United Nations Programme on HIV/AIDS |
| CIOMS | – Council for International Organizations of Medical Sciences | UNCTAD | – United Nations Conference on Trade and Development |
| FAO | – Food and Agriculture Organization of the United Nations | UNDCP | – United Nations International Drug Control Programme |
| IAEA | – International Atomic Energy Agency | UNDP | – United Nations Development Programme |
| IARC | – International Agency for Research on Cancer | UNEP | – United Nations Environment Programme |
| ICAO | – International Civil Aviation Organization | UNESCO | – United Nations Educational, Scientific and Cultural Organization |
| IFAD | – International Fund for Agricultural Development | UNFPA | – United Nations Population Fund |
| ILO | – International Labour Organization (Office) | UNHCR | – Office of the United Nations High Commissioner for Refugees |
| IMF | – International Monetary Fund | UNICEF | – United Nations Children’s Fund |
| IMO | – International Maritime Organization | UNIDO | – United Nations Industrial Development Organization |
| INCB | – International Narcotics Control Board | UNRWA | – United Nations Relief and Works Agency for Palestine Refugees in the Near East |
| ITU | – International Telecommunication Union | WFP | – World Food Programme |
| OECD | – Organisation for Economic Co-operation and Development | WIPO | – World Intellectual Property Organization |
| | | WMO | – World Meteorological Organization |
| | | WTO | – World Trade Organization |

The designations employed and the presentation of the material in this volume do not imply the expression of any opinion whatsoever on the part of the Secretariat of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Where the designation “country or area” appears in the headings of tables, it covers countries, territories, cities or areas.

PREFACE

The Sixty-fifth World Health Assembly was held at the Palais des Nations, Geneva, from 21 to 26 May 2012, in accordance with the decision of the Executive Board at its 129th session.

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¹ Adopted at the second plenary meeting.

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¹ Including election of Vice-Chairmen and Rapporteur.

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- E. Eradication of dracunculiasis (resolution WHA64.16)
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- N. Advancing food safety initiatives (resolution WHA63.3)
- O. Climate change and health (resolutions EB124.R5 and WHA61.19)
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| A65/1 Rev.1 | Agenda ¹ |
| A65/2 | Report of the Executive Board on its 129th, 130th and special sessions |
| A65/3 | Address by Dr Margaret Chan, Director-General, to the Sixty-fifth World Health Assembly |
| A65/4 Rev.1 | Director-General Approval of contract ² |
| A65/5 | WHO reform Consolidated report by the Director-General |
| A65/5 Add.1 | Draft Twelfth General Programme of Work and explanatory notes |
| A65/5 Add.2 | Independent evaluation report: stage one |
| A65/5 Add.3 | Draft decision proposed by the Secretariat |
| A65/6 and A65/6 Add.1 | Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control |
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¹ See page xi.

² See document WHA65/2012/REC/1, Annex 1.

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| A65/11 and A65/11 Corr.1 | Maternal, infant and young child nutrition: draft comprehensive implementation plan ¹ |
| A65/12 | Nutrition of women in the preconception period, during pregnancy and the breastfeeding period |
| A65/13 | Early marriages, adolescent and young pregnancies |
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| A65/19 | Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report of the Advisory Group |
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| A65/22 | Draft global vaccine action plan ³ |

¹ See document WHA65/2012/REC/1, Annexes 2 and 5.

² See document WHA65/2012/REC/1, Annex 5.

³ See document WHA65/2012/REC/1, Annexes 4 and 5.

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| A65/22 Add.1 | Report on financial and administrative implications for the Secretariat of resolutions proposed for adoption by the Executive Board or Health Assembly ¹ |
| A65/23 | Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States |
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| A65/35 | Report of the International Civil Service Commission |
| A65/36 | Amendments to the Staff Regulations and Staff Rules |

¹ See document WHA65/2012/REC/1, Annex 5.

- A65/37 Appointment of representatives to the WHO Staff Pension Committee
- A65/38 Election of the Director-General of the World Health Organization: report of the Working Group
- A65/39 Collaboration within the United Nations system and with other intergovernmental organizations
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- A65/44 Programme budget 2010–2011: performance assessment
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- A65/45 Financial report and audited financial statements for the period 1 January 2010–31 December 2011
Second report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fifth World Health Assembly
- A65/46 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution; and special arrangements for settlement of arrears; and assessment of new Members and Associate Members: South Sudan
Third report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fifth World Health Assembly
- A65/47 Report of the External Auditor
Fourth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fifth World Health Assembly

¹ See document WHA65/2012/REC/1, Annex 3.

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| A65/48 | Report of the Internal Auditor Fifth report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fifth World Health Assembly |
| A65/49 | Human resources: annual report Seventh report of the Programme, Budget and Administration Committee of the Executive Board to the Sixty-fifth World Health Assembly |
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| A65/51 | Committee on Credentials First report |
| A65/52 | Election of Members entitled to designate a person to serve on the Executive Board |
| A65/53 | First report of Committee B |
| A65/54 | Second report of Committee A |
| A65/55 | Third report of Committee A |
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| A65/57 | Third report of Committee B |
| A65/58 | Fourth report of Committee A |
| Information documents | |
| A65/INF.DOC./1 | Director-General Note by the Legal Counsel |
| A65/INF.DOC./2 | Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of the Syrian Arab Republic) |
| A65/INF.DOC./3 | Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Ministry of Health of Israel) |
| A65/INF.DOC./4 | Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report by the Permanent Observer of Palestine to the United Nations and other International Organizations at Geneva) |

A65/INF.DOC./5 Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan (report of the Director of Health, UNRWA, for the year 2011)

A65/INF.DOC./6 WHO reform
High-level implementation and monitoring framework

Diverse documents

A65/DIV/1 Rev.1 List of delegates and other participants

A65/DIV/2 Guide for delegates to the World Health Assembly

A65/DIV/3 Decisions and list of resolutions

A65/DIV/4 List of documents

A65/DIV/5 Address by Her Royal Highness Princess Lalla Salma to the Sixty-fifth World Health Assembly

A65/DIV/6 Address by Mr Jonas Gahr Støre, Foreign Minister of Norway, to the Sixty-fifth World Health Assembly

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President

Professor Thérèse Aya N'DRI-YOMAN
(Côte d'Ivoire)

Vice-Presidents

Dr Esperanza MARTÍNEZ (Paraguay)
Dr Andrei USATII (Republic of Moldova)
Professor ALI GHUFRON MUKTI
(Indonesia)
Dr Suraya DALIL (Afghanistan)
Mr Charles SIGOTO (Solomon Islands)

Secretary

Dr Margaret CHAN, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Guyana, Kyrgyzstan, Luxembourg, Malawi, Marshall Islands, Mexico, Niger, San Marino, Sao Tome and Principe, Thailand, United Arab Emirates, Viet Nam.

Chairman: Dr TRAN THI GIANG HUONG
(Viet Nam)

Vice-Chairman: Dr Robert GOERENS
(Luxembourg)

Secretary: Ms Françoise MOURAIN-SCHUT
(Senior Legal Officer)

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Bahamas, Cambodia, Chad, China, Cuba, Denmark, Djibouti, France, Kenya, Lesotho, Liberia, Mauritania, Nicaragua, Russian Federation, Turkmenistan,

United Kingdom of Great Britain and Northern Ireland, United States of America.

Chairman: Professor Thérèse Aya
N'DRI-YOMAN (Côte d'Ivoire)

Secretary: Dr Margaret CHAN, Director-General

MAIN COMMITTEES

Under Rule 35 of the Rules of Procedure of the World Health Assembly, each delegation was entitled to be represented on each main committee by one of its members.

Committee A

Chairman: Dr Lyonpo Zangley DUKPA
(Bhutan)

Vice-Chairmen: Dr Fenton FERGUSON
(Jamaica) and Mr Herbert BARNARD
(Netherlands)

Rapporteur: Dr Mohamed JIDDAWI (United
Republic of Tanzania)

Secretary: Dr Manuel DAYRIT, Adviser,
Office of the Director-General

Committee B

Chairman: Professor Mohammad Hossein
NICKNAM (Islamic Republic of Iran)

Vice-Chairmen: Professor Charles Kondi
AGBA (Togo) and Dr Enrique TAYAG
(Philippines)

Rapporteur: Dr Paul GULLY (Canada)

Secretary: Dr Clive ONDARI, Coordinator,
Medicines Access and Rational Use

PART I

**SUMMARY RECORDS OF MEETINGS
OF COMMITTEES**

GENERAL COMMITTEE

FIRST MEETING

Monday, 21 May 2012, at 10:35

Chairman: Professor T. N'DRI-YOMAN (Côte d'Ivoire)
President of the Health Assembly

1. ADOPTION OF THE AGENDA: Item 1.4 of the Agenda (Document A65/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 31 of the Rules of Procedure of the World Health Assembly, its first task was to consider the adoption of the agenda. In the absence of any objection, she took it that the Committee wished to recommend the deletion of two items included on the provisional agenda prepared by the Executive Board (document A65/1): item 6, Admission of new Members and Associate Members, as no new applications had been received; and item 16.4, Special arrangements for settlement of arrears, as there had been no request for any such arrangements.

It was so agreed.

The CHAIRMAN further took it that the Committee wished to recommend the adoption of the agenda, as so amended.

It was so agreed.

2. ALLOCATION OF AGENDA ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY: Item 1.4 of the Agenda (Documents A65/1 and A65/GC/1)

The CHAIRMAN said that the General Committee's recommendation on the adoption of the agenda would be transmitted to the Health Assembly at the second plenary meeting. In relation to item 2, Report of the Executive Board on its 129th, 130th and special sessions, she suggested that, since the Chairman of the Executive Board, was not present at the Health Assembly, the plenary should merely take note of the report (document A65/2). The Executive Board representatives would, in accordance with the usual practice, report in Committees A and B on the Board's deliberations and recommendations on specific agenda items. In reply to a request for clarification from the delegate of FRANCE, she added that such a proposal would mean that the Board's report would not be formally introduced in plenary, as it had been at previous Health Assemblies.

In reply to a question from the delegate of LIBERIA concerning the role of the Vice-Chairmen of the Executive Board, the DIRECTOR-GENERAL said that it would be possible to consult with the first Vice-Chairman to determine whether he would introduce the report in plenary instead.

The LEGAL COUNSEL confirmed that it was indeed the role of the first Vice-Chairman to take over as Chairman in the Chairman's absence. He endorsed the view expressed by the

Director-General, adding that the proposal to omit introduction of the Board's report had been made partly to save time.

The delegate of LIBERIA indicated that he was satisfied with the clarification provided and that the Chairman's suggestion was acceptable.

The CHAIRMAN said that, in the absence of any objection, she took it that the Committee endorsed her suggestion concerning item 2.

It was so agreed.

The CHAIRMAN said that items 3 to 5 and 7 to 9 would be taken up in plenary. In the absence of any objection, she took it that the General Committee endorsed the provisional allocation of the remaining agenda items to Committees A and B.

It was so agreed.

The CHAIRMAN suggested that, given the heavy agenda, at its second meeting scheduled for Wednesday, 23 May 2012, the General Committee should, in addition to considering proposals for the election of Member States entitled to designate a person to serve on the Executive Board, review progress and decide to alter the allocation of agenda items to the main committees or to the timetable, as deemed necessary.

It was so agreed.

The CHAIRMAN noted that arrangements had been made to allow the prolongation of the afternoon plenary meetings and meetings of Committees A and B and, if necessary, to arrange evening meetings. In the absence of any objection she took it that the Committee endorsed those arrangements.

It was so agreed.

The observer of PARAGUAY,¹ referring to the preliminary timetable for the Health Assembly (document A65/1), said that, given their importance, agenda item 12, WHO reform, and agenda item 13.14, Consultative Expert Working Group on Research and Development: Financing and Coordination, should be considered early in the Health Assembly in order to benefit from the maximum participation of delegations. She therefore proposed that the discussion of those items, currently scheduled for Thursday, 24 May 2012, be brought forward, preferably to Tuesday, 22 May 2012.

The delegate of NICARAGUA supported those proposals.

The DIRECTOR-GENERAL explained that, consultations with the permanent missions in Geneva had indicated the preference of Member States for the work of Committee B to be suspended during consideration of item 12 in Committee A, so that all delegations, especially the smaller ones, could participate fully in the discussions. The preliminary timetable had been drawn up to take that wish into account. In respect of the two proposals made by the observer of Paraguay, it might be possible to move consideration of one of the items by Committee A to its second meeting on the morning of Tuesday, 22 May 2012; given its priority, that could be item 12. However, consideration of that item might need to continue into the third meeting, in the afternoon, which would mean that

¹ Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

Committee B could not start its work. Time for Committee A on Tuesday afternoon was already limited, as its meeting could not start until the conclusion of item 5 of the agenda, Invited speaker, in plenary. Furthermore, on the afternoon of Wednesday, 23 May 2012, the time available for Committee A's work was also limited, as it could not start its meeting until the conclusion of consideration of item 4 of the agenda, Appointment of the Director-General, in plenary. She requested further guidance from the Committee as to whether the timetable should be adjusted and, if so, how.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND said that, while he had no objection to consideration of item 12 being brought forward, it would be preferable, given the various time constraints, to maintain the timetable as set out in document A65/GC/1.

The delegates of DENMARK, FRANCE, KENYA and Dr DUKPA (Bhutan), Chairman of Committee A, supported the retention of the timetable set out in document A65/GC/1. They were supported by the observer of the REPUBLIC OF MOLDOVA.¹

The delegate of the UNITED STATES OF AMERICA also supported that view, adding that she understood that some delegations would prefer more time for informal discussions ahead of consideration of item 13.14.

The observer of PARAGUAY¹ said that she would respect the consensus view and therefore withdrew her proposals.

In reply to a request for clarification from the delegate of LIBERIA, the CHAIRMAN confirmed that the work of Committee B would be suspended during consideration of item 12 by Committee A to enable full participation by all delegations in the deliberations on the item.

The CHAIRMAN said that, given the timetable, it was hoped that Committee B would hold its first meeting the morning of Wednesday, 23 May, concurrently with the fourth meeting of Committee A.

Professor NICKNAM (Islamic Republic of Iran), Chairman of Committee B, said that his Committee was due to begin its discussions with agenda item 15, Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. Given that the item would likely entail a lengthy debate and a vote, it would be more appropriate for its consideration to be postponed to later in the Committee's timetable so that it could begin its discussions with a topic on which Member States were more likely to achieve consensus.

The delegate of MAURITANIA said that he did not consider it necessary to postpone item 15 and hoped that the current timetable for Committee B's discussions would be maintained.

The observer of the REPUBLIC OF MOLDOVA¹ expressed support for the proposal made by the Chairman of Committee B.

The delegate of MAURITANIA reiterated that he did not see the need to postpone discussion of the item and the timetable as proposed should be respected.

The CHAIRMAN said that the Chairman of Committee B had made his proposal in light of the need to progress with the agenda quickly and efficiently and to reach consensus on all items.

¹ Participating by virtue of Rule 30 of the Rules of Procedure of the World Health Assembly.

The delegate of FRANCE supported the proposal to postpone discussion of such a sensitive topic, as it would allow Member States more time to study the background documents, resulting in more effective discussions and outcomes than in previous years. He requested clarification on when the item would instead be taken up by the Committee.

Professor NICKNAM (Islamic Republic of Iran), Chairman of Committee B, said that item 15 could still be discussed in the Committee's first meeting, but as the second or third item, or it could be postponed to a later meeting.

The DIRECTOR-GENERAL recalled that discussions on health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan were often lengthy and lack of consensus necessitated a vote by Member States. She therefore welcomed the proposal by the Chairman of Committee B, as it would encourage a spirit of consensus and goodwill as the Committee began its work. Recalling that the Committee was not due to open until Wednesday and also would not meet on Thursday owing to the discussions on WHO reform taking place in Committee A, she said that if the Chairman of Committee B did not consider it appropriate to discuss the item on its first day of meetings, it could instead be taken up on Friday.

The delegate of MAURITANIA reiterated again that he could not see the need to postpone discussion of the item, but said that he would yield to the wider consensus.

The delegate of NICARAGUA said that many heads of delegations would not be present at the discussions of Committee B later in the week, which could make it difficult to find an appropriate time to discuss item 15. If that were the case, it would be better to maintain the timetable as originally proposed.

The observer of the REPUBLIC OF MOLDOVA supported the option to postpone the discussion of item 15 to Friday, 25 May 2012.

The CHAIRMAN, supported by Professor NICKNAM (Islamic Republic of Iran), Chairman of Committee B, proposed that the discussion of item 15 be taken up by Committee B in its first meeting, but as its second item.

It was so agreed.

The CHAIRMAN drew attention to the preliminary daily timetable set out in the Annex to document A65/GC/1 and reiterated the proposal that on Thursday, 24 May, while Committee A discussed item 12 on WHO reform, Committee B would not meet in order to allow all delegations to follow that discussion. In the absence of any objection, she took it that the Committee wished to recommend the preliminary daily timetable, as amended.

It was so agreed.

The delegate of LIBERIA said that, given the importance of the Director-General's address to the Health Assembly, to be given during the third plenary meeting, it would not be fitting to hold the first meeting of Committee A concurrently and to deny any participants the chance to hear the Director-General.

The LEGAL COUNSEL clarified that the first meeting of Committee A would only begin after the address by the Director-General.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 23 May.

The CHAIRMAN drew attention to decision EB130(16), whereby the Executive Board had decided that the Sixty-fifth World Health Assembly should close no later than Saturday, 26 May 2012. She took it that the proposal was acceptable.

It was so agreed.

Referring to the list of speakers for the debate on agenda item 3, the CHAIRMAN proposed that, as on previous occasions, the order of the list of speakers be strictly adhered to and that further inscriptions be taken in the order in which they were made. Those inscriptions should be handed in to the Office of the Assistant to the Secretary of the Health Assembly, or during the plenary to the officer responsible for the list of speakers, on the rostrum. He further proposed that the list of speakers be closed the following day at 10:00. In the absence of any objection, he would inform the Health Assembly of those arrangements at its second plenary meeting.

It was so agreed.

The LEGAL COUNSEL underscored the importance of respecting both the deadline for the list of speakers and the limits set on speaking time.

The delegate of LIBERIA said that when a statement was made on behalf of a particular WHO region, it was then unnecessary for so many Member States from the same region to take the floor with supporting, or even repetitive, statements. If Member States refrained from doing so, discussions would move much faster.

The DIRECTOR-GENERAL agreed that it was an important point, especially given the wider discussions on WHO reform, which included how to manage governing body meetings more effectively and to make best use of the time available.

The delegate of LIBERIA, noting that each WHO region discussed and reached consensus on all items of the provisional agenda of the Health Assembly in pre-session meetings, further stressed the need to restrict Member States from taking the floor when statements had already been given on behalf of the relevant regions.

The delegate of BAHAMAS said that those sentiments were shared by all; it was not a matter on which the Secretariat could act, however, but on which Member States in the regions needed to come to a decision themselves.

The CHAIRMAN said that the issue was not on the number of speakers but on the length of interventions; limits on speaking time should be strictly adhered to.

The delegate of LIBERIA agreed that it was not a matter for the Secretariat, but stressed the need for strong chairmen who would ensure that all interventions were relevant and speaking time limits were respected.

The CHAIRMAN reiterated the need to respect the rules applied to meetings. Once the list of speakers wishing to take the floor had been set, it was important that others not be added. Responding to a question from the delegate of the BAHAMAS, she confirmed that the traffic-light system for regulating the speaking time limit would be used throughout the Health Assembly.

In the absence of any objection, the CHAIRMAN took it that the Committee endorsed her suggestion concerning the procedure for the list of speakers for the debate on item 3.

The meeting rose at 11:30.

SECOND MEETING

Wednesday, 23 May 2012, at 17:40

Chairman: Professor T. N'DRI-YOMAN (Côte d'Ivoire)
President of the Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A65/GC/2)

The CHAIRMAN reminded Members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and Rule 100 of the Rules of Procedure of the World Health Assembly. In accordance with those provisions, the Committee needed to nominate 12 new Member States for that purpose.

To help the General Committee in its task, two documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Sixty-fifth World Health Assembly and who had to be replaced. The second (document A65/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. Vacancies, by region, were: Africa, 1; the Americas, 2; South-East Asia, 1; Europe, 4; the Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion had been made by the General Committee, the CHAIRMAN noted that the number of candidates was the same as the number of vacant seats on the Executive Board. She therefore presumed that the General Committee wished, as was allowed under Rule 78 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, she concluded that it was the Committee's decision, in accordance with Rule 100 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly the next day for the annual election of Members entitled to designate a person to serve on the Executive Board: Australia, Azerbaijan, Belgium, Chad, Croatia, Cuba, Islamic Republic of Iran, Lebanon, Lithuania, Malaysia, Maldives and Panama.

It was so agreed.

2. ALLOCATION OF WORK TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY

Dr DUKPA (Bhutan), Chairman of Committee A, and Professor NICKNAM (Islamic Republic of Iran), Chairman of Committee B, reported on the progress of the work of their respective committees.

The CHAIRMAN proposed that, in view of the number of agenda items yet to be considered, evening meetings should be arranged for either or both committees for the next two days.

In response to a question by the delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, Mrs ROSE-ODUYEMI (Office of Governing Bodies) said that the proposed meetings would be held between 18:30 and 21:30 with full interpretation.

The delegate of the UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND, indicating that that was acceptable, suggested that the need for further meetings be reviewed on Friday, 25 May at midday.

The delegate of FRANCE did not object to the proposal for evening meetings but asked why there had been no meeting of Committee A that afternoon; some three hours of work had been lost.

He also asked why the roll-call vote on agenda item 15 in Committee B had been postponed, noting that even in the afternoon more than 70 Member States had been considered absent during a roll-call vote – he asked how, if the Committee had been quorate, that had been determined. The procedure for voting was archaic and slow in contrast to the electronic voting recently used by the United Nations Human Rights Council in the same building.

Dr DUKPA (Bhutan), Chairman of Committee A, explained that there had been too little time to convene a meeting of Committee A between the closure of the seventh plenary meeting and the current meeting of the General Committee. The timetable of subsequent meetings would not change but he agreed that an evening meeting the next day would be necessary.

He and the Secretariat were making efforts to introduce more efficient working methods, but responsibility also lay with Member States to shorten their interventions.

In reply to the delegate of France, the LEGAL COUNSEL explained that the Secretariat and the Chairmen of the Committees regularly monitored the presence of a quorum. In Committee B that morning the number of delegations had never exceeded 75. Given that the quorum for adoption of decisions in committees at the current Health Assembly was 93, the Secretariat had alerted the Chairman to that fact. Consequently there had been an inevitable, and unfortunate, delay to the vote.

Electronic voting was under consideration; systems had to represent a good return on investment. There were few occasions when the Health Assembly put decisions to the vote. Commercial systems investigated so far had proved to be either inadequate or too expensive. There were fee-paying options through the ILO. To date, electronic voting did not appear to be cost effective for WHO's governing bodies; there were both technical and financial aspects under consideration.

The DIRECTOR-GENERAL said that alternative systems would be explored and negotiations undertaken to see whether better conference facilities could be offered.

The delegate of the RUSSIAN FEDERATION questioned the practicality of holding the discussion of agenda item 12, WHO reform, in Committee A's meeting room given the likely full participation of delegations as a result of the suspension of the work of Committee B. The Assembly Hall might be a more appropriate venue.

Mrs ROSE-ODUYEMI (Office of Governing Bodies) said that arrangements had been made for Committee B's meeting room to be used as an overflow venue, but the video link to that room would be in English only. Use of the Assembly Hall's more formal set-up needed consideration.

The DIRECTOR-GENERAL said that the extent of interpretation provided through the video link would be a further element to be considered in the cost of conference services provided.

The CHAIRMAN took it that the current arrangements for the discussion of item 12 and the proposal for evening meetings were acceptable.

It was so agreed.

The CHAIRMAN, recalling the observation in the previous meeting of the Committee by the delegate of Liberia about regional contributions to discussions in the main committees, commented that discussions in Committees A and B were not general discussions. One possible way to accelerate progress in the work of those committees would be to limit contributions to regional interventions.

Dr DUKPA (Bhutan), Chairman of Committee A, reflected on the democratic nature of the proceedings. Limiting interventions to regional statements was certainly a possibility but he recognized the need for Member States to state their individual positions. He cited the example of the introduction of draft resolutions from the floor; some Member States wished to announce their cosponsorship of such texts and others had their own comments to make. The matter needed further consideration.

The DIRECTOR-GENERAL paid tribute to the previous speaker's skilful chairmanship of Committee A, which had minimized delays. She emphasized, however, the prerogative of every Member State to take the floor; it was difficult for a chairman to prevent that. The balance of regional statements and individual Members' interventions was in the hands of Member States and needed to be considered in the discussions on the governance aspects of reform.

The delegate of CUBA proposed reducing the length of the interventions and, in particular, the number of items on the agenda. He recognized that delegates might speak on behalf of regions; a Member State should also be able to speak on its own behalf. He suggested re-examination of the time frame for submission and consideration of draft resolutions.

The delegate of NICARAGUA supported the need to allow Member States to speak and to retain the national character of some statements; regional consensus did not always exist. The main committees' work could be made more effective by reducing the duration of each intervention, for instance to two minutes.

The delegate of LIBERIA questioned the need for all delegates to participate in the WHO reform discussions. As most delegations had more than one member, they could cover both those discussions and simultaneous meetings of Committee B. He suggested that Committee B continue its work in parallel.

The delegate of MAURITANIA suggested the creation of a third committee, Committee C.

The CHAIRMAN recalled the consensus reached on ensuring that all delegates be able to attend discussions on reform. She recognized the call for country specificities to be considered in committee discussions. All proposals, including the suggestion for a third main committee, would be considered by the Secretariat in the context of WHO reform.

Dr DUKPA (Bhutan), Chairman of Committee A, shared concerns about the time frames for accepting draft resolutions submitted from the floor. In response to the suggestion by the delegate of Mauritania, he said that he feared that Parkinson's law would apply: "work expands so as to fill the time available for its completion" and did not support the idea of forming a third committee.

In response to the suggestion of creating a third committee, the DIRECTOR-GENERAL recalled the provisions of a previous Health Assembly resolution on the number of meetings that

might run concurrently.¹ Such a provision could be overturned in a new resolution if Member States so decided.

Responding to the suggestion by the delegate of Cuba to reduce the number of agenda items, she commented that members of the Executive Board had the power to decide on the contents of the provisional agenda. In her experience, however, members did not sufficiently filter proposals for agenda items. Governments continued to submit requests for supplementary agenda items and to propose national priorities for global-level discussion. That called for discipline and was an area where reforms were needed. Efficiency started at regional level and she requested the support of Member States in harmonizing of the regional committee agendas and strengthening links between regions and headquarters.

The delegate of CUBA pointed out that establishing priorities was an important point for discussion under WHO reform. The Health Assembly's agenda needed to be in line with those priorities and a sharper focus on them would allow the number of agenda items to be reduced. In addition, with a shorter agenda, each individual item could be explored in greater depth.

The CHAIRMAN said that the various points raised would be taken into consideration by the Secretariat.

It was so agreed.

The General Committee then drew up the programme of work of the Health Assembly for Thursday, 24 May and Friday, 25 May.

The CHAIRMAN proposed to review the progress of work during those two days with the chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The meeting rose at 18:30.

¹ See resolution WHA35.1, confirmed in resolution WHA36.16.

COMMITTEE A

FIRST MEETING

Monday, 21 May 2012, at 15:40

Chairman: Dr L.Z. DUKPA (Bhutan)

1. OPENING OF THE COMMITTEE: Item 11 of the Agenda

The CHAIRMAN welcomed participants and introduced the representatives of the Executive Board, Dr El Makkaoui (Morocco), Mrs Hanjam da Costa Soares (Timor-Leste), Dr Omi (Japan) and Dr Larsen (Norway), who would report on the Board's discussion of agenda items before the Committee.¹ Accordingly, any views they expressed would be those of the Board, not of their respective governments.

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Dr Fenton Ferguson (Jamaica) and Mr Herbert Barnard (Netherlands) had been proposed as Vice-Chairmen and Dr Mohamed Jiddawi (United Republic of Tanzania) as Rapporteur.

Decision: Committee A elected Dr F. Ferguson (Jamaica) and Mr H. Barnard (Netherlands) as Vice-Chairmen and Dr M. Jiddawi (United Republic of Tanzania) as Rapporteur.²

2. ORGANIZATION OF WORK

The CHAIRMAN said that, in view of the full agenda, delegates should limit their interventions to three minutes and that he would interrupt delegates who exceeded that time. If a delegate spoke on behalf of a group of countries, delegates from other countries within that group should limit their interventions.

It was so agreed.

The CHAIRMAN also pointed out that document A65/7 Add.1, which was listed under item 13.1 of the provisional agenda, had been withdrawn.

Ms SCHJØNNING (Denmark) recalled that, following an agreement between WHO and the European Commission in 2000, the European Union had participated in the World Health Assembly as an observer. She requested that it should also be invited to participate as an observer, without vote, in

¹ Participating by virtue of Rules 42 and 43 of the Rules of Procedure of the World Health Assembly.

² Decision WHA65(4).

meetings of subcommittees and other subdivisions of the Health Assembly dealing with matters within the competence of the European Union.

It was so agreed.

Mrs ESCOREL DE MORÃES (Brazil) expressed concern that, according to the preliminary timetable considered by the General Committee, agenda item 13.14 on the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination was not scheduled for discussion until the eighth meeting of Committee A. As the item was expected to generate considerable discussion, she asked whether the Committee might take it up at its fourth meeting instead.

The CHAIRMAN said that the General Committee had decided that the programme of work should remain unchanged, but he invited comments from delegates.

Ms WISEMAN (Canada), Mr GABERELL (Bolivia, Plurinational State of), Dr RODRÍGUEZ (El Salvador), Dr MALECELA (United Republic of Tanzania), Ms VANCE (Ecuador), Mr URQUIJO VELÁSQUEZ (Colombia), Ms PATTERSON (Australia), Mr TRAORÉ (Mali), Dr DÍAZ (Chile), Dr MANGUELE (Mozambique), Dr THIMOTHÉ (Haiti), Mr McIFF (United States of America), Dr DAHAN (Yemen), Dr NANTHAPHAN CHINLUMPRASERT (Thailand) and Ms SCHJØNNING (Denmark) endorsed the proposal put forward by the delegate of Brazil.

The CHAIRMAN said that the Secretariat would endeavour to reorganize the programme of work in order to accommodate the request.

3. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A65/6, A65/6 Add.1, A65/7, A65/8, A65/9, EB130/2012/REC/1 and resolutions EB130.R6 and EB130.R7)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board) recalled that the Board, at its 130th session, had considered an earlier version of the report contained in document A65/6 on progress made towards the development of a comprehensive global monitoring framework, including a set of indicators and a set of voluntary global targets for the prevention and control of noncommunicable diseases. A draft resolution had been submitted to establish a process and timeline for three areas of work on noncommunicable diseases that would commit Member States to action and enable WHO to meet the deadlines contained in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. The three areas were: development of a global monitoring framework, options and timelines for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through partnership, and development of implementation and follow-up action plans for the prevention and control of noncommunicable diseases. The draft resolution had been amended in order to ensure coherence with WHO's existing strategies and tools for discouraging tobacco use, harmful use of alcohol and unhealthy diets and physical inactivity, and in order to avoid conflicts of interest, and had been adopted as resolution EB130.R7.

The CHAIRMAN proposed that the Committee should begin by considering the first three subitems followed by the draft resolution contained in resolution EB130.R6 and a draft decision.

Mr McIFF (United States of America) said that Member States had had only a short time to consider the report on the second subitem (document A65/7). Given the substantive nature of the report, which included changes to the monitoring framework, voluntary targets and indicators, he proposed, supported by Dr TAKEI (Japan), that it be discussed separately at a later stage.

In the absence of any objection, the CHAIRMAN took it that the Committee agreed to discuss the first and third subitems together and deal separately with the second and fourth subitem.

It was so agreed.

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control**
- **Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan**

Dr TAKEI (Japan) commended the Secretariat's work in preparing for and following up the two high-level meetings. The Organization should continue to provide technical support to countries for policy-planning based on evidence and in keeping with their differing needs. Support was needed in particular to remedy the scarcity of data on noncommunicable diseases, which made it difficult to prepare effective plans. Multisectoral action was needed for the prevention and control of noncommunicable diseases, including promotion of the benefits of a healthy lifestyle as a preventive measure and strengthening of health care systems to ensure adequate care for persons with noncommunicable diseases. In Japan, the fact that ageing was a major contributing factor to the rising incidence and prevalence of noncommunicable diseases made it essential to take steps to encourage healthy and active ageing.

Mr DESIRAJU (India) said that his country had to cope with a serious noncommunicable disease burden while continuing to grapple with communicable diseases and unacceptably high maternal and infant mortality rates. Although it was easy to identify and measure indicators and targets for the latter problems, the same was not true of noncommunicable diseases. His Government could agree in principle to the adoption of the five voluntary targets identified in document A65/6, but it would have problems compiling the data needed to measure progress towards some of those targets. National surveys on dietary salt intake and physical activity would have to be conducted, which would be onerous and expensive. Data on smoking were available and of reasonably good quality, but data on use of smokeless tobacco were not. No voluntary target had been proposed for reduction of alcohol abuse, although it was universally recognized as a major risk factor for noncommunicable disease. Even if some Member States did not want to monitor an alcohol-related target, such a target should be established for those that did. Consideration should also be given to formulating a target relating to mental illness; one possibility was a target for reducing the prevalence of suicide. A target for access to medicines for treating noncommunicable diseases should also be envisaged.

Dr RODRÍGUEZ (El Salvador) emphasized the need to prioritize chronic kidney disease, which was a serious problem in the countries of Central America. Those countries had raised the issue at numerous international forums since 2010, but it was still not receiving the attention it deserved. As most cases of kidney disease in Central America were caused by environmental or occupational exposure to toxins, traditional preventive measures such as control of blood pressure were not effective against it. In that respect, the condition was similar to Balkan endemic nephropathy, which had recently gained international attention. She called on the Health Assembly to take steps to identify and promote measures for preventing chronic kidney disease, particularly in the countries of Central America.

Dr AL-JALAHMA (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that progress had been made since the High-level Meeting of the General Assembly in addressing risk factors for noncommunicable diseases. The Regional Office for the Eastern Mediterranean had taken steps to consolidate and strengthen national policies and plans, but countries' primary health care capacity needed further building in order to enable them to prevent and control noncommunicable diseases. WHO should enhance its leadership role in order to ensure that the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases was applied effectively. Partnerships should be forged with relevant stakeholders and efforts made to increase the availability of human resources to combat noncommunicable diseases.

Ms POLL (Costa Rica) welcomed the development of a global monitoring framework, with a small number of measurable and achievable voluntary global targets. Costa Rica had long worked to improve the health of its population through an approach grounded on health promotion and community participation and underpinned by principles of equity, solidarity, universality and respect for human rights. Its policies, plans and programmes addressed determinants of health and risk factors for noncommunicable diseases, and in March 2012 new tobacco control legislation in line with the WHO Framework Convention on Tobacco Control had been adopted. Although Costa Rica had made progress in tackling noncommunicable diseases and their causes, advocacy tools were needed to ensure that attention was paid to such diseases at the highest political level. Support from the international community, particularly financial support, was needed to strengthen national capacity and facilitate the development of additional action plans.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) expressed support for the five criteria described in document A65/6 for guiding the development of indicators and targets and noted that only five indicators with global targets had been identified. He supported the inclusion of other core indicators with voluntary targets to be set at regional or country level, except for those relating to adult per capita consumption of alcohol and multidrug therapy for use in reducing the risk of cardiovascular diseases. Prevalence of current drinking or prevalence of heavy drinking occasions would be a more suitable indicator of alcohol use. Multidrug therapy for cardiovascular disease risk reduction was not the best choice as an indicator because most Member States lacked electronic medical records and would therefore have difficulty collecting the necessary data. Countries would need guidance on noncommunicable disease risk factors and modelling in order to determine suitable national or regional targets for the various core indicators. Although the targets were voluntary, some standardization of the methods used to determine them would be helpful.

Mr McIFF (United States of America) said that his Government remained committed to raising the profile of noncommunicable diseases as a major public health problem. Continuous support from the Secretariat, Member States, nongovernmental organizations and other stakeholders was needed in order to tackle the problem. He supported the Secretariat's efforts to develop a comprehensive monitoring framework, including indicators and voluntary global targets, and appreciated its responsiveness to Member States' requests for additional information. Success in addressing noncommunicable diseases would require engagement of all levels of society and all regions. Member States should participate fully in developing the global framework, establishing global voluntary targets and assessing whether the targets and indicators could be adapted to the priorities and needs of individual countries and regions. The proposed framework appropriately incorporated three main elements – health outcomes, risk factors and public health systems responses or actions – and the proposed voluntary global targets provided a sound and cohesive foundation for monitoring progress. Additional work was needed on the 15 core indicators without associated targets, and with that in mind his delegation had worked with the delegations of Barbados, Brazil, Canada and the Russian Federation to prepare a draft decision intended to take stock of the progress made to date and guide future work. The text of the draft decision read:

The Sixty-fifth World Health Assembly,
 PP1 Reaffirming the leading role of WHO as the primary specialized agency for health, as recognized by the United Nations General Assembly in the Political Declaration of the High-level meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and its responsibility with the full participation of Member States pursuant to paragraphs 61 and 62 of the Political Declaration toward development of a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, before end 2012,

1. DECIDED to welcome the report A65/6 on prevention and control of noncommunicable diseases and its addendum 1 and recognized the significant progress made in close collaboration with Member States pursuant to paragraphs 61 and 62 of the Political Declaration;
2. DECIDED to note wide support expressed by Member States and other stakeholders around five global voluntary targets considered so far including those relating to mortality, raised blood pressure, tobacco, salt/sodium and physical inactivity, with strong support for more work around targets relating to obesity, fat intake, alcohol, and a health systems response target such as availability of essential medicines for noncommunicable diseases, along with any other targets or indicators that may emerge in the remainder of the process established by resolution EB130.R7;
3. URGED all Member States¹ to participate fully in all remaining steps of the NCD follow-up process described in resolution EB130.R7 including regional and global level consultations;
4. REQUESTED the Director-General to prepare a revised discussion paper on the comprehensive global monitoring framework including indicators and a set of voluntary global targets which reflects the discussions to date, taking into account measurability, feasibility, achievability and the existing WHO strategies in this area, and to continue to consult with WHO regions through Regional Committees or web-based consultations² and other all stakeholders on this revised paper and to convene a formal Member States meeting, pursuant to paragraph 2(g) of EB130.R7, to be held prior to the end of October 2012 to conclude work on the package.

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

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| <p>1. Resolution: Prevention and control of noncommunicable diseases: follow-up to the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases</p> |
| <p>2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf) Strategic objective(s): 3 and 6 Organization-wide expected result(s): 3.3, 6.2 and 6.3</p> |

¹ And, where applicable, regional economic integration organizations.

² As called for in subparagraph 2.1(f) of resolution EB130.R7.

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

The resolution requests the preparation of a revised discussion paper on the global monitoring framework, including indicators and a set of voluntary global targets that reflects the discussions to date. This activity would be in accordance with paragraphs 61 and 62 of United Nations General Assembly resolution 66/2 and would thus support the expected results mentioned above.

Does the programme budget already include the products or services requested in this resolution? (Yes/no)

Yes

3. Estimated cost and staffing implications in relation to the Programme budget**(a) Total cost**

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) Two years (covering the period 2012–2013)

(ii) Total: US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000)

Total: US\$ 2.5 million (staff: US\$ 1.5 million; activities: US\$ 1.0 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

At headquarters and in all six regions.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If “no”, indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

Yes

If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 2.0 million; source(s) of funds: voluntary contributions from bilateral donors.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, thanked the Secretariat for the report on the informal consultations, but regretted its late submission. The global monitoring framework, indicators and targets sent a clear message to governments, nongovernmental organizations and the private sector about what WHO considered important in relation to noncommunicable diseases. Although the consultation process had been transparent and inclusive, the low level of participation by Member States had been disappointing. She appealed to all countries, particularly developing ones, to participate actively in the ongoing dialogue. To date, the discussion had been based on the July 2011 recommendations of the WHO expert group, which had pre-dated the Political Declaration of the High-level Meeting of the General Assembly. The content of the Political Declaration must be incorporated into the monitoring framework. For the purposes of tracking progress globally, it would suffice to monitor mortality from the four diseases and the indicators and targets relating to the four risk factors mentioned in the Political Declaration. The indicators should be measurable, feasible, already in wide use and based on existing WHO strategies, and the voluntary targets should be realistic. The additional core indicators and targets would help countries to define their own national noncommunicable disease control strategies and targets in line with their specific epidemiological parameters, capacities, resources and priorities. Health system targets should be optional and preferably focused on policies and processes.

It was regrettable that the European Union's request to the Executive Board at its 130th session¹ for more information on WHO's actions to implement the recommendations on the marketing of food and non-alcoholic beverages to children had not been followed up. She said that she hoped that the information would be forthcoming during the current discussion.

She could accept the proposed draft decision with several amendments: in paragraph 2, deletion of the word "five" before "global voluntary targets" and addition of "cholesterol" to the group of targets requiring more work, and, in paragraph 4, addition of the words "in full alignment with the United Nations High-level Political Declaration" at the end and insertion of a footnote on participation of regional economic integration organizations after the words "a formal Member States meeting".

Dr CUYBERS (Belgium), welcoming the extensive consultations on the development of a global monitoring framework, agreed that the indicators and voluntary targets must be realistic. Monitoring should, as far as possible, be based on existing mechanisms in order to facilitate the implementation of the framework and the attainment of the targets. The targets and indicators should be decided on a political level, and not on the basis of availability of data sources. The Secretariat and Member States must aim to achieve ambitious goals in order to make a real difference and reduce mortality and morbidity from noncommunicable diseases. Targets relating to obesity, which comprised multiple risk factors and was easy to measure, and to alcohol use should be included in the global monitoring framework.

Ms SKACHKOVA (Russian Federation) acknowledged the active involvement of participants in the first Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control in the discussion of important issues associated with policy-making on the prevention of noncommunicable diseases at the global and country levels. In the year since that Conference, the Russian Federation had taken steps aimed at strengthening its national policies, including the adoption of a law on health protection that placed increased priority on prevention and the signing of a presidential decree setting goals and defining activities for the promotion of healthy lifestyles and prevention of noncommunicable diseases. Action was also being taken to strengthen the infrastructure of medical facilities dealing with noncommunicable diseases, including renovation and modernization of all primary health care establishments. Noncommunicable disease screening programmes were also being introduced.

¹ Document EB130/2012/REC/2, summary record of the eighth meeting.

Ms WISEMAN (Canada) said that her Government attached high priority to tackling the global threat of noncommunicable diseases and would continue to work with other stakeholders to move forward on the commitments made in the Political Declaration. It would also continue to participate in the formulation of implementation plans, including options for multisectoral action, and the development of the global monitoring framework and recommendations on voluntary global targets. Active ageing formed a central component of health promotion and prevention and control of noncommunicable diseases, as recognized in resolution EB130.R6, which sought to address the complex issues associated with population ageing. She appreciated the Secretariat's report on progress in implementing the 2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases; the subsequent action plan for 2013–2020 should take into account the Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Declaration of the Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control, the Rio Political Declaration on Social Determinants of Health, as well as WHO's existing strategies and tools.

Professor MOYEN (Congo), speaking on behalf of the Member States of the African Region, supported the draft resolution. Morbidity from noncommunicable diseases, including sickle-cell anaemia, continued to increase in the Region. Noncommunicable diseases constituted a major public health problem, which was compounding the equally serious problem of communicable diseases, impeding economic development and exacerbating poverty. Strategies and action plans to combat noncommunicable diseases had been adopted and were being implemented in many countries of the Region with the technical support of WHO, civil society and the private sector. However, several factors were preventing real change, including lack of adequate health care infrastructure, a shortage of qualified human resources, lack of social protection and the high cost of care, as well as tobacco use, harmful use of alcohol, poor diet and physical inactivity. Noncommunicable diseases could be prevented through low-cost public health interventions that aimed to reduce risk factors. WHO had an important leadership role to play in strengthening partnerships for the prevention and control of such diseases, as had been highlighted in the Brazzaville Declaration on the subject. The issue should be discussed further at the G20 summit (Mexico, 18 and 19 June 2012) and at the United Nations Conference on Sustainable Development (Rio+20) (Rio de Janeiro, Brazil, 20 to 22 June 2012).

Dr ST. JOHN (Barbados) said that her Government had been very active in the run-up to the United Nations High-level Meeting and had participated in consultations on the targets. Barbados could not tolerate failure by WHO to fulfil its obligations concerning reporting on agreed targets and therefore supported the call for the convening of a formal meeting of Member States to be held before the end of October 2012 to fine-tune the targets and global monitoring framework, as requested in the draft decision put forward by the delegate of the United States of America. With regard to the proposed amendments, she appealed to the European Union to consider including cholesterol in the group of additional targets or indicators that might emerge, not in the current group proposed. She urged all countries to support, as the overarching outcome target to be delivered by WHO, a reduction in mortality of 25% by 2025 for specific noncommunicable diseases. She also called on the Secretariat and the regional offices to provide technical support and facilitate country cooperation to strengthen the management of noncommunicable diseases and, in particular, surveillance systems and mechanisms.

Dr BENSON (South Africa), noting that consultations on the global monitoring framework had taken place in the European Region only, said that it was essential to conduct consultations in all regions. More work should be done on the indicators, as those set out in document A65/6 Add.1 were vague. The monitoring framework should be linked to the global strategy for the prevention and control of noncommunicable diseases, and the framework should therefore cover the issue of harmful use of alcohol. With regard to tobacco use, illicit trade in counterfeit tobacco and tobacco products remained a major concern, in particular for developing countries. WHO should provide the necessary resources to facilitate the establishment of an effective system for tracking and tracing, in order to curb illicit trade in tobacco.

Dr GOUYA (Islamic Republic of Iran) said that his Government was committed to the prevention and control of noncommunicable diseases and conducted annual surveys of selected noncommunicable disease risk factors at the national level, adjusting its noncommunicable disease programme in the light of the results, which was conducive to sound policy-making and programming. He welcomed the mention in the report contained in document A65/7 of population-wide measures to reduce exposure to risk factors and interventions targeting those already suffering from noncommunicable diseases. Noncommunicable diseases lasted a lifetime; provision of lifelong care was therefore essential. Prevention of such diseases should begin before birth. Every country should draw up a national strategic plan for noncommunicable disease prevention and control, involving sectors other than the health sector in its implementation. WHO should support coordination at the international level and the sharing of experience, thereby facilitating the development of such strategic plans. The Islamic Republic of Iran was willing to share its experience in the surveillance, prevention and control of noncommunicable diseases with interested Member States, particularly in the Eastern Mediterranean Region.

Dr TUGSDELGER (Mongolia) said that, as noncommunicable diseases were increasingly affecting young people in her country and elsewhere, the monitoring framework should include specific indicators for noncommunicable disease surveillance among adolescents. In view of the high cost of the human papillomavirus vaccine and uncertainties about its cost-effectiveness, the core indicator on vaccination against infections associated with cancers should be reworded to refer to provision of vaccines that had been found to be cost-effective in the context of an individual country.

Mr KURI MORALES (Mexico) said that noncommunicable diseases represented a major public health challenge in his country. The Government of Mexico therefore welcomed the consultations held with Member States and other stakeholders to identify actions that would facilitate the management of noncommunicable diseases. His Government supported the set of indicators proposed by WHO for monitoring the impact of prevention and control activities. However, it was doubtful that all Member States would have the capacity to generate the information required to monitor the indicators, which might make it difficult to assess the impact of the measures adopted by each Member State and the feasibility of scaling them up. Mexico remained committed to strengthening information systems and indicators for that purpose. A multisectoral approach must be adopted, given the complexity of the issue.

Dr WU Liangyou (China) welcomed the evidence-based global strategy and action plan. The proposed global monitoring framework was comprehensive, and the targets and indicators were ambitious and would be conducive to the prevention and control of noncommunicable diseases. Member States should be able to adopt appropriate technical methods in accordance with specific national conditions. WHO should play a key role in mobilization, policy-making, technical leadership, information exchange, capacity-building, supervision and evaluation. His Government had formulated a five-year plan for the prevention and control of noncommunicable diseases and developed various strategies, which it was willing to share with other Member States. China was prepared to enhance international cooperation, foster the implementation of relevant resolutions, undertake activities in

accordance with an agreed timeline and play a greater role in the global response to noncommunicable diseases.

Mr KHALIL (Lebanon) said that noncommunicable diseases caused high morbidity and mortality in his country. Rates of diabetes and cardiovascular disease were especially high. The health ministry devoted significant resources to prevention. He welcomed WHO's efforts to establish noncommunicable diseases as a priority and supported the Political Declaration of the General Assembly on the Prevention and Control of Non-communicable Diseases. He called upon all countries to develop national workplans to complement the Action plan for the global strategy for the prevention and control of noncommunicable diseases, in order to enhance its impact. His Government supported the six objectives of the action plan and agreed that multisectoral action and political support from all sectors were essential in order to address social determinants of health. Good results in the prevention and control of noncommunicable diseases would not be achieved at the national level without the adaptation of health systems, particularly at the primary health care level, or without adequate supplies of medicines, capacity-building and dissemination of information. WHO should provide technical support for those purposes.

Dr AL-THANI (Qatar), speaking on behalf of the States of the Cooperation Council for the Arab States of the Gulf, said that the prevention of chronic diseases was a priority for the Council, which had urged the health ministries in its Member States to take steps to implement the Gulf plan to combat noncommunicable diseases (2011–2020), including through the provision of essential treatment and the establishment of prevention and control programmes, for which it would ensure budgetary support. The hope was that the plan would attract global attention and inspire other countries to follow suit.

Dr AL-HINAI (Oman) said that commitment to the development of a global framework for the prevention and control of noncommunicable diseases was paramount, as would be the adoption of a set of indicators and global targets agreed during the current Health Assembly. Noncommunicable diseases were a major focus of Oman's national health policy.

Dr TAYAG (Philippines) expressed full support for the six objectives of the action plan for the global strategy for the prevention and control of noncommunicable diseases, which were consistent with those of the Western Pacific regional action plan, adopted in 2008. He highlighted the need for clear targets and measurable indicators that would show the impact of interventions; for an efficient balance between prevention, treatment, care and support; and for sustainable investments to strengthen the collection of information on risk factors, health outcomes and social determinants.

Ms BENNETT (Australia) said that her Government was pleased to be able to support developing countries in implementing the current action plan for the global strategy for the prevention and control of noncommunicable diseases and looked forward to participating actively in the development of the next such plan, which would be crucial for putting into practice the actions agreed in the Political Declaration of the High-level Meeting of the General Assembly. With regard to the global monitoring framework for the prevention and control of noncommunicable diseases, the Government of Australia favoured ambitious yet realistic targets that would galvanize action in all Member States. If the targets and indicators were to be meaningful and measurable, they must be developed carefully, bearing in mind that noncommunicable disease monitoring systems in developing countries might be weak. Consultations should be held with a wide range of Member States before the framework was finalized. Australia looked forward to participating in the consultations to be held in the Western Pacific Region. Her country wished to cosponsor the draft decision and supported the draft resolution contained in resolution EB130.R6.

Dr SUNDARANEEDI (Trinidad and Tobago) noted that his country had hosted the Heads of Government of the Caribbean Community Summit on Chronic Non-Communicable Diseases (Port-of-Spain, 15 September 2007), which had adopted the Port-of-Spain Declaration and led to the convening of other regional summits on noncommunicable diseases. His Government had implemented the actions outlined in the Port-of-Spain Declaration through, *inter alia*, the establishment of a noncommunicable diseases partners' forum to serve as a platform for multisectoral action. Its aim was to promote health and address the key determinants of and risk factors for noncommunicable diseases. Actions undertaken included physical activity and workplace wellness programmes, smoking cessation interventions, school health promotion and vision screening for primary school children, and policies and programmes to promote active ageing. His Government supported the establishment of global targets for the reduction of noncommunicable diseases. However country- and region-specific targets should also be established in order to respond to the determinants driving the noncommunicable diseases epidemic in the local context.

Dr ESCOBAR (Chile) welcomed WHO's action in response to the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. Chile also wished to sponsor the draft decision put forward by the delegate of the United States of America, in order to promote greater consistency between the global monitoring framework and national and regional policies, plans and targets, and facilitate finalization of the global framework by October 2012.

Mr THOMSON (Switzerland) said that his country also supported and sponsored the draft decision, which would enhance the action to be undertaken by WHO pursuant to the Political Declaration. He trusted that the work would culminate in a comprehensive and balanced set of targets that covered all the conditions and risk factors associated with noncommunicable diseases.

Dr SARIIO-LÄHTEENKORVA (Finland) welcomed WHO's leadership of global efforts for the prevention and control of noncommunicable diseases. Monitoring was crucial to the success of those efforts, since "what gets measured gets done". At least some of the indicators to be measured should be conducive to health promotion and building the capacity of health systems. In addition to monitoring, action plans needed to be strengthened and the necessary funds allocated. Finland looked forward to participating in the development of an action plan for the global strategy for the prevention and control of noncommunicable diseases for 2013–2020, building on lessons learnt from the current action plan and using existing WHO strategies and tools on tobacco use, harmful use of alcohol and unhealthy diet and physical inactivity.

Strengthening national capacity to tackle noncommunicable diseases, coupled with a health-in-all-policies approach, could bring about significant reductions in the burden of noncommunicable diseases and an improvement in public health. Mortality from cardiovascular diseases in Finland stood at 10% of the level it had been in the 1960s, when it had been the highest in the world. That success had been achieved using a multisectoral approach, supportive policies, legislation and monitoring and evaluation to bring about dietary improvements, most notably reduced intake of saturated fats. She noted that Finland would be hosting the 8th Global Conference on Health Promotion in Helsinki in June 2012.

Dr AL-TAAE (Iraq) said that vital issues for the prevention of noncommunicable diseases included the complementarity of primary, secondary and tertiary health care services; school health and nutrition; the social determinants of health; engagement of the social sectors in strengthening awareness of health and of anti-tobacco legislation and activities; environmental risk factors; and the complementarity of reproductive health services and nutritional strategies.

Dr FIKRI (United Arab Emirates) said that the convening of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the outcome of the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control together attested to the consensus on the need for greater attention to the prevention and control of noncommunicable diseases. His country's health policy sought to address the challenges posed by chronic diseases in order to reduce their pathological, social and economic impacts. A general framework for a strategy to combat noncommunicable diseases had been developed, as had an initial operational plan (2012–2021), in conjunction with other sectors. School health programmes aimed at encouraging healthy lifestyles were a vital complement to primary health care in the prevention, early detection and treatment of noncommunicable diseases.

The meeting rose at 17:35.

SECOND MEETING

Tuesday, 22 May 2012, at 09:15

Chairman: Dr L.Z. DUKPA (Bhutan)

later: Dr F. FERGUSON (Jamaica)

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

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A65/6, A65/6 Add.1, A65/7, A65/8, A65/9, and EB130/2012/REC/1, resolutions EB130.R6 and EB130.R7) (continued)

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control** (continued)
- **Implementation of the global strategy for the prevention and control of noncommunicable diseases and the action plan** (continued)

Dr AL-JALAHMA (Bahrain), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Organization should strengthen its capacity to create a comprehensive global monitoring framework for the prevention and control of noncommunicable diseases and follow up on the action plan for the global strategy for the prevention and control of noncommunicable diseases, ensuring that all Member States respected their commitments and streamlined their efforts. Effective partnerships between Member States, the Secretariat and all relevant stakeholders should be formed in order to deal with noncommunicable diseases. She supported the development and expeditious implementation of a set of indicators and global voluntary targets. Appropriate steps should be taken to prepare a set of targets before the end of 2012, pursuant to paragraph 62 of the Political Declaration of the High-level Meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases.

Dr LARSEN (Norway) said that the development of a comprehensive global monitoring framework, including a set of voluntary global targets and indicators, must be completed by the end of 2012. The list of voluntary targets should be extended to cover harmful use of alcohol. With regard to health system responses, a target should be included reflecting general access to primary health services with the capacity to diagnose and treat common diseases, including noncommunicable diseases.

Dr CARBONE (Argentina) expressed support for the set of indicators and voluntary global targets outlined in document A65/6. Solid surveillance systems for noncommunicable diseases had to be established in all countries. Her Government had created a surveillance unit and had implemented a range of long-term strategies to tackle such diseases. A national multisectoral commission for the prevention and control of noncommunicable diseases had been established with the participation of several ministries, the food industry, civil society and relevant scientific societies.

Dr NANTHAPHAN CHINLUMPRASERT (Thailand), speaking on behalf of the Member States of the South-East Asia Region, welcomed the Secretariat's work on a global monitoring

framework and a set of voluntary global targets, but expressed concern that some of the proposed targets were too ambitious for many countries in the Region, in particular those relating to the reduction of dietary salt intake and the prevalence of hypertension. Also of concern was the omission of targets that were especially relevant to the Region, notably those relating to the harmful use of alcohol, childhood obesity, diabetes, air pollution and increased access to essential medicines for noncommunicable diseases. Limited national capacity to measure indicators together with a lack of baseline values could hinder the achievement of the voluntary global targets, and the Secretariat should take those concerns into consideration when developing and finalizing the set of targets. In general, she supported the draft decision, but it did not adequately reflect the results of the informal consultations that had taken place. She therefore proposed that paragraph 2 should be deleted and that, in paragraph 4, the words “regional technical working groups with approval from” should be inserted before “Regional Committees”.

Professor ADITAMA (Indonesia), expressing support for WHO’s work on noncommunicable diseases, said that responses needed to be tailored to country needs and capacities. Prevention and control measures implemented by Indonesia included strengthening health system capacity, developing multisectoral collaboration, community empowerment, and the implementation of a five-year strategic plan for the period 2010–2014. Multisectoral engagement was essential to preventing and controlling noncommunicable diseases, with the involvement of government sectors other than the health sector, as well as civil society and the private sector.

Mr URQUIDO VELÁSQUEZ (Colombia) said that governments should tackle the risk factors associated with noncommunicable diseases and promote healthy lifestyles, in particular by curbing tobacco use and promoting physical activity and the consumption of fruit and vegetables, especially among poor populations with low educational levels. He shared the concerns of previous speakers regarding the definition of indicators for monitoring noncommunicable diseases and the impact of the proposed actions, especially in relation to lifestyle changes. The Health Assembly should consider giving greater impetus to global public policies aimed at reducing harmful use of alcohol and consumption of sugary drinks and foods with high salt and *trans*-fatty acid content, as with the tobacco policies established under the WHO Framework Convention on Tobacco Control. Welcoming the Secretariat’s efforts to facilitate and improve the effectiveness of Member States’ responses, he called for the identification of more evidence-based, cost-effective policies to prevent and control noncommunicable diseases and the development of cooperation strategies targeting least developed countries.

Mr BARBOSA (Brazil), noting that his country was a sponsor of the draft decision, said that developing countries were faced with increased prevalence of noncommunicable diseases. It was important to implement the recommendations of the High-level Meeting on the Prevention and Control of Non-communicable Diseases. His Government had launched a national strategic action plan on noncommunicable diseases for the period 2011–2022 and was making significant progress in reducing the risk factors for and the rates of such diseases.

A major challenge for WHO was monitoring and assessing the social and economic determinants of noncommunicable diseases and establishing effective forms of intersectoral action. Commitments must be translated into concrete action and clear goals and indicators must be adopted in line with the capacities of national health systems.

Dr EL MENZHI (Morocco) expressed satisfaction at progress made in preventing and controlling noncommunicable diseases. The Secretariat should provide technical and scientific support to enable countries to apply the proposed indicators. As sustainable financing was needed in order to implement the action plan for the global strategy for the prevention and control of noncommunicable diseases, a global fund should be established, akin to that in place to fight AIDS, malaria and tuberculosis.

Dr PAUVADAY (Mauritius) said that the greatest contributors to noncommunicable diseases were lack of physical activity, tobacco use, consumption of junk food and harmful alcohol use. The section on global partnership options in the Secretariat's report (document A65/7) should have referred to the possibility of developing mechanisms similar to the WHO Framework Convention on Tobacco Control. The document should also have reflected the need for coordinated action among United Nations bodies to help countries to develop national frameworks for health literacy. Finally, proposals should be formulated for capacity building to remedy the limited expertise in surveillance of noncommunicable diseases.

Dr SA'IDI (Saudi Arabia) announced that an international conference on healthy lifestyles would be held in Riyadh, Saudi Arabia, in September 2012, in coordination with the Regional Office for the Eastern Mediterranean and with the support of the Arab League and other expert bodies, to discuss measures to prevent and control noncommunicable diseases. He asked all those involved in the prevention and control of noncommunicable diseases to share their successful experiences. He supported the implementation of the action plan for the prevention of avoidable blindness and visual impairment (document A65/9), and expressed concern at the increased prevalence of diabetes.

Dr GONÇALVES (Mozambique) said that, even though communicable diseases remained her country's main public health concern, the prevalence of noncommunicable diseases had increased in recent years. The Government had made significant efforts to meet the six objectives outlined in the global strategy for the prevention and control of noncommunicable diseases, but lack of funding to monitor risk factors and other constraints had hindered those efforts. The Government remained committed to overcoming those obstacles in order to implement proven cost-effective strategies and reverse rising rates of noncommunicable disease.

Mr McIFF (United States of America), acknowledging the amendments to the draft decision proposed in the previous meeting by the delegate of Denmark, suggested that the addition of the words "including cholesterol" after the words "other targets or indicators that may emerge" in paragraph 2 would more accurately reflect the current state of the discussion on voluntary global targets and indicators. Paragraph 2, which the delegate of Thailand proposed to delete, fulfilled the essential purpose of capturing the progress made by Member States and the Secretariat. Its language closely followed that of document A65/6 Add.1, for example with regard to the risk factors for harmful alcohol use and obesity. He agreed that further work was necessary in order to reach consensus on the targets and indicators. Although the main aim of the draft decision was to capture progress and provide a way forward, it was not intended to prejudge the outcome of the proposed meeting of Member States later in the year to conclude the work on those items.

Dr RODIN (Canada) said that the draft decision, of which Canada was a sponsor, recognized the significant progress made by Member States towards the global monitoring framework and set a path for the finalization of a set of indicators and voluntary global targets by the end of 2012. She agreed with the proposal to insert the word "including cholesterol" in paragraph 2 of the draft decision and suggested that the last part of the paragraph should read "along with any other targets or indicators emerging, including cholesterol, in the remainder of the process established by resolution EB130.R7". She asked the delegate of Thailand to clarify the reasons for the proposed deletion of paragraph 2. She needed additional time to consider the delegate of Thailand's proposed amendment to paragraph 4, but questioned the feasibility of an approach involving regional technical working groups, given the timing of the regional committee meetings and the aim to finalize the global monitoring framework by the end of 2012; that goal could be achieved if Member States worked together to ensure that regional perspectives were highlighted during global consultations.

Mr KAZI (Bangladesh) welcomed the Secretariat's efforts to scale up global action on the prevention and control of noncommunicable diseases and commended the progress made thus far in developing a global monitoring framework and a set of voluntary global targets. The targets should be ambitious, but also feasible and achievable, taking into account varying regional and national circumstances and capacities, especially in low-income countries. Referring to the comments made by the delegate of Thailand, he agreed that further work was needed to define the targets, particularly those of regional importance, including reduction of the prevalence of diabetes and childhood obesity, as well as enhanced access to essential and generic medicines. In view of the aim to finalize the set of indicators and targets by the end of 2012, it would be advisable to include only those that enjoyed strong support and could feasibly be achieved. The main focus of the draft decision should be on the process rather than the substance of the Secretariat's further work. He urged the Secretariat to continue providing support to developing countries, especially the least developed, to strengthen their national health information systems and improve their monitoring capacities.

Dr MAHDI (Sudan) welcomed the efforts made by WHO to prevent and control noncommunicable diseases. He supported the proposed targets, which should be feasible and therefore achievable.

Dr Ferguson took the Chair.

Dr FORSTER (Namibia) expressed satisfaction at the progress made to date regarding the prevention and control of noncommunicable diseases and the increased momentum created through the Moscow Declaration on Healthy Lifestyles and Noncommunicable Disease Control and the Political Declaration of the High-level Meeting of the United Nations General Assembly. Expedient finalization of the global monitoring framework would enable the swift integration of the set of indicators into national health systems. His Government recognized the need to establish a reliable and comprehensive baseline for targeted subsequent action. In order to address the double burden of communicable and noncommunicable diseases, a cohesive, well-integrated, holistic approach that took full account of the social determinants was needed. He therefore supported the resolution contained in resolution EB130.R7, which emphasized broad-based multisectoral action. Broad partnerships built on community participation would be crucial, together with strong stewardship of global health systems.

Dr AL DOWAIRI (Kuwait) said that his Government had adopted a multisectoral plan to tackle noncommunicable diseases. All sectors should be involved in the prevention and control of noncommunicable diseases. Health information systems in the Member States of the Region of the Eastern Mediterranean were being strengthened with a view to reducing morbidity caused by unhealthy lifestyles. The Regional Office was coordinating its activities with governments and consulting experts in an effort to develop joint strategies to combat noncommunicable diseases.

Mr GLASSIE (Cook Islands) said that his country was facing a crisis due to noncommunicable diseases, the prevalence of which had risen dramatically over recent years. As a result, the Government had stepped up its efforts, focusing on the risk factors and implementing a national strategy and action plan. The WHO global forum on addressing the challenge of noncommunicable diseases (Moscow, 27 April 2011) and the High-level Meeting of the General Assembly had spurred his country to increase its efforts; the Government aimed to replicate and implement the action taken at the global level to the extent possible and in accordance with national needs, including multisectoral engagement.

Mr SAMO (Federated States of Micronesia) thanked the Secretariat for incorporating the outcomes of the High-level Meeting on the Prevention and Control of Non-communicable Diseases into its work. He supported the options and timeline for strengthening and facilitating multisectoral action for the prevention and control of such diseases through partnership outlined in document A65/7,

particularly the call for strengthened multisectoral action and the proposed partnership functions. He also supported the whole-of-government approach to noncommunicable diseases. Mortality indicators should be set according to age, sex and socioeconomic status indices. Data collected by means of WHO's STEPwise approach to surveillance should be used to finalize a set of common global indicators. He supported the establishment of a global monitoring framework, as proposed in document A65/6 Add.1, but agreed that further consultations were necessary to ensure that it would lead to meaningful action at the regional, national and local levels. He supported the proposal put forward by the delegate of the United States of America regarding the inclusion of cholesterol in paragraph 2 of the draft decision.

Dr WARIDA (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, emphasized the need for further work on noncommunicable diseases. The finalization of a set of voluntary global targets before the end of 2012 was crucial to tackling the problem on a global scale and to fulfilling the mandate entrusted to WHO by the United Nations General Assembly. The progress made needed capturing, but it was also essential to conclude the work referred to in resolution EB130.R7, especially in relation to the development of a set of voluntary global targets and indicators. At the regional level, consultations between Member States and stakeholders should be intensified in order to achieve the goal of finalizing the global monitoring framework during the formal consultations scheduled to take place in October 2012. With a view to meeting the deadline for the completion of the process, he called for the establishment of an informal working group at the current session, with the participation of two Member States from each region, to discuss and reach consensus on the set of global indicators and voluntary targets.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its 27 Member States, said that she favoured including cholesterol in the list of targets that required more work, rather than including it after the words "other targets or indicators that may emerge" in paragraph 2 of the draft decision. She would discuss the wording suggested by the delegate of the United States of America with the Member States of the European Union and would report later on the outcome.

Professor ELY (Mauritania) said that developing countries should remain vigilant in managing the double burden of communicable and noncommunicable diseases. Global efforts to tackle noncommunicable diseases should not detract from the work needed to fight against communicable diseases, especially in developing countries. Innovation, imagination and rigour should be the keywords in the development of national public-private partnerships for funding purposes, in order to obviate excessive reliance on external aid.

Dr DIXON (Jamaica) noted that the global monitoring framework was not expected to be adopted until 2013, two years after the High-level Meeting of the United Nations General Assembly; that interval could result in a loss of momentum in terms of the action initiated by the Political Declaration. She therefore suggested that, at the current session, Member States should adopt the proposed target of a 25% relative reduction, by 2025, in overall mortality from cardiovascular disease, cancer, diabetes and chronic respiratory disease, on which there appeared to be consensus.

Dr MALECELA (United Republic of Tanzania) commended the consultative work that had fed into the reports prepared by the Secretariat. She urged WHO to focus on the promotion of activities that linked communicable and noncommunicable disease programmes in order to make optimal use of limited resources. Those activities should include increased surveillance and capacity building through field epidemiology training programmes. The list of voluntary global targets should include a target relating to harmful use of alcohol, which was specifically linked to injuries and gender-based violence as well as to noncommunicable diseases. She highlighted the need for the participation of the private sector in the global fight against noncommunicable diseases.

Dr TUITAMA (Samoa) supported the proposal by the delegate of Jamaica to endorse during the current session a target of 25% relative reduction in mortality by 2025.

Dr DANKOKO (Senegal) supported the proposal by the delegate of Egypt to establish an informal working group.

Dr ALLENDE (Paraguay) welcomed the reports, in particular as they related to efforts to achieve universal access to health care, extend the coverage of health systems and promote the right to health care for all, so as to enhance quality of life and increase life expectancy. His Government was working within the framework of MERCOSUR (the Common Market of the South) and the Union of South American Nations to raise the priority of noncommunicable diseases on political agendas. He shared the concerns of other speakers regarding the feasibility of some of the targets and indicators and agreed on the need to continue reviewing and revising the targets before their finalization by the end of 2012. He also supported the suggestion made by the delegate of El Salvador to include chronic kidney disease in the list of targeted noncommunicable diseases and underlined the need to develop prevention strategies.

Dr Shu-Ti CHIOU (Chinese Taipei) said that Chinese Taipei provided universal health coverage and attached high priority to prevention and control of noncommunicable diseases. She welcomed the establishment of a global monitoring framework and set of indicators. Chinese Taipei allocated separate funds to noncommunicable disease prevention and health promotion, which were used to plan and implement various health programmes including tobacco control, cancer screening, obesity prevention and control, and maternal and child health programmes. Raising the price of tobacco had generated additional revenue to fund prevention and control of noncommunicable diseases. With regard to social determinants, Chinese Taipei had implemented a multisectoral strategy to reduce levels of obesity, as a result of which the rising trend in obesity had been halted in 2011.

Dr ALOMARI (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation's framework to prevent and control noncommunicable diseases focused on prevention, innovation, research, monitoring, evaluation, partnership and advocacy. Prevention should start at the community level by raising public awareness to enable people to adopt healthier lifestyles; the Federation could work closely with governments to provide programmes and services to that end. Such programmes and services should be guided by a holistic approach. The Federation was committed to supporting the efforts of Member States and the Secretariat towards achievement of the goals outlined in the Political Declaration of the High-level Meeting. Member States should support the global monitoring framework and voluntary targets, with a focus on prevention. Noncommunicable diseases should be central to the development agenda and should be included in the outcomes of the United Nations Conference on Sustainable Development (Rio+20), which would be a key process in determining the post-2015 development framework.

Dr TAUBERT (World Heart Federation), speaking at the invitation of the CHAIRMAN, agreed that noncommunicable diseases should rank highly on the post-2015 development agenda and be included in the outcomes of the Rio+20 Conference. Her organization was committed to supporting Member States and the Secretariat in catalysing global action to prevent and control noncommunicable diseases. She called on all countries to support a global monitoring framework and set of targets. The limited number of proposed targets, however, should be doubled and should include an 80% availability rate for affordable, quality-assured, essential medicines and technologies for noncommunicable diseases. Member States should report on the progress made towards achieving those targets every two years. Countries should support the establishment of a global coordinating platform on noncommunicable diseases led by Member States and organizations in the United Nations system, with representation from civil society and the private sector in order to facilitate multisectoral action to combat noncommunicable diseases, with safeguards against vested interests.

Ms MWATSAMA (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, and representing the National Heart Forum, World Cancer Research Fund International, World Action on Salt and Health, World Public Health Nutrition Association and Consumers International, welcomed the inclusion of nutrition goals in the draft global monitoring framework and endorsed a target to reduce dietary salt intake to five grams per day. She urged Member States to include targets on obesity, alcohol, *trans*-fatty acids, cholesterol and marketing of foods to children. WHO should, in collaboration with other United Nations organizations, develop global governance structures and comprehensive food policies integrating the prevention of noncommunicable diseases with the reduction of hunger and the promotion of nutrition security for all. She welcomed the set of recommendations on the marketing of foods and non-alcoholic beverages to children endorsed in resolution WHA63.14 and called on Member States to mandate the Secretariat to draft an international code to strengthen controls on cross-border marketing and to protect children in countries without national controls.

Dr FISHER (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, noted that the Political Declaration of the High-level Meeting of the General Assembly recognized the major disease burden posed by oral diseases, in particular dental caries and oral cancer. Such diseases shared common risk factors and could benefit from common responses to noncommunicable diseases. Countries should: implement an integrated response to noncommunicable diseases and ensure that oral diseases were incorporated into all global, regional and national noncommunicable disease strategies, in line with resolution WHA60.17; include oral cancer in the proposed global monitoring framework as one of the major outcomes for cancer incidence by type; support targets for diet and obesity, including sugar consumption; and strengthen health systems through emphasis on primary health care, including primary oral health care. He pledged full support for WHO's Global Oral Health Programme.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that in order to maintain the momentum generated by the Political Declaration of the High-level Meeting of the General Assembly, coordinated action must be taken in the areas of prevention, diagnosis, treatment, care and support at the global level, and all chronic diseases should be addressed. A robust global monitoring framework for noncommunicable diseases should be developed, with clear indicators and targets. Although the targets should be achievable, they should also set a benchmark encouraging sustained action, and the 10 original targets should be reinstated. The current targets neglected treatment, and that omission should be rectified by inclusion of a target to ensure the availability of affordable, high-quality treatments, diagnostics and palliative care for noncommunicable diseases. Multisectoral action was vital to success. Although patients' organizations provided a wide range of health care services, their essential work was often undervalued. The Secretariat and Member States should undertake a mapping exercise in order to understand better the work of patients' organizations and its impact. All policies, programmes and strategies must be based on the fundamental right to patient-centred health care.

Mr PLEYER (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that the current set of five targets envisaged under the global monitoring framework was insufficient. A comprehensive set of targets was needed, including targets relating to the banning of *trans*-fatty acids and the marketing of unhealthy foods to children. Although indicators were crucial for monitoring progress, they did not fulfil the same role as targets. Since noncommunicable diseases disproportionately affected the poorest people in society, the principle of equity was of paramount importance and that should be reflected in the indicators. Mortality was an appropriate overarching target, but any reduction in the global burden of noncommunicable diseases could not be assessed accurately without also monitoring morbidity. WHO should seize the opportunity afforded by the Rio+20 United Nations Conference on Sustainable Development to put noncommunicable diseases firmly on the sustainable development agenda.

Dr FISHER (FDI World Dental Federation), speaking at the invitation of the CHAIRMAN, presenting the statement on behalf of the World Medical Association and speaking also on behalf of the International Council of Nurses, the International Pharmaceutical Federation, and the World Confederation for Physical Therapy, said that WHO should ensure that the monitoring framework covered a broad range of diseases, including, for example, mental illness, musculoskeletal diseases and oral diseases and reflected a holistic approach, emphasizing the importance of healthy lifestyles, social determinants of health and health system strengthening. Morbidity should be included among the indicators, and the proposed targets on alcohol and obesity should be reinstated. It was essential to form a committed partnership that included Member States, organizations of the United Nations system, civil society and the private sector, while avoiding conflicts of interest.

Dr PERICO (International Society of Nephrology), speaking at the invitation of the CHAIRMAN and on behalf of the People's Health Movement, welcomed the reference in the Political Declaration to kidney disease as a major health threat that could benefit from common responses to noncommunicable diseases. His organization had published a comprehensive review of the epidemiological evidence showing that chronic kidney disease was a major risk factor for cardiovascular disease and demonstrating the value of albuminuria as a predictor of renal disease and excess risk of cardiovascular disease. Measuring albumin concentration in urine should be part of the noncommunicable diseases monitoring framework in primary care settings. Strategies for the prevention, detection and early treatment of diabetes and cardiovascular disease would not eliminate the need to address kidney disease separately. In developing countries, up to 40% of those with chronic kidney disease did not have diabetes or cardiovascular disease. Effective low-cost interventions were available for chronic kidney disease when it was caught early. The disease should be recognized as a major noncommunicable disease and a specific policy for its early detection and treatment should be drawn up.

Ms FABRI (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the prospects for effective regulation of the global agri-food industry were fading because of the inclusion of investor-protection provisions in trade agreements. The attack by the tobacco industry on Australia's plain-packaging regulations should serve as a warning to policy-makers who saw a role for industry regulation in the prevention and control of noncommunicable diseases. The global strategy for the prevention and control of noncommunicable diseases mentioned trade and industry factors, but commitment to effective action in that area was lacking. As WHO's mandate covered the social and economic determinants of noncommunicable diseases and ensuring health and trade policy coherence, she urged Member States to strengthen their commitment to tackling noncommunicable diseases through action in diverse fields, including trade, agriculture, urban development and taxation. Because the global strategy involved collaboration with the private sector, the provisions on conflict of interest envisaged under the WHO reform process were urgently needed.

Dr COSTEA (International Special Dietary Food Industries), speaking at the invitation of the CHAIRMAN, said that good nutrition, especially in early life, was essential to the prevention and control of noncommunicable diseases. Her organization supported exclusive breastfeeding for the first six months of life and continued breastfeeding thereafter. The timely introduction of safe and appropriate complementary foods beyond six months was important in promoting children's optimal health and development, and her organization would continue to contribute to the improvement of knowledge in that area. Members of her organization continued to invest in research and development to enhance nutrition for infants and young children, which would have a positive impact on health outcomes later in life. She supported the objectives set out in document A65/8.

Dr REED (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, said that medicines were crucial in the treatment of noncommunicable diseases and provisions relating to availability of medicines should be included in all programmes for the

prevention and control of such diseases. Studies had shown that generic medicines were significantly less available for noncommunicable diseases, particularly asthma, epilepsy, depression and hypertension, than for communicable diseases. He therefore proposed the inclusion of two targets in the global monitoring framework: 80% availability of generic essential medicines for noncommunicable disease in the public and private sectors; and 80% availability of essential health products for diagnosis, monitoring and treatment of noncommunicable diseases, consistent with the targets established under WHO's Medium-term strategic plan 2008–2013. A method for assessing the affordability of standard treatments for noncommunicable diseases should be developed in order to ensure that meaningful targets and indicators could be established.

Mgr VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, welcomed the report on the implementation of the action plan for the prevention of avoidable blindness and visual impairment (document A65/9), which was an area that did not always receive equitable attention and action from the public health community. In November 2011, the Holy See had sponsored a global conference on the prevention of blindness, at which expertise, experience and lessons learnt by Catholic and other religious institutions working in that field had been shared.

Dr BOULYJENKOV (Thalassaemia International Federation), speaking at the invitation of the CHAIRMAN, said that the global health burden of inherited haemoglobinopathies, such as thalassaemia and sickle-cell disease, was increasing, and he welcomed the governing body resolutions on the subject adopted in 2006.¹ It was to be hoped that a progress report would be prepared, documenting Member States' activities aimed at developing relevant national programmes. Haemoglobin disorders required specific strategies and interventions based on advanced research. He therefore welcomed WHO's ongoing initiatives in that regard (outlined in document A65/8) and supported the global strategy and action plan for the prevention and control of noncommunicable diseases, especially in so far as they related to research.

Dr KEENAN (International Pediatric Association), speaking at the invitation of the CHAIRMAN, said that the prevalence of major noncommunicable diseases in children and adolescents had reached epidemic proportions. Most preventable forms of behaviour that led to noncommunicable diseases took root in childhood or adolescence. Cost-effective, child-focused interventions existed, including second-hand smoke exposure control and nutrition and vaccine programmes. Nevertheless, limited resources had been allocated to the prevention and treatment of noncommunicable diseases in children and adolescents, which meant avoidable deaths. National approaches should take into account the specific needs of those age groups, at all levels of the health care system, to ensure that development assistance included support for child and adolescent health interventions.

Dr CHESTNOV (Assistant Director-General) acknowledged the comments and the general support expressed for the noncommunicable disease agenda, in particular for the five global targets relating to mortality, raised blood pressure, tobacco use, salt intake and physical inactivity. Other targets had also been discussed, and the Secretariat would continue to review the necessary balance between political will and technical expertise, and take into account the need to show that progress had been made in implementing the recommendations contained in the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.

The comments on the marketing of food and alcohol products to children, the suggestion to establish a database of best practices, and the proposals on cholesterol-related indicators would all be taken into consideration. The Secretariat would continue to prioritize food and nutrition security for

¹ Resolutions WHA59.20 and EB118.R1.

children, as well as healthy ageing. It was important to learn from mistakes made in the past relating to the prevention and control of communicable diseases in order to improve future activities. Despite demonstrated political will, international experience and technical expertise in combating obesity, and consumption of sugar and saturated fats was still limited, but those areas would be included among the global targets. He thanked Member States for their participation in the three regional consultations held thus far, and said that consultations would be undertaken shortly in the African, Eastern Mediterranean and Western Pacific regions. A third web-based consultation would be launched in June or July 2012, followed by a formal consultation with Member States in October in order to finalize the targets and indicators and to formulate a concrete proposal for the comprehensive global monitoring framework.

The CHAIRMAN drew attention to the draft decision on prevention and control of noncommunicable diseases put forward by the delegate of the United States of America in the first meeting.

Ms SCHJØNNING (Denmark) said that she needed time to consult on the draft decision.

Mr McIFF (United States of America), supported by Dr WARIDA (Egypt) and Dr THAKSAPHON THAMARANGSI (Thailand), proposed establishing a drafting group to revise the draft decision in the light of the rich discussion, with particular attention to the proposals concerning mortality targets.

Dr RODRÍGUEZ (El Salvador) emphasized the need for attention to chronic kidney disease and to work-related and environmental risk factors.

The CHAIRMAN took it that the Committee wished to establish a drafting group to discuss the draft decision.

It was so agreed.

The CHAIRMAN took it that the Committee wished to approve the draft resolution contained in resolution EB130.R6.

The draft resolution was approved.¹

(For continuation of the discussion and approval of the draft decision, see the summary record of the seventh meeting, section 2.)

- **Options and a timeline for strengthening and facilitating multisectoral action for the prevention and control of noncommunicable diseases through partnership**

The CHAIRMAN drew attention to the report by the Secretariat contained in document A65/7.

Dr ST. JOHN (Barbados) welcomed the report, but expressed a preference for the use of established networks, without prejudice to the principle of WHO's leadership and coordinating role. Regarding the section of paragraph 18 on capacity building, she urged recognition of the impact of chronic diseases on all developing countries, rather than only low-income, middle-income and least developed countries.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65.3.

Dr RODIN (Canada) said that national contexts had to be taken into account in considerations of effective and sustained multisectoral action. Existing mechanisms should be used where possible, ensuring integration and sharing of best practices for the optimal use of limited resources. Partnerships would only continue when their impacts were tangible and relevant. Paragraphs 12 and 13 of the report noted the importance of civil society and the private sector, but not the higher priority assigned to those sectors in paragraph 37 of the Political Declaration of the High-level Meeting. A multisectoral approach would support national efforts for the prevention and control of noncommunicable diseases and strengthen their effectiveness. Those key principles for multisectoral action, as well as the value of sharing effective partnership models among Member States, should be highlighted in WHO's input to the United Nations Secretary-General.

Mr KOLKER (United States of America) said that multisectoral action was critical to the prevention and control of noncommunicable diseases and stressed the need for engagement by non-health sectors to address the growing burden of such diseases. The Secretariat's report contained practical ideas on how stakeholders could work together to address the social and environmental factors contributing to noncommunicable diseases, and he welcomed its conclusion that a single, stand-alone partnership might not cover all needs. Existing global partnerships, alliances and results-oriented arrangements should be strengthened, and new ones established only when required. Task-focused networks could effectively exchange information and improve coordination to achieve specific goals while maintaining operational flexibility with minimal transaction costs. The report contained a useful set of questions to be considered in determining the work streams and structure of a global partnership mechanism. It was unlikely that all those questions could be answered at the current stage, but the Secretariat, in preparing recommendations for the United Nations Secretary-General, should use existing examples of best practice in multisectoral approaches, results-oriented alliances and national programmes embodying effective communication strategies.

Ms SCHJØNNING (Denmark) said that all sectors and stakeholders that had an impact on health should contribute to the prevention and control of noncommunicable diseases. Such diseases required local solutions, and partnerships with nongovernmental organizations and civil society were essential. The six necessary functions of partnerships, listed in paragraph 18 of the report, reflected a disease- or treatment-based approach; more emphasis should be placed on determinants, prevention and the development of public policy measures in consultation with stakeholders. More research on public health interventions, policies and capacities was needed, and conflicts of interest would have to be addressed. The report to be submitted to the United Nations Secretary-General should provide a strategic approach, driven by policies to reduce the burden of noncommunicable diseases. She encouraged Member States to participate fully in consultations to finalize that report.

Dr JACOBS (New Zealand), recognizing that multisectoral action was crucial to success in the fight against noncommunicable diseases, said that the challenge was to put theory into practice. The likelihood of success, which depended on the investment of resources, expertise and political will, would be reduced if responses were limited to the health sector. He strongly encouraged the Secretariat to continue to prioritize multisectoral action and to adopt a motto such as "Noncommunicable diseases are everyone's business", which could be put forward in the forthcoming report to the United Nations Secretary-General as an approach applicable across the United Nations system.

Mr THOMSON (Switzerland) said that health issues could no longer be dealt with by the health sector alone. He therefore welcomed the report's emphasis on multisectoral action in the fight against noncommunicable diseases, noting that the implementation of the options set out in the report would be the responsibility of Member States. He expressed concern at the short time available for the preparation of the report to the United Nations Secretary-General. His Government was anxious to make its own national contribution to the report and trusted that the Secretariat would include in it all

relevant information relating to multisectoral cooperation. He welcomed the consultations that had been undertaken in that regard. In the light of its international experience and expertise, WHO was well placed to respond to the expectations raised by the new global awareness of the burden of noncommunicable diseases.

Dr TUGSDELGER (Mongolia) said that her country had made considerable progress in the area of multisectoral action for the prevention and control of noncommunicable diseases over the previous two years. Flows of foreign aid to prevention and control programmes had only recently increased, and limited resources had to be used effectively. Development partners should support and not complicate coordination at country level, avoiding activities that undermined national institution-building, optimizing the use of country systems and procedures, and minimizing overheads for development assistance, in accordance with the principles enshrined in the Paris Declaration on Aid Effectiveness. Those principles should guide all multisectoral action for the prevention and control of noncommunicable diseases.

Dr AL-TAAE (Iraq) stressed the relevance of partnerships to the achievement of Millennium Development Goal 8 (Develop a global partnership for development). Active partnerships with clearly defined targets and indicators were important to WHO's work at country and regional levels. National partnerships should be enhanced, with the involvement of civil society as well as international organizations. All partnerships should be active, including those within the United Nations system, to ensure optimal use of the resources available. They should be reviewed regularly to ensure their continued usefulness, and enable them to be strengthened.

Professor UDOM KACHINTORN (Thailand) said that multisectoral collaboration was required to tackle noncommunicable diseases. Experience had shown, however, that in some cases the private sector had opposed proven and effective interventions, and it was therefore essential to safeguard health from any potential conflict of interest involving, for example, the tobacco and alcohol industries. National legislation should be developed to that end. Regarding the functions of partnerships outlined in the report, product access and the availability and affordability of all health products, not just medicines and technologies for the treatment of diseases, should be guaranteed. Commending the report, he endorsed the health-in-all-policies approach.

Ms BENNETT (Australia) said that her Government was committed to a multisectoral approach to health and had put in place programmes and activities that promoted healthy outcomes in various non-health settings, such as schools and workplaces. She agreed that there was no "one-size-fits-all" solution and that a single, stand-alone, formal partnership might not cover all needs. A mix of partnerships, alliances and collaborations would be more flexible, and should build on existing models wherever possible. She asked for clarification of the possible function of a collaborative network or coordination mechanism and of how it would build on existing mechanisms such as the Global Noncommunicable Disease Network (NCDnet).

Mr MESBAH (Algeria) agreed that a multisectoral approach was essential. The challenge lay in the implementation of partnerships. He wondered whether participation by the various stakeholders in surmounting that challenge would be voluntary and emphasized the public health obligations of all. That issue should be examined in the light of existing experience.

Dr CHESTNOV (Assistant Director-General) welcomed Member States' recognition of the need to engage other sectors in health policies and policy development, and to build and coordinate results-oriented partnerships in the context of national efforts to address noncommunicable diseases. Such partnerships should have the following key functions: advocacy, political leadership, coordination, resource mobilization, capacity building and the expansion of access to health technology. Increased clarity of function would facilitate a more rational, effective and efficient

allocation of resources to strengthen national programmes for noncommunicable disease prevention and control. Member States had indicated a strong preference for building on existing structures rather than creating new ones. To that end, a platform for dialogue was needed, which would be guided by WHO norms and values and shaped by ongoing challenges. Member States had welcomed regional and bilateral consultations and had proposed further informal consultations, which would take place in June or July 2012. He underlined the importance of synthesizing the experience of countries and the Secretariat as a basis for further multisectoral collaboration.

The Committee noted the report.

• Implementation of the action plan for the prevention of avoidable blindness and visual impairment

The CHAIRMAN drew attention to the report contained in document A65/9.

Dr ESCOBAR (Chile) said that her country had made significant advances in eye health. Access to eye care and treatment for a variety of eye diseases, including cataract, retinopathy of prematurity, retinoblastoma, strabismus, diabetic retinopathy and refractive errors, had been expanded. Specialized ophthalmology services were provided in remote rural areas by travelling medical and surgical teams. An intersectoral programme involving the health and education sectors ensured the availability of ophthalmology services, including the provision of glasses, to all primary schoolchildren. Prevention of blindness and visual impairment should remain a priority for WHO.

Mr DESIRAJU (India), emphasizing the seriousness of visual impairment, said that his country's national programme for control of blindness focused on comprehensive eye care delivery and the quality of services. An integrated public-private partnership for treatment of cataracts had become the best model health programme in the country, and budgetary allocations to eye care had steadily increased. According to a rapid assessment of avoidable blindness conducted during 2006–2007, the prevalence of blindness had fallen to 1.0%. The target was 0.3%. India was also committed to eliminating trachoma by 2020.

Problems to be tackled during the period covered by the action plan included integrating eye care into broader health plans to reflect the rise in chronic noncommunicable eye conditions and scaling up funding. The Secretariat, in collaboration with Member States and international partners, should begin work on a follow-up plan for the period 2014–2019, the draft of which could be submitted through the Executive Board to the Sixty-sixth World Health Assembly.

Dr AL-TAAE (Iraq) said that Iraq had established a visual health programme as an integral part of its primary health care system. Eye care coverage was to be extended to all schools, and a programme to raise awareness was under way. As children accounted for 10% of visual impairment cases, special provision should be made for them, particularly in view of the economic and social implications of such disabilities.

Ms LAMOURELLE (United States of America) observed that avoidable blindness and visual impairment disproportionately affected countries with the least resources. She welcomed the action taken to increase awareness through advocacy, strengthen national policies and programmes, expand research, improve coordination, enhance data collection and surveillance and monitor progress. Those activities would be crucial in strengthening Member States' capacity to identify and prioritize issues and areas for improvement in relation to accurate assessment of disease burden, better monitoring of the causes of avoidable blindness and visual impairment, and more coordinated and multidisciplinary research. The provision of vision care that reflected the disease burdens and demographics of individual Member States should be encouraged in order to address the varying causes of preventable blindness and visual impairment. It was also imperative to enhance awareness among the public and

health care providers of all aspects of visual impairment, including comorbidity, and to ensure that screening and prevention were integrated into routine health services.

In the current global economic situation, the Secretariat should continue to play a role in coordinating health activities, focusing on high-impact, cost-effective interventions. Despite concerns as to the financial and technical capacity of Member States and the Secretariat to carry out the activities envisaged under the current action plan, her Government supported the development of a new action plan for the period 2014–2019, as called for in decision EB130(1).

Dr SA'IDI (Saudi Arabia) said that the Member States of the Eastern Mediterranean Region also supported the development of a new action plan, which would lend continuity to current blindness prevention efforts at national and regional level. Greater political will was required on the part of national governments, which should step up their efforts to provide better training in visual health and ensure that visual health care was provided in remote and rural areas. The Secretariat should play a coordinating role, facilitating cooperation among stakeholders at various levels.

Dr WU Liangyou (China) said that the protection of visual health was a compelling obligation on governments at all levels. He welcomed the progress made in visual health since the establishment of the Global Initiative for the Elimination of Avoidable Blindness (VISION 2020: the Right to Sight). His Government had implemented many programmes for the prevention and treatment of blindness, especially in the context of a major reform of the health system in 2009. A national programme was being developed, covering the period 2011–2015. Under a special project, cataract surgery had been provided to 1.09 million people by the end of November 2011. He called on WHO to continue efforts to raise awareness of visual health, to enhance support for the prevention and treatment of blindness by governmental and nongovernmental organizations and to help to strengthen health education in less developed regions. Greater support was also needed for investment, epidemiological research, strengthening of information systems and professional training.

Ms SKACHKOVA (Russian Federation) said that health centres in her country had begun to provide ophthalmological services for the detection and prevention of serious eye problems, including blindness, cataract and glaucoma. She supported the development of national action plans, for which adequate funding should be provided. Such plans should include the provision of social reintegration services. She called on the Secretariat and all Member States to prioritize intersectoral approaches to blindness and visual impairment.

Ms PATTERSON (Australia) thanked the Secretariat for its work on the five objectives set out in the current action plan and its work with Member States and international partners on an initial draft of the action plan 2014–2019. She commended its role in promoting investment in eye health and in drawing attention to the barriers to implementing the plan fully. Eye health and vision care remained priorities for Australia, where consultations were under way on the development of the new action plan. She encouraged all Member States to continue to engage in the consultation and drafting process.

Dr ALLENDE (Paraguay) said that his Government was addressing the serious public health problems of blindness and visual impairment in an integrated manner, in accordance with the principles of universality and equality. Gaps in detection, monitoring, treatment, rehabilitation and funding were being tackled systematically under a strategic plan, and the coverage of the national programme had been expanded through service networks encompassing a range of facilities, from family health units to specialized hospitals. Despite progress made since 2008, better intersectoral cooperation was required to meet WHO targets, with particular regard to prevention, epidemiological surveillance and primary health care guidelines.

Dr RAPEEPONG SUPHANCHAIMAT (Thailand), acknowledging the good progress reported, noted that activities related to Objective 1 of the action plan had been mostly technical, without reference to political or financial issues. Assessments of the global magnitude of visual impairment should include policy analysis in order to provide lessons about how best to implement policies. Priority should be given to cataract as recent estimates had shown that it was the second leading cause of visual impairment and the leading cause of blindness. It was not clear whether the actions described for Objective 2 were sufficient to sustain eye care programmes at country level. They did not address fundamental problems of health systems, in particular with regard to resources, delivery mechanisms, early screening, diagnosis and treatment. Screening and enhanced access to treatment were essential to reverse the increasing prevalence of diabetic retinopathy. More auxiliary eye health workers were needed. Cooperation between developing countries could offer benefits.

Work on Objective 3 should focus on strengthening countries' research capacity and the use of cost-effectiveness analyses to guide decisions on investment and resource allocation. The activities undertaken in respect of Objective 4 seemed to consist mostly of holding WHO meetings. The question arose of what other activities had been undertaken to improve collaboration between partners. Member States themselves had a critical role to play. He commended the progress reported under Objective 5 for the elimination of trachoma and onchocerciasis but urged more attention to the increasing burdens of age-related macular degeneration, cataract and diabetic retinopathy. Improvements in eye care services needed to be monitored and sustained.

Mr SIME (Ethiopia), providing data from the 2006 National Survey on Blindness, Low Vision and Trachoma in Ethiopia, said that the prevalence rates of blindness (1.6%) and visual impairment (3.7%) in his country were among the highest in sub-Saharan Africa. National five-year strategic plans based on the recommendations of the VISION 2020 initiative had been implemented since 2001. The current strategic plan, which was based on the national health policy and drew on national and regional data, included advocacy for greater financial, political and technical commitments and gave priority to strengthening and expanding research, monitoring programme implementation, and technical support.

Dr BRENNEN (Bahamas), recognizing the dual burden of disease related to avoidable blindness, asked the Secretariat to ensure that global and regional policies, plans and programmes for eye health were focused on a balanced and comprehensive approach encompassing communicable and noncommunicable diseases. Noting the national and regional shortage of human resources for comprehensive eye care programmes, he said that his country wished to be included in the strategy and activities for training more eye care professionals, as both a contributor and recipient of support.

The meeting rose at 12:30.

THIRD MEETING

Tuesday, 22 May 2012, at 15:45

Chairman: Dr L.Z. DUKPA (Bhutan)

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

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A65/6, A65/6 Add.1, A65/7, A65/8, A65/9, and EB130/2012/REC/1, resolutions EB130.R6 and EB130.R7) (continued)

- **Implementation of the action plan for the prevention of avoidable blindness and visual impairment** (continued)

Professor ELY (Mauritania) said that, despite the considerable human and economic cost of blindness and visual impairment, such conditions were a neglected area of noncommunicable disease prevention and control and should be given far greater priority. Mauritania was endeavouring to eliminate trachoma and had achieved good progress in tackling blindness due to cataract. The fight against blindness and visual impairment should be accelerated in developing countries, and greater support should be provided for human resources training and access to equipment and good quality consumables at reduced prices.

Ms ARRINGTON AVIÑA (Mexico) welcomed Member States' support for a follow-up action plan for 2014–2019 for the prevention of avoidable blindness and visual impairment, conditions that were an important concern for many Member States. Mexico had made good progress in battling trachoma and was collaborating in Central American projects aimed at eliminating the disease, which remained a major public health problem in the region. The web-based consultation on the new action plan, initiated in February 2012 by the Secretariat, had provided a welcome opportunity to review progress to date and discuss future action.

Dr CHESTNOV (Assistant Director-General) said that, as requested by the Executive Board in decision EB130(1), the Secretariat was developing a new action plan for the period 2014–2019. The draft plan would be submitted to the Sixty-sixth World Health Assembly for consideration. To ensure the full participation of Member States and international partners in the process, a preliminary draft would be posted on the WHO web site in July 2012 and comments thereon would be taken into account in subsequent revisions of the plan. He had taken careful note of delegates' comments on the report, which would serve as additional input for the development of the new action plan.

The Committee noted the report.

The CHAIRMAN suggested that further consideration of agenda item 13.1 should be suspended, pending the outcome of the deliberations of the drafting group formed to consider the draft decision on prevention and control of noncommunicable diseases.

It was so agreed.

(For approval of the draft decision, see the summary record of the seventh meeting, section 2.)

- **Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level:** Item 13.2 of the Agenda (Documents A65/10 and EB130/2012/REC/1, resolution EB130.R8)

Dr LARSEN (representative of the Executive Board) said that, at its 130th session in January 2012, the Board had considered a Secretariat report that described the impact of the global burden of mental disorders on health, socioeconomic development and human rights, and reviewed effective health and social strategies for the prevention and treatment of mental disorders and the promotion of mental health. The Board had adopted resolution EB130.R8 that contained a draft resolution in which the Health Assembly requested the Director-General to develop a comprehensive mental health action plan covering services, policies, legislation and activities to provide treatment, facilitate recovery and follow-up, prevent mental disorders and promote mental health. The Committee was invited to consider the draft resolution.

Mr DESIRAJU (India) said that mental illness was widespread and existed in every society, affecting rich and poor, men, women and children, and that mental disorders accounted for a growing proportion of the global burden of disease. Yet, mental illness remained on the margins of public health concerns. India, with the support of Switzerland and the United States of America, had therefore submitted a draft resolution on the global burden of mental disorders to the Executive Board at its 130th session, which had been adopted as resolution EB130.R8. He urged the Committee to approve the draft resolution recommended therein.

Mr GLASSIE (Cook Islands) said that, as in other Member States, the prevalence of mental disorders was rising in the Cook Islands, which had seen a dramatic increase in youth suicide. His Government had convened a youth forum in 2011, with the participation of relevant ministries, nongovernmental organizations, community leaders and young people. The forum's recommendations would be taken into account in developing a comprehensive and coordinated response in the form of a five-year plan.

Ms HYDE (United States of America) said that her Government was committed to raising awareness of the public health implications of mental, neurological, developmental and substance abuse disorders. It supported the draft resolution, welcoming in particular its reference to United Nations General Assembly resolution 65/96, which recognized that mental health problems were significant contributors to the burden of disease, and its acknowledgement that mental health disorders fell within a wider spectrum, since many people experienced concurrent physical and mental disorders. Her Government endorsed the call for Member States to emphasize human rights in their mental health policy development and to work with the Secretariat in developing a comprehensive mental health action plan, which would encompass prevention, screening, early intervention, treatment and support services for those living with mental disorders and their caregivers, including during humanitarian emergencies.

Mr TOBAR (Argentina) said that his Government's approach to mental health placed emphasis on the social determinants of health, in particular poverty, violence, abuse and the home environment. Recognizing the many social and economic repercussions of mental illness, which included marginalization, scarcity of opportunities for education and work, and human rights violations, Argentina had enacted mental health legislation in 2010 that broadened the rights of people with mental disorders and included treatment of substance addiction. A national mental health assessment system was being developed and introduced across the country. He supported the draft resolution.

Ms SKACHKOVA (Russian Federation) said that she supported the Secretariat's efforts to develop and implement comprehensive and coordinated measures to reduce the global burden of mental disorders. Recognizing the need to protect the mental health of its citizens, the Russian Federation had included mental health measures in the federal health programme for 2007–2012, which aimed to improve quality of life, extend life expectancy, help people with mental disorders to remain at work, promote the adoption of healthy lifestyles and reduce social and psychological tensions in the community. Those measures had proved effective, resulting in the stabilization of morbidity figures for mental disorders, and would be pursued under the new health programme, to end in 2020. An Internet-based service offering emergency psychological support had been set up. Her country's extensive network of clinics and hospitals provided specialist support, and outreach programmes that included community-based care were being developed.

Mr SIME (Ethiopia), expressing support for the draft resolution, said that Ethiopia was launching a national mental health strategy which, in line with WHO recommendations, provided for the integration of mental health into the primary health care system, promoted a decentralized approach to ensure that services were available in health facilities at all levels and provided access to treatment close to home, in the least restrictive environment possible. With the support of WHO and other partners, Ethiopia had developed a mental health gap action programme with a view to establishing productive intersectoral partnerships that could lead to greater investment in efforts to reduce mental, neurological and substance abuse disorders.

Ms SCHJØNNING (Denmark), speaking on behalf of the Member States of the European Union, the acceding country Croatia, the candidate countries the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidate Bosnia and Herzegovina, as well as Albania and Armenia, welcomed the renewed commitment to mental health and the recognition of its link to noncommunicable diseases. Mental disorders gave rise to health inequalities and were closely associated with low socioeconomic status, poverty and unemployment. There were, however, many effective strategies for managing mental disorders. In recent years, the Member States of the European Union had made great strides in that regard, including through the adoption of the European Pact for Mental Health and Well-being and the development of comprehensive mental health programmes.

High priority should be accorded and adequate resources ensured for the Secretariat's work on the effective management of mental disorders, which should encompass both prevention and promotion activities. Strategies should be underpinned by a set of key principles that included a value system promoting dignity, human worth and social justice; mental health training for all health professionals; measures to combat stigmatization and discrimination; commitment to the mental health recovery model; and holistic approaches combining practical and emotional support. Efforts should be made to develop a service culture that acknowledged the importance of early intervention, assured an effective patient/public risk balance, delivered optimum community-based care in the least restrictive environment possible, promoted independence and gave equal attention to the physical and mental health needs of service users. Duplication of work already being carried out under the WHO Mental Health Gap Action Programme should be avoided. She welcomed the draft resolution.

Dr WU Liangyou (China) expressed concern that, despite the rising burden of mental disorders, people with such conditions remained largely untreated and were often marginalized, especially in low- and middle-income countries. He commended the work carried out under the WHO Mental Health Gap Action Programme. The Secretariat should continue encouraging Member States to implement effective measures for combating mental disorders; to strengthen mental health legislation; to reinforce mutual information-sharing; to maintain academic and professional exchanges on mental health; and to enhance communication among mental health decision-makers.

Dr YARDIM (Turkey) pointed out that access to mental health services was a challenge in developing and developed countries alike, although the treatment gap was lower in developed countries. There was an urgent need for comprehensive, holistic, intersectoral community-based programmes to prevent and treat mental disorders and to discourage stigmatization of those affected. As a result of studies conducted in cooperation with WHO, Turkey had decided to implement a community-based national mental health programme and to bolster the capacity of community-based services for people with disabilities, a project in which several ministries were collaborating closely. Prevention of childhood traumas and early diagnosis and treatment of mental disorders were crucial to protecting mental health. He supported the draft resolution.

Dr GEDEON (Seychelles), speaking on behalf of the Member States of the African Region, said that there had been few studies on mental illness in the Region even though mental and neurological disorders were a major cause of disability and contributed to morbidity, premature mortality and social ills, all of which were exacerbated by alcohol and drug abuse. People with mental disorders were subjected to stigmatization, discrimination and human rights violations, and the vast majority did not receive care owing to a lack of financial and human resources. Increased access to effective and affordable interventions through the primary health care system was needed. Implementation rates for the Regional Strategy for Mental Health (2001–2010) had varied, but some progress had been made. Still, mental health budgets remained low, often representing less than 2% of the health budget, and there was a critical shortage of trained health professionals. Member States in the Region must work together to develop mental health policies and plans, increase budget allocations for mental health and develop human resources. Tangible support from committed partners was also needed.

Dr ALMANEA (Bahrain), endorsing the draft resolution, welcomed the Secretariat's efforts in the area of mental health. Mental disorders were often closely linked with other diseases and had considerable socioeconomic repercussions. Yet, many people living with such disorders did not receive appropriate treatment. To tackle that problem, countries should include mental health in their national health plans, provide appropriate social services and enact legislation that protected the human rights of individuals with mental disorders. Bahrain offered health services to all its citizens, including mental health care, which was provided through primary health care services, psychiatric hospitals and schools. Efforts were also being made to reduce discrimination against people with mental disorders.

Dr NOZAKI (Japan) said that inadequate attention had been paid to mental health until recently, thanks to a growing interest in noncommunicable diseases. Japan had added mental health to its list of health priorities and was reforming its health policies and social services to give more precise definition to community-based support systems and mental health care. Efforts were being made to raise public awareness and to improve the quality of care for people with mental disorders and facilitate their social integration. Consideration was being given to the preparation of guidelines for the prevention and treatment of depression, post-traumatic stress disorder and suicide. Suicide prevention, in particular, was being bolstered through measures to raise awareness, promote mental health in the workplace and broaden outreach activities. His Government stood ready to share its experience in addressing the mental health impact of the March 2011 earthquake.

Dr RODIN (Canada) said that Canada was committed to promoting the mental health and well-being of its citizens, and in 2007 had established a mental health commission to build the partnerships needed to raise awareness of mental illness and develop a national mental health strategy. The strategy, released in May 2012, emphasized the need for intersectoral action and highlighted the role of nongovernmental organizations and the media in promoting mental health. It recommended a comprehensive approach to mental health needs, promotion of mental health in the workplace and reduction of the stigmatization associated with mental disorders. She endorsed the draft resolution,

welcoming in particular its emphasis on mental health promotion and mental illness prevention, which were at the centre of Canada's approach.

Dr FEISUL IDZWAN MUSTAPHA (Malaysia) supported the draft resolution. He endorsed WHO's strategies on mental health in general but emphasized that the development of national surveillance networks must take into account the specific conditions in each Member State. In 1998 his Government had adopted a national mental health policy in line with WHO recommendations, and in 2010 it had set up a mental health promotion advisory council to provide policy and programme guidance. It had enacted mental health legislation which, among other things, encouraged the establishment of psychiatric nursing homes and community mental health centres. A national strategic action plan for suicide prevention was being developed in collaboration with nongovernmental organizations. The proposed comprehensive mental health action plan should further strengthen Malaysia's mental health initiatives.

Ms POLL (Costa Rica) agreed that a coordinated response to mental disorders by the health and social sectors was needed. Mental disorders had a costly social and economic impact, ranging from increased marginalization, poverty and noncommunicable disease risk to lack of educational and employment opportunities. Costa Rica was experiencing difficulty in pursuing an integrated approach to mental disorders because it lacked effective mechanisms for achieving genuine change. The Government recognized the need to improve its mental health services through effective intersectoral strategies and policies. It was drafting a mental health policy and implementation plan for the coming decade that would set out rehabilitation and social integration strategies for people with mental disorders. Financial and technical support was needed nationally and regionally to sustain the work being carried out. She called on the Secretariat to develop a comprehensive mental health action plan with clear, measurable targets.

Dr BRENNEN (Bahamas) said that acknowledgement of the burden of mental disorders and of the need to combat the stigmatization and discrimination related to them was a welcome development, as was the inclusion of neurological and substance abuse disorders in the WHO Mental Health Gap Action Programme. Greater emphasis should be placed on a coordinated and comprehensive response to combating noncommunicable diseases, and support should be provided to Member States for the establishment of noncommunicable disease frameworks with a mental health component, including cost-effective, evidence-based interventions at community level and human rights safeguards. The WHO Mental Health Gap Action Programme Forum would provide an opportunity to facilitate training of mental health professionals, raise the priority of mental health disorders and put mental health and other noncommunicable diseases on the development agenda. He endorsed the draft resolution.

Dr DÍAZ (Chile) expressed support for the draft resolution and for the development of the action plan. In order to tackle the growing burden of mental disorders, his country had launched a national mental health plan that had fostered the development of a mental health care network and a community-based mental health care model. Most mental disorders were chronic and, if not detected and treated in time, could lead to serious disability. Multisectoral efforts were needed, including job creation for people with chronic mental disorders, social measures to identify and support such people and their families, and provision of decent housing for people with mental disorders and associated disabilities.

Mr EDWARDS (Marshall Islands) endorsed WHO's efforts to reduce the burden of mental disorders. His Government was implementing a strategic action plan to that end and was endeavouring to encourage the families of individuals with mental disorders to get involved in their treatment, in particular in the recovery phase. He supported the draft resolution.

Mrs SITHOLE (Zimbabwe) said that mental disorders, in particular psychosis and depression, were a major public health concern in Zimbabwe. Anxiety-related conditions were on the rise as a result of socioeconomic threats, natural disasters and the growing number of AIDS orphans. Substance abuse was also increasing. Her Government had adopted a national mental health policy, which had been integrated into general health care services at all levels, and a national mental health strategy had recently been launched. Essential medicines were provided at primary health care level and mental health was included in the country's integrated diseases surveillance and response system, although service delivery was hampered by a lack of resources and medicines. She supported the draft resolution. A comprehensive mental health action plan would provide guidance at regional and national levels, and should enhance the priority given to programmes relating to mental health and development.

Dr GOUYA (Islamic Republic of Iran) said that comprehensive programmes were needed to tackle depression and anxiety, the most common mental disorders. Little attention was paid to predisposing factors or to mental disorders themselves at onset, and treatment was therefore often started only at an advanced stage. Substance abuse was contributing to increasing rates of mental disorders and could have a devastating impact on users' personal and social relationships. Support was needed from WHO for the integration of mental disorder prevention and treatment programmes in national primary health care systems, and for the provision of mental health education to primary health care personnel. Primary health care offered an effective approach to the problem and could reduce the stigma associated with mental disorders. Other activities to be carried out included the development of regional and national indicators and health information systems to monitor the status of mental health and substance abuse and implementation of capacity-building programmes in remote primary health care settings.

Dr TUGSDELGER (Mongolia) said that there was a growing need to assess the burden of mental disorders and to develop evidence-based interventions on which local priorities could be based. Unfortunately, many low- and middle-income countries lacked the technical and financial resources to conduct that type of research. It was therefore incumbent on WHO to mobilize resources and to provide countries with additional data on the prevalence of mental disorders, which could guide them in setting policy to meet local needs. In Mongolia, children, adolescents and the elderly were the most severely affected by economic hardship and the mental health problems to which it could give rise. Adolescent suicide was on the rise, owing mainly to an increasingly inequitable distribution of wealth and bullying in schools. There was an urgent need to implement effective school-based mental well-being programmes and to provide them with greater resources from national and international sources.

Dr HIEN (Burkina Faso), expressing gratitude for the efforts of her country's development partners in helping to control neurological and behavioural disorders such as schizophrenia, psychoactive substance abuse, depression and epilepsy, said that the burden of mental disorders was growing. Their chronic nature made them very costly, both in terms of medication and days of work lost. Burkina Faso had for the past two decades been implementing strategic plans and programmes to combat mental disorders and substance abuse, but, like other African countries, lacked the human and financial resources needed to tackle the problem effectively. She urged Africa's development partners to sustain the gains made and provide resources for meeting new challenges.

Dr TAYAG (Philippines) said that the Philippines, like other developing countries, suffered from a lack of reliable scientific information on the burden of mental disorders and underlined the importance of support for surveillance activities. The draft resolution should declare mental health a new global priority to be accompanied by a strategic road map and measurable indicators for attaining the stated objectives. He welcomed the recommendation in document A65/10 that mental health should be included in broader health policies and strategies. Indeed, mental health facilities could coexist with general health care facilities and mental health care should be reoriented in that direction.

Dr ABD ALHADI (Kuwait), noting the impact of mental disorders on social and economic factors, said that his Government had adopted health legislation that gave priority to mental health issues. Its mental health programme was being implemented at the primary health care level throughout the country. He supported the draft resolution and emphasized the importance of implementing the recommendations contained therein.

Dr KIMANI (Kenya) said that mental disorders affected around 10% of his country's population, with unipolar depression being one of the most prevalent complaints. Mental health had been included in his country's national health policy for the period 2012–2030, and legislation was being drafted that would recognize the right of people with mental disorders to health care. Nevertheless, a number of challenges remained, including stigmatization of persons with mental disorders, lack of public awareness about mental health issues and high cost of treatment. He endorsed the draft resolution and urged the international community to give greater prominence to the subject of mental health.

Dr AL-MOLA (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Regional Committee for the Eastern Mediterranean had approved a mental disorder and substance use plan for the period 2012–2013,¹ which was in line with the draft resolution contained in resolution EB130.R8 and included measures to improve mental health and ensure that treatment was available for those in need, in cooperation with other sectors. She commended WHO's efforts to develop prevention measures and seek solutions to mental health issues. However, the comprehensive mental health action plan recommended in the draft resolution would not necessarily be fully effective in all countries owing to differences in national situations, resource availability and constitutional limitations. At the same time, such a plan was needed to bolster national and regional collaboration.

Mr RAMÍREZ RAMÍREZ (Colombia) welcomed the draft resolution. Reducing the consumption of psychoactive substances had long been part of his country's mental health strategy and under its national mental health plan it was seeking to improve institutional and knowledge management and stimulate social and community development in order to ensure early intervention for mental disorders, provide community-based treatment and reduce the stigmatization attached to mental disorders. Legislation had also been adopted to protect the rights of people suffering from epilepsy, guaranteeing them comprehensive education and health care. It was appropriate that WHO should tackle the issue of mental disorders, which had given rise to stigmatization, discrimination and violation of human rights. He encouraged Member States to evaluate the quality of their mental health services, develop guidelines for treatment of the most common mental disorders, design models for community-based treatment and study the determinants of mental health, which involved factors that went beyond the health sector.

¹ Resolution EM/RC58/R.8.

Dr ALLENDE (Paraguay) said that family health services had an important role to play in extending health care coverage for mental disorders and in protecting and promoting mental health at the community level. Second-generation antipsychotic medicines were expensive but had fewer side effects; debate was needed on whether the cost was justified by the outcome, especially in terms of less stigmatization and discrimination and better quality of life. Member States should discuss comprehensive treatment approaches for victims of domestic, intrafamilial or gender-based violence, which should be integrated into mental health services, with special emphasis on community outreach through health promotion and disease prevention strategies.

Dr CHOSITA PAVASUTHIPAISIT (Thailand) said that mental disorders placed a heavy burden on both families and economies, especially in low- and middle-income countries. Progress towards greater investment in mental health systems remained disappointingly slow. Developing countries in particular lacked the essential building blocks to improve mental health care delivery. Prevention and promotion activities were sorely lacking as were trained mental health professionals, especially those working with children and adolescents. Surveillance and comprehensive assessments of mental health systems, including financing, health care delivery, access, medicines and health workforces, were needed at the country level to establish the extent of the disease burden and its social costs; the information gathered could then be used in making health care policy decisions.

Turning to the draft resolution, she suggested that in the tenth preambular paragraph, the words “early diagnosis and treatment, in particular childhood mental disorders, result in long-term good outcomes” should be inserted after “can be prevented”. A new subparagraph 1(1)*bis* should be inserted, to read: “to conduct a national mental health systems assessment which covers service delivery, human resources, information systems, financing, policy framework, access to care in order to identify gaps for development”. In subparagraph 1(2), the words “families and communities” should be inserted after “empower service users” and a new subparagraph 2(4)*bis* should be inserted, to read: “to support collaboration among Member States in order to strengthen capacity of mental health care systems, including surveillance systems”.

Ms VANCE (Ecuador) said that her country had begun reorienting mental health care services towards outpatient primary care and was endeavouring to encourage greater social networking and community and family member participation in the treatment and management of mental health disorders. Mental health services in Ecuador had been bolstered by staff increases at most provincial hospitals and at health centres in five provinces. Nevertheless, further improvements were needed. She supported the draft resolution.

Mrs KHUMALO (Swaziland), endorsing the draft resolution, said that the comprehensive mental health action plan to be developed should cover people of all ages, including children. More mental health specialists should be trained to ensure proper management of mental disorders. Her country was in the process of finalizing its own mental health policy and urged development partners to support mental health activities in order to improve the quality of life for all.

Mr SIBILLE RIBERA (Peru) said that, as part of its comprehensive health reform, his Government had set up a sectoral commission to evaluate and propose amendments to existing legislation in order to give mental health and psychiatric services a more community-based and decentralized focus. It was also incorporating mental health services into the country’s comprehensive health care system at all levels and was finalizing a strategic mental health plan that drew on a number of international human rights instruments related to mental health and the rights of those suffering from mental disorders. He endorsed the draft resolution, which was in line with his Government’s efforts to provide mental health services to all citizens and protect the human rights of those suffering from mental disorders.

Ms RIJKS (International Organization for Migration) said that migrant populations frequently faced unhealthy living conditions, including restricted access to mental health services, which could exacerbate existing mental health problems or create new psychosocial vulnerabilities, especially within populations fleeing conflict or natural disasters. The action plan proposed in the draft resolution should include policies and activities that would ensure that migrants and displaced populations had access to mental health care, foster sensitivity to cultural diversity, build capacities to respond to mental health needs in crisis situations and reduce the social risk factors and determinants of poor mental health in migrant populations. Her organization stood ready to provide technical support to WHO in that regard.

Dr Tsung-Hsi WANG (Chinese Taipei) said that Chinese Taipei had adopted legislative measures to safeguard the rights of people with mental disorders and protect them from discrimination and human rights violations. Mental health policies had been in place for nearly 30 years; the overarching goal was to establish a human-centred, community-based, holistic mental health system. Recent developments had included the establishment of community follow-up care centres, treatment of disaster-related mental disorders and the creation of psychiatric facilities for persons who had attempted suicide. The scope of mental health services had also been enlarged to cover victims of abuse and offenders. A new department of mental health would be set up in 2013.

Professor COPELAND (World Federation for Mental Health), speaking at the invitation of the CHAIRMAN, welcomed the proposed mental health action plan and said that the World Federation stood ready to assist in its development and implementation. It had recently commenced a survey of civil society organizations involved in mental health promotion to determine which mental health issues they regarded as most important. The survey results would be provided to WHO. He urged Member States to place mental disorders prominently on the noncommunicable diseases agenda; approach women's mental health from a "whole life" perspective that included social issues and gender-based violence; regard mental disorders not only as a medical issue, but also a development issue that had an impact on poverty, productivity and human rights; and ensure adequate funding and resources for national mental health initiatives.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, stressed the role of Member States in ensuring equitable access to affordable and quality health services that integrated mental health at all levels. Efforts to develop the human resources needed to provide comprehensive mental health care should include pharmacy professionals, who often served as a primary and regular point of contact for patients and had demonstrated their ability to provide community-based interventions for mental health promotion and the prevention of mental disorders, including through early detection of at-risk individuals, provision of high-quality treatment, and assistance to patients in following their treatment regimen. He urged WHO to advocate for the provision of appropriate training to pharmacy workers, not only in hospitals but also at the primary care level.

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that little progress had been made in improving access to mental health prevention and treatment services, owing in part to a failure to integrate mental health care into primary health care and a shortage of nurses and other personnel with mental health training. With such training, nurses could play a leading role in improving mental health services and in helping to ensure that health policy focused on mental health. Her organization had launched an initiative in five African countries to develop nursing capacity in the field of noncommunicable diseases, which included training in the management of diabetes and depression as co-morbid conditions. She called on governments to increase the number of mental health nurse specialists and to authorize them to identify, assess and treat common mental disorders in primary health care settings.

Mr PLEYER (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that stigmatization of those suffering from mental, neurological and substance abuse disorders hindered their access to health care and perpetuated social exclusion and poverty. Only half of the number of young persons with serious mental disorders received proper treatment. The proposed draft resolution should place greater emphasis on promoting mental health among young people, with a special focus on equal access to care, the consequences of risk-taking behaviour and the development of coping skills. Such an approach would help to combat stigmatization and isolation and give young people a chance to develop a sense of belonging and self-esteem. The mental health action plan recommended in the draft resolution should have specific, measurable and achievable targets and fixed deadlines, to which Member States could commit themselves, thereby ensuring that they would implement the plan.

Dr CHESTNOV (Assistant Director-General) welcomed the pledge made by Member States to develop policies aimed at the promotion of mental health and the empowerment of persons living with mental disorders. The Secretariat had taken note of the comments made and would continue developing the comprehensive mental health action plan through consultation with Member States, nongovernmental organizations and various other partners, with a view to determining an overarching vision and general objectives for regional and national programmes and activities. The plan would be submitted to the Sixty-sixth World Health Assembly.

Mr THOMSON (Switzerland), speaking on behalf of the sponsors of resolution EB130.R8, namely, his own country, India, and the United States of America, welcomed the many helpful suggestions that had been made by Member States with regard to the draft resolution. He nevertheless hoped that the Committee would not reopen discussion on the text, or would at least make only minor amendments. In drafting the resolution, the sponsors had given careful consideration to many of the points just raised, in particular the question of whether to include a list of conditions, risks and specific disorders. In the end, they had considered it more appropriate to include those details in the mental health action plan, since it would present qualitative and quantitative factors relating to each disorder. The reminder by the delegate of Thailand of the important role played by families and communities was a helpful one and reference to that in the draft resolution should certainly be strengthened. He proposed that in paragraph 1(1), the words "and strengthen" should be inserted after the words "to develop".

Ms BENNETT (Australia), endorsing the comments of the delegate of Switzerland, agreed that the proposed amendment to reflect family and community involvement was useful. Nevertheless, she was not in favour of amending the text extensively and supported approval of the text as it stood.

Ms HYDE (United States of America) agreed that only minimal changes to the text should be made.

Dr CHOSITA PAVASUTHIPAISIT (Thailand) said that she still would like to see a reference to families and communities in the text.

The CHAIRMAN requested the Secretary to read out the amended version. Mr ROBERTS (Assistant Secretary) said that subparagraph 1(1), with the amendment proposed by the delegate of Switzerland, would read: "according to national priorities and within their specific contexts, to develop and strengthen comprehensive policies and strategies ..."; subparagraph 1(2), with the amendment proposed by the delegate of Thailand, would read: "to include in policy and strategy developments the need to promote human rights, tackle stigma, empower service users, families and communities, address poverty and homelessness ...", with the rest of those two subparagraphs remaining unchanged.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to approve the draft resolution with those amendments.

The draft resolution, as amended, was approved.¹

The meeting rose at 17:55.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.4.

FOURTH MEETING

Wednesday, 23 May 2012, at 09:30

Chairman: Dr L.Z. DUKPA (Bhutan)
later: Mr H. BARNARD (Netherlands)

1. FIRST REPORT OF COMMITTEE A (Document A65/50 (Draft))

Dr JIDDAWI (United Republic of Tanzania), Rapporteur, read out the draft first report of Committee A.

The report was adopted.¹

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

Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 13.14 of the Agenda (Documents A65/24 and A65/24 Corr.1)

The CHAIRMAN drew attention to four draft resolutions on the item, the first of which, proposed by Kenya, read:

The Sixty-fifth World Health Assembly,

PP1 Recalling resolution WHA63.28 which requested the Director-General to establish a Consultative Expert Working Group (CEWG) to take forward the work of the expert working group earlier established under resolution WHA61.21, and to submit the final report to the Sixty-fifth World Health Assembly;

PP2 Further recalling resolutions WHA59.24, WHA61.21 and WHA62.16;

PP3 Recalling the consultations and diplomatic processes undertaken at WHO around the issue of needs-driven research and development (R&D) for health and access to affordable medicines, which led to the unanimous adoption by the World Health Assembly in 2008 and 2009 of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

PP4 Recognizing the progress made in the implementation of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, in particular the establishment by the United Nations Economic Commission for Africa and the World Health Organization of the African Network of Drugs and Diagnostics Innovations (ANDI), which is promoting and sustaining African-led health product innovation to address African public health needs through the assembly of research networks, and the building of capacity, including innovation and local pharmaceutical production; the Eighth World Trade Organization Ministerial Conference adoption of measures on extending the transition period under Article 66.1 of the TRIPS Agreement beyond the year 2013 among other measures to increase access to

¹ See page 274.

medicines, the World Intellectual Property Organization new initiatives to accelerate research and development of medicines for neglected tropical diseases, among others;

PP5 Noting element 2.3(c) of the WHO Global Strategy on Public Health, Innovation and Intellectual Property, which calls for “exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical R&D, including, inter alia, an essential health and biomedical R&D treaty” as an integral component of the global strategy’s mandate to promote innovation, improve access to medicines, diagnostics, vaccines including medical devices and enhance sustainable needs-driven health research and development relevant to diseases which disproportionately affect developing countries;

PP6 Aware of the existing need to secure additional and sustainable financing for research and development to address the health needs of developing countries, improve coordination, facilitating the maximum use of and complement existing financing in order to develop and deliver safe, effective and affordable medicines, diagnostics, vaccines and medical devices;

PP7 Considering the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination as a solid basis for supporting further the efficient and effective implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;

PP8 Recognizing the analysis and proposals contained in the CEWG report, particularly the recommendation that WHO should convene formal intergovernmental negotiations on a binding agreement to strengthen global financing and coordination for R&D for health needs of developing countries under the auspices of WHO;

PP9 Acknowledging the unique normative function of WHO deriving from Article 2(k) and Article 19 of the WHO Constitution, and recognizing the indispensable imprimatur of WHO in the setting of new binding legal norms aimed to the attainment for all people of the highest possible level of health;

PP10 Emphasizing the importance of public funding of health research and development and the role of Member States in coordinating, facilitating and promoting health research and development, and recognizing that it is ultimately the responsibility of Member States to secure access to affordable medicines for people in need;

PP11 Having considered the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination,

1. WELCOMES the report of CEWG and expresses its appreciation to the Chair, Vice Chair and all the Members of the Group for their work;

2. DECIDES to establish an Intergovernmental Negotiating Body to develop the WHO Convention on Research and Development Financing and Coordination taking into account the CEWG recommendations, in particular the strengthening and securing sustainable funding to address identified R&D priorities of developing countries; promoting R&D in diseases that disproportionately affect developing countries; delinking R&D costs and prices of products; enhancing innovative capacity of developing countries and technology transfer; generating R&D outcomes as public goods and strengthening R&D coordination mechanisms all predicated on five key principles of:

(1) knowledge sharing as a condition for the implementation of the universal right to health which encompasses an obligation on the State to generate health research and development that address the health needs of disadvantaged individuals, communities and populations;

(2) knowledge as a global public good that requires collective action and de-links research and development costs from product prices for diseases that disproportionately affect 2.7 billion people living in developing countries;

- (3) capacity building and institutional strengthening to ensure the use of scientific knowledge to respond to people's health needs;
 - (4) ensuring sustainable financing mechanism for R&D for health needs of developing countries; and
 - (5) access to affordable medicines as a key component of primary health care and universal coverage;
3. URGES Member States:
- (1) to consider the recommendations of the report, and ensure that the report is included on the agenda of WHO's regional Committees in 2012;
 - (2) to give high priority to accelerating work on the development of the WHO Convention on Research and Development Financing and Coordination for health needs of developing countries;
 - (3) to provide additional resources and enhance cooperation to accelerate the work of the INB on the WHO Convention on Research and Development Financing and Coordination;
 - (4) to significantly increase funding for implementation of the WHO Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property, including additional funding for national, regional and international health research and development institutions;
 - (5) to make access to affordable medicines, diagnostics, vaccines and medical devices a priority sector for investment and sustainable development;
4. REQUESTS the Director-General:
- (1) to convene immediately the Intergovernmental Negotiating Body to draft and negotiate the WHO Convention on Research and Development Financing and Coordination, and to allocate the necessary resources to it;
 - (2) to provide secretarial and other support to the Intergovernmental Negotiating Body including required financial resources, services and facilities for the performance of its work, and as necessary regional consultations;
 - (3) to invite in consultation with Member States, six experts to attend the sessions of the Intergovernmental Negotiating Body to provide advice and expertise, as necessary upon request of the Chairman, taking into account the need to avoid conflicts of interest;
 - (4) to invite observers at sessions of the INB on the WHO Convention on Research and Development Financing and Coordination in accordance with the provisions of resolution WHA27.37 and other relevant Rules of Procedures and resolutions of the Health Assembly;
 - (5) to submit progress report to the Sixty-seventh World Health Assembly and the final WHO Convention on Research and Development Financing and Coordination through the Executive Board to the Sixty-eighth World Health Assembly.

The second draft resolution, proposed by Switzerland, read:

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the consultative expert working group on research and development: financing and coordination;

PP2 Recalling resolution WHA61.21 which requests the Director-General "to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consideration of proposals from Member States;"

PP3 Further recalling resolution WHA63.28 which requests the Director-General to establish a Consultative Expert Working Group on research and development to take forward the work of the former Expert Working Group, with a view to submitting its final report to the Sixty-fifth World Health Assembly;

PP4 Noting previous and ongoing work on innovative financing for health, research and development and the need to build on this work as relevant;

PP5 Emphasizing the importance of public funding of health research and development and the role of the Member States in coordinating, facilitating and promoting health research and development;

PP6 Reaffirming the importance of other relevant actors in health research and development;

PP7 Recognizing the necessity to supplement the existing intellectual property rights system where the current system is not working as incentive for research and development;

PP8 Noting that the Consultative Expert Working Group recommends the adoption of a binding global instrument for research and development and innovation for health related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases;

PP9 Considering that the recommendations of the report require further analysis and discussion among Member States, experts and with the Director-General;

PP10 Expressing concerns regarding the short period of time between the publication of the Consultative Expert Working Group's report and the Sixty-fifth World Health Assembly and the impossibility for Member States to complete a substantive analysis of its recommendations before the Sixty-fifth World Health Assembly,

1. WELCOMES the report of the Consultative Expert Working Group and expresses its appreciation to the Chair and Members of the Group for their work;
2. URGES Member States to analyse thoroughly and consider the feasibility, at national level, of the recommendations of the Consultative Expert Working Group in its report;
3. REQUESTS the Director-General:
 - (1) to hold informal, in-depth consultations with Member States on the feasibility of the recommendations contained in the report, in particular concerning a binding global instrument for research and development and innovation in health related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, together with the funding implications of such an instrument;
 - (2) to compile the views expressed during the consultations in a document to be presented under a substantive item dedicated to the follow up to the Consultative Expert Working Group's report, which shall be included in the agenda of the Sixty-sixth World Health Assembly through the 132nd session of the Executive Board;
4. REQUESTS the Regional-Directors to include a debate on the recommendations of the report of the Consultative Expert Working Group on research and development in the agenda of the regional committees in 2012.

The third draft resolution, proposed by the members of the Union of South American Nations,¹ read:

¹ Argentina, Bolivia (Plurinational State of), Chile, Colombia, Ecuador, Guyana, Paraguay, Peru, Suriname, Uruguay and Venezuela (Bolivarian Republic of).

The Sixty-fifth World Health Assembly,

PP1 Recalling that access to safe, high-quality, effective and affordable medicines is an fundamental component of the right to health;

PP2 Recalling that it is important to promote the development of integrated policies that ensure access to essential medicines, vaccines and other health technologies by promoting research and development based on the health needs of Member States, and especially developing countries;

PP3 Reaffirming the importance of the strategic global, regional and national approach to the research, development and production of active pharmaceutical ingredients and high-quality, safe, effective and affordable medicines that meet the health needs of Member States and especially developing countries;

PP4 Recalling that the Global Strategy on Public Health, Innovation and Intellectual Property was the outcome of painstaking work that Member States of WHO undertook in 2008;

PP5 Keeping in mind paragraph 2.3 (c) of the Global Strategy on Public Health, Innovation and Intellectual Property, namely “encourage further exploratory discussions on the utility of possible instruments or mechanisms for essential health and biomedical research and development, including inter alia, an essential health and biomedical research and development treaty”, which is part of the terms of reference of this strategy to promote innovation, improve access to medicines, diagnostic methods and vaccines, including medical devices, and to secure a sustainable basis for needs-driven, essential health research and development relevant to diseases that disproportionately affect developing countries;

PP6 Recalling in this context that resolution WHA61.21 requested the Director-General of WHO to establish an expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate such activity related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and to submit a final report to the Sixty-third World Health Assembly;

PP7 Recalling that the Sixty-third World Health Assembly noted that “there was divergence between the expectations of Member States and the output of the Group” and that it consequently requested the Director-General of WHO “to establish a [new] Consultative Expert Working Group”, indicating the tasks that it should accomplish (WHA63.28);

PP8 Recalling that the resulting [new] Consultative Expert Working Group established by resolution WHA63.28 was constituted and submitted its final report for the consideration of the Sixty-fifth World Health Assembly (document A65/24),

1. WELCOMES the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination – CEWG – (document A65/24), and notes that it fully complies with the mandate established by the Sixty-third World Health Assembly;
2. CONGRATULATES the Director-General of WHO on carrying out the established mandate;
3. ALSO WELCOMES the conclusion of the CEWG that the current system of intellectual property does not sufficiently incentivize research and development of medical products to treat diseases that affect developing countries;
4. DECIDES to promote and incentivize the development of the proposal recommended by CEWG whereby Member States would set in motion a process to negotiate a binding agreement and resolutions on research and development to satisfy the needs of developing countries, in accordance with the provisions of article 19 of the Constitution of WHO, the essence of which would be to stimulate and prioritize science, technology and innovation in a less asymmetrical

manner and would address the issue of access to medicines, in accordance with the Global Strategy on Public Health, Innovation and Intellectual Property;

5. REQUESTS the Director-General:

(1) to convene a meeting of all Member States, represented by their health authorities, in order to:

(a) initiate an open-ended, Member State-driven process to make a detailed, in-depth study of the mechanisms proposed by the CEWG with a view to their implementation;

(b) achieve consensus on the principles, objectives and governance instruments that could form part of a binding agreement, and the necessary means of bringing this about;

(c) submit a progress report on these activities to the 132nd Executive Board and subsequently to the Sixty-sixth World Health Assembly;

6. URGES Member States:

(1) to participate actively in the meeting referred to in paragraph 5 of this resolution;

(2) to implement on a complementary basis in their respective countries and regions the proposals outlined in the report of the CEWG, and to continue to develop proposals that contribute to the promotion of research and development, separating out the costs of the research and development from the price of the products;

(3) to ensure that, under the auspices of WHO and in collaboration with its regional offices, mechanisms to coordinate research and development for diseases affecting developing countries are established and strengthened with a view to expanding access to medicines and other health technologies.

The fourth draft resolution, proposed by Australia, Canada, Japan, Monaco and United States of America, read:

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on the consultative expert working group on research and development: financing and coordination;

PP2 Recalling resolution WHA61.21, whereby WHO Member States adopted the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property; and which requested the Director-General “to establish urgently a results-oriented and time-limited expert working group to examine current financing and coordination of research and development, as well as proposals for new and innovative sources of funding to stimulate research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases, and open to consideration of proposals from Member States”;

PP3 Further recalling resolution WHA63.28, which noted that although the Expert Working Group made some progress in examining proposals for financing of, and coordination among, research and development activities, there was divergence between the expectations of Member States and the Group’s findings, and which requested the Director-General to establish a Consultative Expert Working Group on research and development to take forward the work of the former Expert Working Group, with a view to submitting its final report to the Sixty-fifth World Health Assembly;

PP4 Noting previous and ongoing work on innovative financing for health, research and development and the need to build on this work as relevant;

PP5 Noting also the relevance of ongoing work in this area to the reform of WHO now under way, and the need for future work to be harmonized and aligned with the results of that reform effort;

PP6 Considering that proposals submitted to the Consultative Expert Working Group and the recommendations of its report require further analysis by and discussion among Member States and with the Director-General,

1. NOTES the report of the Consultative Expert Working Group and expresses its appreciation to the Chair and Members of the Group for their work;
2. URGES Member States to analyse thoroughly and consider the feasibility, at national level, of the recommendations proposed by the Consultative Expert Working Group in its report;
3. CALLS UPON Member States, the private sector, academic institutions and nongovernmental organizations to invest in health research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases;
4. REQUESTS the Director-General:
 - (1) to hold informal, in-depth consultations with Member States on improving coordination of and financing for research and development to better address the health-care needs of developing countries, including, but not limited to, the possible methods recommended by the Consultative Expert Working Group, in the context of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property;
 - (2) to request WHO Regional Committees to include on the agenda of their meetings in 2012 a consideration of methods to improve coordination and financing of research and development to better address the health-care needs of developing countries, including but not limited to the possible methods recommended by the Consultative Expert Working Group;
 - (3) to compile the views expressed during the consultations and regional committees in a document to be presented under a substantive item dedicated to the follow-up to the Consultative Expert Working Group's report, which shall be included in the agenda of the Sixty-sixth World Health Assembly, through the 132nd session of the Executive Board.

The CHAIRMAN invited delegates' views on whether a working group should be formed to consolidate the four draft resolutions into a single consensus draft resolution.

Dr EL OAKLEY (Libya), speaking on behalf of the Member States of the Eastern Mediterranean Region, acknowledged the report of the Consultative Expert Working Group and its recommendations for enhancing financing and coordination of research and development, particularly translational research related to Type II and III diseases. A funding mechanism was needed in order to facilitate research and development in that area and promote the development of essential medicines, vaccines and other products to help to tackle the burden of disease related to the health challenges faced by developing countries. A working group comprising representatives of all regions should be formed to propose further practical steps to help implement the initiative and to consider the pros and cons of introducing a binding mechanism such as a convention, taking into account the needs of Member States and regions.

Dr SILBERSCHMIDT (Switzerland), supported by Dr MALECELA (United Republic of Tanzania), agreed that, in order to ensure efficient use of the Committee's time, a drafting group should be convened to consolidate the four proposals into a single draft consensus text and that general statements on the item should be deferred.

The CHAIRMAN said that in the absence of any objection he took it that the Committee wished to set up an informal drafting group to consolidate the four draft resolutions. The group's meetings would be open to all Member States. He noted a proposal for Mr Desiraju (India) to chair the group. Further discussion of the item would be suspended until after the drafting group had met.

(For resumption of the discussion, see page 68 below.)

Nutrition: Item 13.3 of the Agenda (Documents A65/11, A65/11 Corr.1 and A65/12)

- **Maternal, infant and young child nutrition**
- **Nutrition of women in the preconception period, during pregnancy and the breastfeeding period**

The CHAIRMAN drew attention to a draft resolution proposed by Swaziland and Uganda and its financial and administrative implications, which read:

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan;

PP2 Recalling resolutions WHA34.22, WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA47.5, WHA49.15, WHA54.2, WHA55.25, WHA58.32, WHA59.21, WHA61.20, WHA63.23, on infant and young child nutrition; WHA30.51 and WHA31.47 on the role of the health sector in the development of national and international food and nutrition policies and plans; WHA46.7 on the follow-up action to the International Conference on Nutrition; and WHA46.7 and WHA59.11 on nutrition and HIV/AIDS; and WHA49.15 and WHA61.20 on preventing conflicts of interests;

PP3 Concerned that maternal and child undernutrition account for 11% of the global burden of disease and has a negative impact on cognitive development, school and physical performance and productivity;

PP4 Mindful that breastfeeding is the norm for infant and young child feeding, for optimal nutrition, health, growth and cognitive development. Exclusive breastfeeding and sustained rates remain well below recommended levels;

PP5 Alarmed that exclusive and sustained breastfeeding rates are stagnating or declining in many parts of the world,

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;
2. URGES Member States:
 - (1) to develop national targets and commit resources, in accordance with the global targets contained in the comprehensive implementation plan and is applicable to national contexts;
 - (2) to put into practice the comprehensive implementation plan on maternal, infant and young child nutrition and, in particular:
 - (a) to revise nutrition policies to include nutrition actions in overall country health and development policy and establish effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with the particular emphasis on the framework of the Global Strategy on Infant and Young Child Feeding;
 - (b) to review sectoral policies in the agriculture, social welfare, education and trade sectors in order to determine their impact on nutrition;

- (c) to include effective and safe nutrition actions in maternal, child and [adolescent] health services and ensure universal coverage of these actions;
- (d) to develop or strengthen legislative measures for controlling the marketing of breast-milk substitutes and foods for infants and young children;
- (e) to implement a comprehensive approach to enhancing the capabilities of health workers and managers to deliver nutrition actions;
- (f) to implement sustainable financing mechanisms for funding the expansion and the sustained implementation of nutrition programmes;
- (g) to develop or strengthen surveillance systems for the collection of information on indicators of inputs, outputs and outcomes, and impact of nutrition actions;
- (h) to establish a national mechanism to deal with conflicts of interest;

3. REQUESTS the Director-General:

- (1) to review, update and expand WHO's guidance and tools on effective nutrition actions, analyse their cost-effectiveness, illustrate good practice of delivery mechanisms and adequately disseminate the information;
- (2) to develop guidance and describe successful examples of multisectoral policy measures on nutrition;
- (3) to support Member States, on request, in strengthening national health and development policies that include proven nutrition actions; developing technical and managerial capacities; strengthening legislative, regulatory or other effective measures to control the marketing of breast-milk substitutes and monitoring their implementation;
- (4) to develop guidelines on the marketing of complementary foods;
- (5) to support Member States to monitor and evaluate policies and programmes according to the framework of the Global Strategy for Infant and Young Child Feeding;
- (6) to report to the Health Assembly in even-numbered years on progress in applying the comprehensive implementation plan on maternal, infant and young child nutrition, together with the report on progress in implementing the Code of Marketing Breast-milk Substitutes and related Health Assembly resolutions;
- (7) to establish a guideline and mechanism to deal with conflicts of interest for the Secretariat and partnerships that emerge.

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

| | |
|---|---|
| 1. Resolution: Maternal, infant and young child nutrition | |
| 2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf) | |
| Strategic objective(s): 9 | Organization-wide expected result(s): 9.1, 9.2, 9.3 and 9.4 |
| How would this resolution contribute to the achievement of the Organization-wide expected result(s)? The resolution would: support Member States' commitment to nutrition in collaboration with several partners, with clearly measurable targets (see indicators 9.1.1 and 9.1.2); highlight the need to implement evidence-based interventions (Organization-wide expected result 9.2); identify specific areas for prioritization and scaling up in the health sector (Organization-wide expected result 9.4); and clarify reporting requirements and stimulate better surveillance (Organization-wide expected result 9.3). | |
| Does the programme budget already include the products or services requested in this resolution? (Yes/no) Yes, most of the products are already included. | |

3. Estimated cost and staffing implications in relation to the Programme budget

(a) Total cost

Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).

(i) 10 years (covering the period 2012–2021)

(ii) Total: US\$ 32.4 million (staff: US\$ 23.9 million; activities: US\$ 8.5 million)

(b) Cost for the biennium 2012–2013

Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000).

Total: US\$ 8.28 million (staff: US\$ 4.78 million; activities: US\$ 3.5 million)

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant.

Headquarters: US\$ 1.07 million (staff); US\$ 1.2 million (activities)

Regional offices/country offices: US\$ 3.71 million (staff); US\$ 2.3 million (activities).

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

No

If "no", indicate how much is not included.

Although the implementation of the comprehensive implementation plan on maternal, infant and young child nutrition is already included in the approved Programme budget, the resolution calls for further action by the Secretariat in two areas:

(a) the development of guidance on multisectoral policy measures on nutrition;

(b) the development of guidelines on the marketing of complementary foods.

The cost of such additional activities would amount to approximately US\$ 600 000.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Although most of the Secretariat activities requested by the resolution can be implemented by current staff, the provision of support to Member States in strengthening national health and development policies that include proven nutrition actions would require additional human resources in the regional offices.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

For the biennium 2012–2013, US\$ 4.6 million are available for the implementation of the resolution, as part of currently available resources. Additional funding of US\$ 3.68 million would need to be secured through active fundraising.

In addition, a draft decision had been submitted, which he invited the delegate of Canada to read out.

Ms WISEMAN (Canada) said that in order to facilitate the adoption of the comprehensive implementation plan the Health Assembly should send a clear signal; she therefore proposed a draft decision, which read: “The Sixty-fifth World Health Assembly DECIDES to endorse the comprehensive implementation plan on maternal, infant and young child nutrition contained in the annex of document A65/11”. She noted that the draft decision was also sponsored by Mexico, Mozambique, Peru, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America and Zimbabwe.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, observed that under- and over-nutrition were key risk factors for noncommunicable diseases and pregnancy complications. A life-course approach to nutrition was needed. It was especially important to ensure balanced nutrition during the 1000-day period from conception through the first two years of life, when undernutrition and malnutrition could have irreversible health consequences. High levels of chronic undernutrition worldwide showed that previous efforts had been insufficient. Although most governments had policies on nutrition, the situation remained worrying, and she therefore encouraged Member States to develop further comprehensive implementation plans on maternal, infant and young child nutrition, which should include efforts to improve women’s education and enhance their social and economic power and actions to fight gender-based discrimination in access to food, notably in countries affected by disasters and crises. The broad range of determinants of healthy and sufficient nutrition must also be addressed. Education and media campaigns to promote healthy habits, coupled with the involvement of local authorities and other stakeholders, had been shown to have had a positive effect on childhood obesity in the European Union.

The discussions at the 130th session of the Executive Board had marked a first step towards strengthening access to proper nutrition and health care and promoting exclusive breastfeeding, while respecting the right of mothers to make an informed choice as to whether to breastfeed their children, taking into account the importance of preventing mother-to-child transmission of HIV in countries with high HIV prevalence. She welcomed the opportunity to consult on the draft implementation plan and noted with satisfaction the inclusion of a global target on reducing wasting. The countries of the European Union were prepared to endorse the plan, but without the attached tables, which should be further developed to include relevant dietary interventions and indicators for all six global targets. The next programme budget should allocate the resources needed to implement the plan.

Dr GUILLÉN (Paraguay) said that nutrition issues had to be viewed in the context of social determinants of health, particularly poverty and social inequalities, which in turn had to be addressed through a multisectoral approach. Her Government had taken a number of steps to improve access to health and nutrition services, including elimination of out-of-pocket fees for health services and expansion of the health services network. A national nutrition plan had been implemented with a view to achieving the Millennium Development Goals on malnutrition, and conditional cash transfer programmes had been implemented. As a result, malnutrition among children under five years of age and pregnant women had begun to decrease. Nevertheless, further action was needed to ensure the allocation of public funds to implement social policy measures aimed at combating poverty and hunger, particularly among indigenous populations; reducing gender-based poverty and enable women to exercise their sexual and reproductive rights; and promoting employment among adults, especially young adults, and encouraging children to stay in school.

Ms WISEMAN (Canada) said that the Health Assembly should endorse the proposed comprehensive implementation plan for maternal, infant and young child nutrition, including the proposed global targets, which were complementary to the voluntary targets identified under the global monitoring framework for noncommunicable diseases. She welcomed the addition of a global target on wasting, which was in line with Millennium Development Goal 1 (Eradicate extreme poverty and hunger). The targets must be supported by good monitoring and surveillance tools and their

implementation must take account of national contexts and jurisdictional responsibilities. Implementation of the plan should begin as soon as possible.

Dr QIN Geng (China) expressed support for the objective, global targets, actions and time frame set out in the draft comprehensive implementation plan and welcomed the Secretariat's analysis of global nutrition challenges. In order to enhance work on maternal, infant and young child nutrition, the Secretariat should provide technical support, conduct training tailored to the political and social environment and the health systems of countries or regions, and facilitate the implementation of effective maternal and child health interventions at country level. It should also formulate a plan for evaluating policies and monitoring the draft comprehensive implementation plan. Member States should adopt national strategies for improving maternal and child health and nutrition, and set up multisectoral cooperation mechanisms.

Mr GLASSIE (Cook Islands) said that his Government placed the highest priority on reproductive health and emphasized antenatal education, including education for expectant mothers on the benefits of good nutrition and the perils of smoking, the latter of which accounted for most cases of low birth weight in the Cook Islands. Expectant mothers were also educated about gestational diabetes, how to manage it, what its impact on future health might be and how to lower their risk for type 2 diabetes after pregnancy.

Mr LAHLOU (Morocco) expressed strong support for the draft comprehensive implementation plan, which addressed the need for international action and national policies to tackle the issue of maternal, infant and young child nutrition. Particular emphasis should be laid on social determinants of health and on the need for multisectoral coordination. With regard to the first action envisaged under the draft comprehensive implementation plan, an international body should be established to oversee the process of implementation. Under action 2, Member States should be encouraged to adopt legislation concerning maternity leave, especially during the breastfeeding period. Such legislation should be aligned with best practice in that area. As for action 3, it was important to ensure the participation of all sectors, including the social security and education sectors. Education curricula should include a component of nutrition education. Concerning action 4, a monitoring component was needed. He proposed adding a sixth action, to the effect that international instruments on nutrition should be incorporated and used in any proposals at national level.

Dr NIK RUBIAH ABDUL RASHID (Malaysia) expressed support for the draft comprehensive implementation plan and endorsed a life-course approach to improving nutrition. She noted with satisfaction that the proposed activities for Member States had taken into consideration various strategies and initiatives to create a supportive environment for the implementation of comprehensive food and nutrition policies. Her country's national plan of action for nutrition for the period 2006–2015 was aligned with the approach set out in the plan. Nutrition must be integrated into national development policies through multisectoral collaboration among governmental and nongovernmental agencies, as called for by the World Declaration and Plan of Action on Nutrition adopted by the International Conference on Nutrition in December 1992. International partners had an important role to play in supporting and facilitating Member States' implementation of the International Code of Marketing of Breast-milk Substitutes or their corresponding national codes. She acknowledged the importance of optimal nutrition for women in the preconception period, during pregnancy and the breastfeeding period.

Dr UGYEN (Bhutan), speaking on behalf of the Member States of the South-East Asia Region, said that interventions to address most forms of malnutrition in infants, children and women existed in all Member States in the Region. The health sector should take the lead in coordinating nutrition policies and programmes, but multisectoral engagement was vital. The role of the education, social

welfare and development sectors should be strengthened. At the same time, precautionary measures should be taken to prevent conflicts of interest when working with the private sector.

With regard to the draft comprehensive implementation plan, he proposed that global target 5 should be extended to include continued breastfeeding plus complementary feeding for two years or beyond. To achieve that goal, all Member States should enact national legislation in line with the International Code of Marketing of Breast-milk Substitutes and strengthen enforcement, reporting, monitoring and evaluation. Under global target 6, he proposed adding early detection and treatment of wasting in order to ensure adequate child growth and prevent stunting. Nutrition problems among women of reproductive age were not limited to anaemia, and nutrition interventions targeting that group should therefore include, in addition to folic acid and vitamin B12 supplementation, a range of micronutrients and macronutrients derived mainly from food-based sources. Measures to improve maternal nutrition should be reviewed in conjunction with the comprehensive implementation plan, which the countries of the Region were committed to implementing.

Dr TUGSDELGER (Mongolia) said that her country had made significant progress in improving the nutritional status of mothers, infants and young children, having reduced low birth weight by 7% each year between 1999 and 2008 and increased rates of exclusive breastfeeding in the first six months by 10% each year between 2005 and 2010. The key to Mongolia's success had been the constructive support of international partners, which had put aside differences in their institutional mandates and procedures and aligned their efforts with national systems and procedures. She therefore welcomed the emphasis in the draft comprehensive implementation plan on following the principles of the Paris Declaration on Aid Effectiveness, and supported the draft decision to endorse the plan.

Dr RUSIBAMAYILA (United Republic of Tanzania), speaking on behalf of the Member States of the African Region, welcomed the draft comprehensive implementation plan, in particular its focus on maternal nutrition, an area that had not received sufficient priority on the nutrition agenda. A life-cycle approach was critical for addressing malnutrition, which remained a public health problem among young children and women of childbearing age in the Region. Overweight was also becoming a problem, and was contributing significantly to the rise in noncommunicable diseases. She therefore welcomed the decision to ensure that the plan dealt with the double burden of malnutrition.

She applauded the plan's multisectoral approach and its linkage with the "Scaling Up Nutrition" movement. However, the proposed target for exclusive breastfeeding in the first six months was not ambitious enough. Several countries in the African Region were close to reaching or had already exceeded the 50% target, and she therefore proposed that it be increased to 75%. Implementation of the International Code of Marketing of Breast-milk Substitutes was of particular importance in the Region in the face of the HIV/AIDS pandemic. It was also essential to implement the WHO child growth standards for monitoring purposes in order to detect problems such as stunting – which remained prevalent in the Region – in a timely manner.

The draft plan should include a research component, and she therefore proposed that action 5 be revised to read "To monitor and evaluate the implementation of policies and programmes and conduct operational research", and that research activities should be added under that action. In Africa, research was needed in particular on infant and young child nutrition in the context of HIV/AIDS. Although effective, evidence-based maternal, newborn and child nutrition interventions had been available for over a decade, many had still not been implemented on the required scale. Ensuring sufficient human and financial resources to achieve the global targets and actions would be central to the success of the implementation plan. The Member States of the African Region endorsed the plan, with the amendments she had proposed.

Dr AL BELOOSHI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that nutrition problems were prevalent throughout the Region. Malnutrition was a contributing factor in about one third of deaths of children under five years of age, and 50% of children in that age group suffered from stunting. Anaemia was widespread among

mothers and children under five years of age. A multisectoral approach was required to address those problems, and cooperation and partnership with various stakeholders responsible for nutrition should therefore be strengthened. She supported the approval of the draft plan, which took account of comments made during the 130th session of the Executive Board. However, she would like more information on the scientific basis for the plan. It was vital to ensure that it was objective and evidence-based.

Dr BART-PLANGE (Ghana) said that, in line with action 3 of the draft comprehensive implementation plan, her Government had put in place a school feeding programme to ensure that all schoolchildren received at least one nutritious meal a day and had launched a project to fortify flour and vegetable cooking oil with vitamin A and iron. A World Bank-sponsored project on nutrition and malaria control for child survival sought to develop effective intersectoral coordination and accountability for nutrition, with emphasis on community responsibility. Those interventions had contributed to recent improvements in nutrition, including a reduction in severe anaemia among children under five years of age, the prevalence of which currently stood at 2.5%.

Ms SHEVYREVA (Russian Federation) said that the draft plan would make a significant contribution to the implementation of the Moscow Declaration adopted by the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control and the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. She welcomed the plan's recognition of the need for early intervention to address nutrition problems and for an integrated approach, with the participation of multiple sectors. In 2010 her Government had adopted a multisectoral plan of action to improve the nutrition and health of the Russian population, which sought, *inter alia*, to increase the prevalence of breastfeeding, reduce anaemia and other nutritional deficiencies, and prevent low birth weight. Those measures had ensured a significant reduction in infant mortality. The Government was also working to improve nutrition in preschools and schools and to that end had introduced nutritional standards for children, which all educational institutions were required to follow. She supported the adoption of the comprehensive implementation plan.

Dr AL-TAAE (Iraq) said that nutrition required a global approach that took account of the social determinants of health and was linked to other strategies relating to the health of women and children. Action should be stepped up in order to achieve the nutrition-related Millennium Development Goals. Clear guidance in line with the International Code of Marketing of Breast-milk Substitutes was needed in order to ensure that such substitutes met requirements for micronutrients. Women should be educated about nutrition from an early age.

Dr SAKAMOTO (Japan) commended WHO's leadership in the field of nutrition and welcomed the draft comprehensive implementation plan. However, she questioned whether the data currently available provided sufficient evidence to support the indicators. A more comprehensive and systematic review of various aspects of the plan was needed before it could be finalized. For example, the WHO child growth standards had been developed utilizing data from only one country in Asia, whereas nutritional status there varied considerably from country to country. The limitations of the standards and their applicability to the development and use of standard growth curves should be made clear. It should be borne in mind that breastfeeding practices had changed greatly as a result of women's increased social participation. It was also important to recognize that low birth weight was increasing as the number of premature births increased. In that connection, she requested clarification of the target of 30% reduction of low birth weight proposed in the draft plan.

Mr PRADHAN (India) welcomed the plan, which rightly acknowledged the multisectoral nature of malnutrition and sought convergence between policies and programmes of all sectors that had a bearing on nutrition. It also correctly highlighted the need for provision of maternity

entitlements in order to increase exclusive and sustained breastfeeding rates, which were stagnating or declining in many parts of the world. The plan should create mechanisms for enforcing subparagraph 1(4) of resolution WHA63.23 and should spell out what was meant in that paragraph by “inappropriate promotion” of breast-milk substitutes. There was a need for universally accepted guidelines on the marketing of complementary foods and strengthened national legislation barring promotion of baby foods for children under two years of age, as had been done in India. Effective implementation of the International Code of Marketing of Breast-milk Substitutes would require attention to the other nine areas of action listed in the Global Strategy for Infant and Young Child Feeding, including regular evaluation of relevant policies and programmes in order to identify gaps and develop action plans to bridge them. The WHO growth standards should be used to identify faltering growth and prevent malnutrition.

In disaster and crisis situations, it was especially important to protect and support women who were breastfeeding, including through the creation of a comprehensive set of guidelines on the distribution of free breast-milk substitutes and baby foods. Such guidelines should include a robust mechanism for dealing with conflicts of interest. A life-cycle approach to nutrition was essential, as was optimal nutrition for women during pregnancy in order to break the intergenerational cycle of malnutrition. He supported the draft resolution put forward by Swaziland and Uganda.

Mr SAMO (Federated States of Micronesia), recognizing the important role that nutrition played in health and development, would support a programme of work that integrated nutrition into a life-course approach to individual development. He supported the draft decision put forward by the delegate of Canada.

Dr AL-RAOBEI (Yemen) said that the importance of preconception, maternal and infant nutrition must be reflected in national programmes, and noted that measures to improve nutrition in adolescents would serve to prevent malnutrition in mothers and young children.

Dr GONÇALVES (Mozambique) said that her Government was committed at the highest political level to reducing chronic malnutrition and had approved a strategy for food and nutritional supplementation for pregnant women, infants and young children, and adolescent girls. It had also introduced a national multisectoral action plan to reduce chronic malnutrition, which involved sectors such as agriculture, education and social work, and included measures to improve the nutrition of women before conception, during pregnancy and postpartum. She supported the draft comprehensive implementation plan and the draft decision put forward by the delegate of Canada.

Ms BENNETT (Australia), noting that malnutrition was a serious problem in the Asia-Pacific region, welcomed the draft comprehensive implementation plan. Some of the global targets remained very ambitious and might not reflect the nutrition priorities of individual Member States; it would be important for national circumstances and priorities to be recognized in carrying out the plan. The indicators for monitoring the plan should be aligned with the indicators developed by the United Nations Commission on Information and Accountability for Women’s and Children’s Health. While it was clear from the comments of other speakers that there was room for further emphasis or additional input in relation to many aspects of the draft plan, she was prepared to endorse the current version in order to move forward on the issue during the present Health Assembly.

Professor MAHMUD HASSAN (Bangladesh) said that the draft comprehensive implementation plan was generally acceptable, but suggested that global target 1 be rephrased to read “40% reduction of stunted children by 2025”, which would be more consistent with the wording of global targets 4 and 6. The Secretariat should strengthen its efforts to promote food-based dietary guidelines and locally available homemade food, rather than creating dependence on commercially advertised so-called “nutritious foods”. He was sceptical about the value of ready-to-use therapeutic foods for malnourished children, as evidence was emerging that such foods might reduce children’s

consumption of locally available homemade foods. His Government had launched a five-year health, population and nutrition sector development programme catering to the needs of both males and females in every age group, with particular attention to vulnerable and high-risk groups. It was hoped that the programme would bring about major improvements in the nutrition situation. He shared the views expressed in the report contained in document A65/12 and endorsed the recommendations put forward in the “Future directions” section.

Dr DIXON (Jamaica) said that the draft comprehensive implementation plan could be enhanced through the inclusion of some reference to the link between nutrition and noncommunicable diseases. Jamaica had recently introduced a child health and development “passport” that had facilitated identification and monitoring, on the basis of the WHO growth charts, of children at risk for undernutrition and overweight. There was currently no routine testing for micronutrient deficiencies, nor were maternal undernutrition and overweight tracked in the surveillance system, although clinical and survey data showed that the prevalence of anaemia among pregnant women was between 15% and 21%. Her Government was currently developing a national infant and young child feeding policy, for which the draft plan would provide valuable insights. She endorsed the plan.

Mr EDWARDS (Marshall Islands) reported that his Government was endeavouring to improve maternal nutrition through health education and promotion activities stressing the importance of breastfeeding and consumption of local foods. It had also developed regulations on food safety, which touched on healthy food for mothers. He endorsed the draft comprehensive implementation plan.

Mr ÁLVAREZ LUCAS (Mexico) welcomed the draft comprehensive implementation plan, which correctly emphasized the need for a life-course approach and the importance of optimum nutrition for women before pregnancy in order to minimize the risks associated with malnutrition. His country had a policy aimed at providing preconception counselling for women in order to assess their nutritional, metabolic and reproductive health. A healthy pregnancy programme provided free obstetric care. The health sector was stepping up its efforts to promote exclusive breastfeeding for the first six months of life. Mexico had implemented the UNICEF baby-friendly hospital strategy in 1991. He supported the draft decision and fully endorsed the plan.

Dr NAPAPHAN VIRIYAUTSAHAKUL (Thailand) commended the draft comprehensive implementation plan and acknowledged the need for multisectoral action, including cooperation with the private sector, although caution was needed to prevent conflicts of interest, protect public interests and safeguard the health of the population. Slow progress in increasing exclusive breastfeeding rates worldwide was attributable to the voluntary nature of the International Code of Marketing of Breast-milk Substitutes, lack of compliance by infant formula manufacturers and suppliers, and lack of political support for an enabling environment that would promote breastfeeding by working mothers in the workplace. The voluntary international code should be translated into domestic law, with effective enforcement, monitoring and reporting systems, and labour laws supporting maternity and paternity leave should be enhanced.

The six global targets in the implementation plan should be reformulated as country-level targets, and global target 5, which was not ambitious enough, should be increased to 75%. In addressing micronutrient deficiencies, priority should be given to consumption of locally available agricultural products, rather than expensive vitamin and mineral supplements. Subparagraph 39(d) of the draft plan should also refer to control of the marketing of unhealthy food.

Mr Barnard took the Chair.

Ms CHANESTA (Swaziland), endorsing the amendments to the draft plan put forward by the delegate of the United Republic of Tanzania, expressed strong support for global target 5, the achievement of which would be critical to success in achieving global targets 1, 4 and 6. Too little

attention was being paid to the importance of breastfeeding after six months and during the second year of life, when breast milk continued to provide significant nutritional benefits. With a view to increasing breastfeeding rates, her Government was finalizing legislation based on the International Code of Marketing of Breast-milk Substitutes that would regulate the promotion of commercial foods for infants and children. She could support the draft decision proposed by the delegate of Canada in place of the longer draft resolution cosponsored by Swaziland and the United Republic of Tanzania, provided it was amended to include subparagraphs 2(2)(a), (d) and (h) and subparagraphs 3(4) and (7) of the draft resolution.

Ms NÚÑEZ (Chile) said that maternal, infant and young child nutrition formed a continuum and should be addressed as such. Thanks to antenatal care and child growth and development monitoring programmes, legislation extending maternity leave for six months, a complementary feeding programme for pregnant women and young children and other measures, Chile had largely conquered undernutrition, while also reducing poverty and ensuring stable economic development. The challenge now was tackling overnutrition among pregnant women and children. She supported the draft comprehensive implementation plan and welcomed the incorporation of a target relating to wasting.

Dr MAHUGU (Kenya) said that stunting, underweight and wasting remained significant problems among children in his country. Steps had been taken to encourage breastfeeding and to fortify various foods. Guidelines on management of acute malnutrition were available in most health care facilities, and deaths of children under five years of age from malnutrition had fallen.

Ms HARUTYUNYAN (Armenia) supported the draft comprehensive implementation plan. The double burden of under- and over-nutrition was a serious risk factor for complications in pregnancy and for noncommunicable diseases. She welcomed the work of WHO and partners through the “Scaling Up Nutrition” movement to support countries in addressing malnutrition. Effective strategies for addressing nutrition existed in Armenia but had not yet been implemented on a large scale, and malnutrition remained a significant public health issue, particularly in rural areas. While breastfeeding rates were high, the prevalence of exclusive breastfeeding was relatively low. Complementary feeding regimens were often inappropriately prescribed. Priority actions to address the situation included promoting flour fortification and developing comprehensive nutrition policies with a human rights-based approach.

Dr MOXEY (Bahamas) welcomed the draft comprehensive implementation plan. Her Government continued to monitor stunting, iron-deficiency anaemia and undernutrition, recognizing their negative impact on child development, and lent its full support to the efforts of regional partners in their efforts to address issues associated with global targets 1, 2 and 6. The Bahamas faced particular challenges in encouraging exclusive breastfeeding among mothers under 25 years of age and in reducing high levels of obesity and overweight among school-age children.

Mr PIPPO (Argentina), rising to a point of order, said that he had been surprised that consultations on agenda item 13.14 had been referred, without discussion, to a working group. He formally requested that an open and transparent discussion on the item be held within the Committee, immediately and with the consensus of all Member States.

The CHAIRMAN asked whether the Committee wished to suspend the debate on nutrition and resume its consideration of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination.

Mr GADELHA (Brazil) strongly supported the request by the delegate of Argentina. The topic of financing and coordination for research and development was complex and crucially important, and it should be discussed immediately in order to provide input for the work of the drafting group.

Dr ALLENDE (Paraguay), speaking on behalf of the members of the Union of South American Nations, endorsed the comments of the delegates of Argentina and Brazil. It had been agreed that the item would be taken up during the current meeting in order to allow for a thorough discussion of countries' positions. While it had been proposed that a drafting group be formed, at no time had it been agreed that discussion of the item would be suspended or that the item would be removed from the programme for the current meeting.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, supported the request to hold a general debate on the topic before the drafting group met.

Mr COTTERELL (Australia) said that he believed that there was good will among delegations to find a constructive way forward on the issue and that there would be merit in holding a brief general debate before the drafting group met.

Dr SILBERSCHMIDT (Switzerland) said that in proposing the formation of a drafting group he had not intended to avoid a general debate on the topic and that he therefore supported the request by the delegate of Argentina.

The CHAIRMAN took it that the Committee wished to suspend the discussion of nutrition and resume its consideration of the report of the Consultative Expert Working Group on Research and Development.

It was so agreed.

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

Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 13.14 of the Agenda (Documents A65/24 and A65/24 Corr.1) (resumed)

Dr ALLENDE (Paraguay), speaking on behalf of the members of the Union of South American Nations, said that the report of the Consultative Expert Working Group afforded an opportunity to reflect on one of the most important challenges facing health systems in a globalized context: how to ensure universal access to safe, effective and affordable medicines. He wished to affirm the importance of a strategic approach at the global, regional and national levels to research, development and production of high quality pharmaceuticals to meet the needs of all Member States, but especially those of developing countries.

The report contained many valuable recommendations on which Member States should act. The Union of South American Nations favoured the negotiation of a binding agreement on research and development that would respond to the needs of developing countries, promoting research, development and innovation in a more balanced manner and enhancing access to medicines. To that end, the Union of South American Nations had put forward the draft resolution introduced earlier, calling upon the Director-General to initiate an open-ended, Member State-driven process aimed at implementing the mechanisms proposed by the Consultative Expert Working Group and requesting the regional offices to support the development of mechanisms for coordinating research and development on diseases that primarily affected developing countries, with a view to increasing access to medicines and health technologies.

Mr MATUTE (Colombia) welcomed the opportunity to engage with all Member States of the Organization in a friendly discussion of the report of the Consultative Expert Working Group. Protection of the right to health and access to high quality medicines for all was a priority for his Government. The activities needed to implement global strategies on research and development should be carried out in the framework of WHO. Such strategies should effectively ensure access to the

medicines and health technologies needed to address the health problems of all peoples, but especially those of the poor and vulnerable. His Government was committed to active participation in a multilateral dialogue with a view to implementing suitable research and development mechanisms.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union, welcomed the range of recommendations in the report and commended the transparent manner in which the Consultative Working Group's work had been conducted. The European Union was firmly committed to implementing the global strategy and plan of action on intellectual property rights, innovation and public health and stood ready to discuss what action should be taken. However, more clarity was needed on what was to be achieved before the legal nature of the outcome of that discussion could be considered. Although there had been inadequate time to review the recommendations of the report in full, she had identified several issues to be considered. First, the scope of the initiative and how to deal with the categories of diseases had to be agreed. Second, adequate data on current efforts and public spending on health research and development by Member States were needed. The forthcoming overview by the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases of funding for research and development on infectious diseases would provide useful information in that regard. Third, it was important to consider the issue in the light of the WHO reform process and to determine where it should fit within the Organization's priorities and its draft twelfth general programme of work. The European Union supported the draft resolution put forward by Australia, Canada, Japan, Monaco and the United States of America.

Mr PIPPO (Argentina) said that the Consultative Expert Working Group had produced a sound analysis of the problems that developing countries faced in meeting their public health needs. He shared the Working Group's conclusion that the current intellectual property system did not create sufficient incentives for research and development on diseases affecting developing countries. Negotiations on a binding agreement could be the start of a process that would address that problem. His Government was convinced that public health problems could only be solved through collective commitment by all States and supported the proposal to initiate an open-ended, Member State-driven process to examine the mechanisms proposed by the Consultative Expert Working Group, which would lay the groundwork for the establishment of a negotiating body and the development of a binding agreement.

Dr AL-TAAE (Iraq) said that health research played an important role in improving public health and that any research financed and conducted should respond to specific needs. Greater emphasis should be put on primary health care research. Joint research between countries and regions could bolster health security and should be encouraged. WHO technical support would be crucial in ensuring that the health research and development process was sustainable, that it contributed to capacity-building and that research was conducted for the right purposes. Partnership between health ministries and academic institutions could improve public health.

Mr ROSALES (Plurinational State of Bolivia), expressing support for the draft resolution put forward on behalf of the Union of South American Nations, said that he supported the conclusions of the Consultative Expert Working Group. He recalled that, in 2008, his Government, together with those of Barbados, Bangladesh and Suriname, had proposed the negotiation of a treaty on biomedical research for Type II and III diseases and those Type I diseases that disproportionately affected developing countries, delinking the costs of research from medical products. He therefore strongly supported the Working Group's proposal to begin negotiations on a legally binding global treaty that would help to address problems that particularly affected the developing world, where millions of people continued to suffer and die because they lacked access to life-saving medicines, vaccines and other interventions readily available in the developed world. Member States were faced with an historic opportunity to rectify that situation.

Mr TOSCANO VELASCO (Mexico) said that the report of the Working Group dealt well with a problem that all States acknowledged: investment in and coordination of research and development for diseases that principally affected the least developed countries were clearly insufficient. It was vital to tackle health inequities that continued to exist between and within States through a human rights-based approach that emphasized the fundamental role of the public sector. Research and development must address the needs of people, not just those of markets, although the importance of the involvement and contribution of industry should not be overlooked. The international community must find efficient financing and coordination mechanisms for promoting research and development that complemented the current system of intellectual property rights and ways of expanding health technologies that met the specific needs of developing countries. In-depth discussions were needed to achieve broad, consensus-based agreements. Global health problems required global action and a commitment by all States. His Government favoured the immediate convening of consultations with Member States, with the participation of nongovernmental organizations, to discuss the recommendations of the Working Group.

Dr MORA (Panama) expressed support for the draft resolution proposed on behalf of the Union of South American Nations and urged Member States to engage in a friendly and constructive multilateral dialogue on the topic.

Mr COTTERELL (Australia), noting that his delegation had not had time for a thorough examination of the report, which was complex and contained recommendations for action that fell outside the purview of the health sector, acknowledged that the existing mix of funding and incentives for research and development did not always lead to the timely development of affordable medicines for developing countries. However, before entering into treaty negotiations, it was important to explore other means of achieving collective goals. He therefore favoured further consultations among Member States to consider the most efficient and effective ways to improve coordination and financing of research and development. While the recommendations of the Consultative Expert Working Group should be considered carefully, they should not be the only options examined. He affirmed his support for the draft resolution put forward by his country and Canada, Japan, Monaco and the United States of America.

Dr DAULAIRE (United States of America) said that more financing was needed for research and development on neglected diseases of the poor and emphasized that both the public and the private sectors in his country were deeply committed to such research and development. Indeed, his was the only country already investing at the levels called for in the report. Others, particularly middle-income countries, should be encouraged to reach the proposed levels of financing.

He recognized that neither market forces nor intellectual property protections were sufficient to focus attention on neglected diseases of the poor; the most appropriate way forward was to identify incentives for research and development coordination and to build capacity within research institutions in developing countries. His Government did not support the establishment of an intergovernmental working group to further develop the proposals put forward in the report, nor did it support the negotiation of a binding instrument on financing by Member States, particularly as many Member States were not prepared to commit 0.01% of their gross domestic product for research and development, as called for in the report. His Government would not support any proposal that could be characterized as a globally collected tax or a single pooled financing mechanism, since past experience suggested that such a mechanism would be unlikely to foster innovation.

The Director-General should be asked to undertake discussions with Member States, individually or regionally, on the concepts and recommendations in the report, and report to the Executive Board in January 2013, as proposed in the draft resolution tabled by his delegation and others. Those discussions should include greater consideration of proposals passed over by the Consultative Expert Working Group, including advance marketing and procurement agreements, orphan drug legislation, regulatory harmonization and priority review vouchers. The original

recommendations of the Expert Working Group on the topic should also be considered. The goal of the consultation process should be to identify areas of agreement and determine which proposals enjoyed the broadest support and what action might begin immediately on a voluntary basis and on a small scale, with the possibility of scaling up in time. Following the consultations, the Director-General should seek advice from Member States on next steps, including the further development of proposals and, if warranted, a more formal discussion process. Holding consultations as described in the draft resolution would provide more time to ensure that the response to the Working Group's recommendations was appropriate in the light of the WHO reform process and that the issue received the attention it deserved among competing priorities.

Ms WISEMAN (Canada) said that, after many years spent analysing various proposals, it was important to take collective action to support greater investment in research and development on diseases that mainly affected developing countries, both through market mechanisms and public funding. Her Government favoured voluntary initiatives whereby Member States could support activities reflecting their own priorities. She agreed with the report's conclusion that much more should be done to improve the global coordination of existing mechanisms and structures. WHO had a role to play in coordinating research and development, possibly by acting as a central hub for data collection and analysis and by facilitating networking of research institutions and funders. Her Government viewed the report's recommendation to establish a binding legal framework as premature and had therefore joined Australia, Japan, Monaco and the United States of America in sponsoring the draft resolution introduced earlier.

Dr LINDGREN (Norway) said that the report made a valuable contribution to the debate on research and development on diseases that primarily affected developing countries. It was important to recall, however, that it built on a decade of previous work on issues relating to public health, innovation and intellectual property. The report was comprehensive, dealt with complex issues and included far-reaching proposals and recommendations, which his Government was still studying. He looked forward to participating in discussions at the national level and within WHO in order to gain a better understanding of the report's recommendations and their implications. The Health Assembly's goal for the moment should be to outline a process whereby Member States could work together towards a lasting solution to a longstanding problem.

Mr KABANGE NUMBI MUKWAMPA (Democratic Republic of the Congo), speaking on behalf of the Member States of the African Region, supported the report's recommendations on the mobilization of resources and establishment of a coordination framework. The recommendation concerning a legal instrument should be examined in depth by each Member State and discussed by the regional committees. While most of the African Member States that had taken a position favoured a binding instrument, they recognized that all countries should have the opportunity to state their views on whether the instrument should be binding or non-binding. The current Health Assembly should adopt a resolution calling for the establishment of an international negotiating body to develop an instrument reflecting the views expressed by Member States, which should also consider innovative financing methods beyond those proposed by the Consultative Expert Working Group. While public-sector funding for research and development was important, resources should also be mobilized from the private sector. International cooperation to facilitate technology transfer could both support research and strengthen local industry. The process should move forward as quickly as possible in order to alleviate the suffering of people in Africa.

Dr LIU Peilong (China) said that the current intellectual property protection system did not provide enough incentives to encourage investment in the research needs of developing countries, leading to a lack of effective health technologies and to pharmaceutical prices that were beyond the reach of many countries. WHO should play a leading role in establishing a global coordination and financing mechanism. The proposals and recommendations contained in the report should be studied carefully by stakeholders from various sectors in Member States, as some of the recommendations concerned matters outside the remit of the health sector. The Secretariat could help Member States to interpret the report and facilitate consultations. The Executive Board, at its 132nd session, could be asked to make recommendations on future steps to be taken.

Health ministers from the BRICS group of countries (Brazil, Russian Federation, India, China and South Africa) had met in 2011 and had agreed to strengthen South–South cooperation on research and development with a view to improving access to medicines, vaccines and diagnostic technologies. It was important for developing countries to work to provide financial and policy incentives in order to encourage their research institutes and businesses to increase research and innovation, enhance their productive capacity and improve the quality, efficacy and affordability of the medicines they produced.

Dr CHUTIMA AKALEEPHAN (Thailand) said that the Health Assembly should agree on a clear process for moving forward to increase access to medical products for neglected diseases prevalent in developing countries. The stakes were high, and Member States must not fail to reach consensus.

Dr HUSAIN (Bahrain), expressing support for the recommendations of the Consultative Expert Working Group, said that research and development should be supported and financed at the national level. It was important, nonetheless, to establish a financing mechanism. She favoured setting up a working group to develop proposals for such a mechanism, which could then be examined by each Member State in the light of its domestic needs.

Dr SAKAMOTO (Japan), noting that her Government was a sponsor of one of the draft resolutions, said that feasibility, practicality and potential for a positive outcome should be considered when reviewing the options proposed in the report. Research agendas must be defined carefully, bearing in mind disease burden and other factors, and all aspects and stages of research and development must be examined before discussing financial implications. Clarification was needed of how the coordination framework proposed in chapter 5 of the report would be formed, as was a detailed analysis of risks and advantages. It was unclear whether a binding instrument was necessary or how such an instrument would operate. Financing was not the sole solution; it should be combined with other support mechanisms, such as technical cooperation, technology transfer and capacity-building.

Dr SILBERSCHMIDT (Switzerland) said that he largely agreed with the Consultative Expert Working Group's analysis of the problems to be addressed. Action should be taken promptly to remedy the lack of investment in research, especially phase III trials, related to Type II and III diseases. In-depth interministerial and intergovernmental consultations were needed in order to gain a clear vision on what type of instrument – binding or non-binding – would be best to address the challenges identified in the report. Opening negotiations on an instrument without a clear mandate on what was to be negotiated risked prolonging the process. It was the desire to quickly find a way to make global public goods available to those who needed them that lay behind the draft resolution proposed by his Government.

Ms FARANI AZEVÊDO (Brazil) said that, despite improvements in social indicators, access to the benefits of human knowledge remained largely segmented according to the stage of economic development. The huge scale of inequality around the world left many deprived of access to essential

medicines and technologies. Member States had a moral obligation to ensure that the benefits of human progress were accessible to all. The work of the Consultative Expert Working Group represented a concrete step towards the implementation of the global strategy and plan of action on public health, innovation and intellectual property. Member States should give due consideration to the Working Group's proposals, which provided a way to overcome problems of access to medicines and reduce technological asymmetries in the world. A debate should be initiated without delay on how to implement the recommendations in the report. It was essential to approach that debate with an open mind and not to dismiss any of the recommendations out of hand or insist on a single option. Her delegation stood ready to engage in an open and constructive discussion with the aim of overcoming differences of opinion, as proposed in the draft resolution put forward on behalf of the Union of South American Nations.

Dr EL OAKLEY (Libya) observed that most Member States acknowledged the need for a funding mechanism, although not all agreed on what form such a mechanism should take. He wished to propose an alternative mechanism based on the concept of earmarked funding for research and development in relation to Type II and III diseases, to be used in consultation with the countries concerned. He endorsed the comments of the delegate of Brazil. It was to be hoped that the proposed open-ended consultations would bring debate on the subject to a close.

Dr AGUILAR (Ecuador), endorsing the draft resolution proposed on behalf of the Union of South American Nations, highlighted the importance of identifying innovative mechanisms for implementing the proposals of the Consultative Expert Working Group so that his subregion could begin to reap the benefits as soon as possible.

Dr Chia-En LIEN (Chinese Taipei) said that medical and pharmaceutical research and development not only helped to improve standards of health but contributed to economic development. Chinese Taipei had enacted legislation aimed at promoting biotechnological and pharmaceutical development and stood ready to share its experience with others.

Ms IVERSEN (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, urged Member States to begin formal negotiations on a global convention on research and development as the best means of addressing health needs of neglected populations and spurring biomedical innovation and global economic growth through coordinated public investment. Investment in innovative approaches to global health research should be encouraged, as should a commitment to ensuring open access to research findings, which would increase the scope and pace of health innovation and enable producers in low- and middle-income countries to manufacture affordable versions of new medicines for neglected populations. The information and technology sector had long embraced many of the innovation models recommended in the report, thereby fostering innovation and generating immense economic benefits. A global research and development convention would afford an opportunity to apply those same innovative approaches to health research.

Dr KIENY (Assistant Director-General) thanked delegates for their useful guidance on how to move forward on the recommendations contained in the report. She looked forward to continuing the discussion with Member States.

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

The meeting rose at 12:35.

FIFTH MEETING

Thursday, 24 May 2012, at 09:10

Chairman: Dr L.Z. DUKPA (Bhutan)

WHO REFORM: Item 12 of the Agenda (Documents A65/5, A65/5 Add.1, A65/5 Add.2, A65/5 Add.3, A65/40, A65/43 and A65/INF.DOC./6)

The CHAIRMAN invited the representative of the Executive Board to introduce the report contained in document A65/5, drawing attention to a draft decision contained in document A65/5 Add.3.

Dr LARSEN (representative of the Executive Board) said that the Executive Board, at its 130th session, had considered various reports prepared by the Secretariat, which addressed the three elements of WHO reform: programmes and priority setting, governance and management. The Board had agreed the scope of work and terms of reference for the Member State-driven process that would provide guidance on programmes and priority setting for the preparation of future general programmes of work, including establishing categories, criteria and timelines. A meeting for that purpose had been held in February 2012; the outcomes were reported in document A65/40.

Member States had been invited to submit comments through a web-based platform on two proposals concerning governance: draft revised terms of reference for the Programme, Budget and Administration Committee and a proposal for increasing linkages between regional committees and the governing bodies and harmonizing the practices of regional committees. The Board had requested that further discussions on WHO engagement with external stakeholders be held during the Sixty-fifth World Health Assembly.

On managerial reform, the Board had requested the Secretariat to elaborate proposals for a predictable financing mechanism based on feedback from members of the Executive Board. It had also requested the Secretariat to prepare a revised draft of the evaluation policy based on the comments of Member States received during the web-based consultation for submission to the Executive Board at its 131st session. The Board had welcomed an offer by the External Auditor to conduct the first stage of the independent evaluation of WHO, including the development of a proposed road map for the second stage, to be submitted to the current Health Assembly, as well as the agreement of the Joint Inspection Unit to update its 1997 and 2003 reports on decentralization and management and administration within WHO.

The consolidated report contained in document A65/5 addressed all aspects of WHO reform and incorporated the outcomes of the Member State-driven process for priority setting. The Health Assembly was invited to consider the report.

Dr AMMAR (Lebanon), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region was fully engaged in the reform process. Sustainable financing had often been discussed in the context of reform; however, the options put forward had been limited and not always well developed. Only two of the 133 paragraphs in the consolidated report addressed that critical issue. It should be tackled head on, not avoided simply because there were many divergent views. Fewer earmarked contributions would allow greater flexibility. He looked forward to further discussions on predictable financing and the articulation of clearer options. In order to maintain its leadership role in global health, WHO needed to enhance its normative function and its technical

support by strengthening regional and country offices. In addition, improvements in transparency, accountability and responsiveness were urgently required.

In general, the Region endorsed the report and the various decision points proposed in document A65/5. Strengthening the links between regional committees and global governing bodies, as described in the section on scheduling, alignment and harmonization of governance processes, should have a positive effect on the work of the Organization. With regard to decision point 3, the Region supported option (b). The rules of procedure of the Regional Committee were currently being reviewed with a view to improving harmonization and alignment with global governance and strengthening regional governance, the work of the Region and the engagement of Member States.

The Region also endorsed the five technical categories contained in the draft twelfth general programme of work (document A65/5 Add.1). Progress would only be made, however, if social determinants of health were fully integrated into those categories. Given that reform was a dynamic process, the priorities within each category should be re-evaluated at a later stage. Concerning managerial reform, he recognized the need for a more flexible workforce, capable of responding to rapidly changing programmes, situations and funding, which would require more attention to diversity, rotation and mobility. He noted that the annual human resources report (document A65/34) revealed that 66% of staff at headquarters came from two regions, and only 4% were from the Eastern Mediterranean Region.

Dr MARTÍNEZ (Paraguay), speaking on behalf of the members of the Union of South American Nations, noted that the delegates of Argentina, Chile and Ecuador would also be making remarks on behalf of that group. The documents on the item constituted a good point of departure for considering the WHO reform process. WHO should ensure coordination in the reform process with the various stakeholders in accordance with the global programmes and priorities identified by Member States. To that end, it would be helpful to have an exchange of views on global health governance and the role of WHO, covering, *inter alia*, the relationship of the Organization with other United Nations bodies with respect to issues such as development, the environment, intellectual property and trade. She agreed that the next draft proposed programme budget should be examined by the regional committees and that the collective revision of the criteria, categories, priorities and timelines should continue. The proposed categories should be used to structure the debate in future meetings.

Since consensus had not yet been reached on the categories, it was impossible to move forward on the draft twelfth general programme of work. During the sixty-third session of the Regional Committee for the Americas, the members of the Union of South American Nations had suggested using the categories already agreed within subregional groups, which had not been included in the documents under discussion. The proposed categories focused on disease rather than on the relationship between health and development, determinants of health, equity, social justice, human resources, universal coverage of health systems, and availability of medicines and health promotion. A new category should be incorporated, encompassing health equity, sustainable development and social, economic and cultural determinants of health, the goal of which was to reduce inequities and promote multisectoral action to improve health.

Mr TOBAR (Argentina), also speaking on behalf of the members of the Union of South American Nations, said that the principles set out in paragraph 14 of document A65/5 reflected the proposals agreed by Member States and underlined the need to establish a framework governing the actions of all stakeholders involved in health. He emphasized the importance of strengthening global health governance as a strategic part of the reform process and reaffirmed the need for an inclusive and participatory approach that would lead to a consensus outcome. To that end, he favoured replacing the current top-down approach with the adoption of the cycle of meetings proposed under option (d) of decision point 3, which would allow the work of the regional committees to feed into that of the Executive Board and the Programme, Budget and Administration Committee and thus enable issues that were of importance to the regions to be reflected in the agenda of the Health Assembly. The new

cycle of meetings could also lead to more effective dialogue on financing within the governing bodies. He supported the proposal to realize economies by holding more virtual meetings.

He endorsed the proposals for enhancing alignment referred to in decision point 4, however noted that they should not weaken the contribution of the regional committees; ways of ensuring better articulation and coherence between the committees' deliberations and those of the Board should be examined. Nevertheless, paragraph 26(a) of document A65/5 should be reviewed. He supported greater harmonization among regional committees in the process of nomination of Regional Directors, review of credentials, and the rules governing the participation of observers, which would foster greater transparency. The Programme, Budget and Administration Committee should strengthen its oversight role in relation to independent evaluation and financing. Further discussion should be held on the role of observers, as mentioned in paragraph 33. In principle, he concurred with decision points 7 and 8 and stressed the importance of collaboration with other stakeholders, provided that it did not undermine participation by Member States or lead to conflicts of interest. Relations with nongovernmental organizations, private entities and other bodies were an important part of WHO's coordinating role and leadership in global health, and care should be taken to safeguard the principles of the Organization's relations with third parties from which it derived its intergovernmental character and its legitimacy as the lead authority in health matters.

Dr SILBERSCHMIDT (Switzerland), supported by Dr PRASAD (India), Dr DAULAIRE (United States of America) and Mr AGHAZADEH KHOEI (Islamic Republic of Iran) suggested that in order to avoid confusion, general statements should be made on behalf of regional groupings, to be followed by a discussion of the three main areas of reform: programmes and priorities, governance and managerial reform.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that, in principle, he supported that proposal; however, before discussing the three main areas of reform, Member States should be able to make comments on the reform process overall, and there was no reason why the three main areas should be discussed in any particular order.

Dr DAULAIRE (United States of America) and Mr SMIDT (Denmark) expressed concern that there was insufficient time for general statements.

Mrs ESCOREL DE MORÃES (Brazil) supported the view expressed by the delegate of Thailand. While it would be desirable to structure the discussion, individual Member States should be allowed to comment.

Dr SILBERSCHMIDT (Switzerland) explained that his intention had not been to prevent a general discussion and noted that the discussion on programmes and priority setting would provide an opportunity for delegates to make general comments.

Dr LARSEN (Norway) said that, although he agreed with the logic of organizing the discussion as suggested, many delegations had understood that the debate would be general. He was also concerned that the proposed approach would result in delegates speaking for longer than three minutes.

Dr GUEVARA CLAVIJO (Plurinational State of Bolivia) endorsed the comments of the delegates of Brazil, Norway and Thailand and agreed that many delegations had come prepared to make general comments rather than to focus their remarks exclusively on programmes and priorities.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, agreed that the debate should be organized as proposed by the delegate of Switzerland and suggested

that Member States might make brief general statements before commenting specifically on the three elements of reform.

The DIRECTOR-GENERAL, intervening at the request of the CHAIRMAN, suggested that in the interests of ensuring an efficient discussion and taking into account the various points of view expressed by delegates, Member States might wish to consider making three-minute statements on the total reform package. The Secretariat would then prepare a compilation of the views expressed on the three specific areas of reform.

Dr DANKOKO (Senegal) said that, since he would be speaking on behalf of the African group, three minutes would not be enough.

The CHAIRMAN said that, provided delegates made it clear they were speaking on behalf of regional groupings, they would be allowed more time.

Dr AGUILAR (Ecuador), speaking on behalf of the members of the Union of South American Nations, said that WHO needed to improve the quality of its work at all levels in order to strengthen its capacity to support Member States and enhance its normative and standard-setting role. He supported the following elements: enhancing the role of heads of country offices and refining the process of preparing country cooperation strategies; allocating resources according to priorities; and clearly delineating the functions and responsibilities of the different levels of the Organization, in accordance with decision point 9. The Union of South American Nations remained of the view that it was inappropriate to discuss a proposal to establish a fund for public health emergencies in the context of WHO reform. That matter should be discussed as a separate agenda item. With a view to establishing a new financing dialogue, a complete proposal should be developed. Given the difficulty of increasing regular budget resources, other funding sources were needed, particularly more flexible voluntary contributions. Such contributions should be allocated in accordance with agreed priorities, and transparency in their use must be ensured. By 2014, 70% of the Organization's budget should come from predictable sources.

Dr DÍAZ (Chile), also speaking on behalf of the members of the Union of South American Nations, said that a workforce suited to the needs of the Organization at all levels was key to strengthening global health governance. He noted the progress made in relation to staffing (decision point 10). Any policy on human resources should clearly articulate the functions and responsibilities corresponding to the different levels of the Organization in order to avoid duplication. He supported results-based budgeting. It was the responsibility of governments to guide the Secretariat in setting priorities under the draft twelfth general programme of work and proposed programme budget 2014–2015. He also supported the proposal to hold a financing dialogue with donors in order to align funding with priorities and endorsed the proposal regarding the timing of that dialogue (decision point 11). He attached particular importance to the management of risk and conflicts of interest, especially conflicts of an institutional nature; all such conflicts should be managed strictly in accordance with the priorities set by Member States. Regarding the WHO evaluation policy and decision point 14, Member States should be informed of the outcome of the review to be carried out by the Programme, Budget and Administration Committee prior to the policy's submission to the 131st session of the Executive Board. The points raised during the current Health Assembly should be taken into account during the second stage of the independent evaluation, in particular those relating to priority setting and governance.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the reform process would enhance the roles and functions of WHO as the lead global public health agency. He welcomed the outcome of the Member States' consultation on programmes and priority setting, in particular the proposed criteria and categories. Financial and other resources should be in line with the development

orientations of the proposed categories. Multilateralism and WHO's intergovernmental nature were paramount in the reform of governance. With regard to enhancing alignment between the regional committees and the Board, he favoured an option that would allow the regional committees to contribute more fully to the work of the governing bodies. The interval between sessions of the Programme, Budget and Administration Committee and the Executive Board should allow the Board enough time to review the outcome of the Committee's deliberations. He supported harmonization of the process of nominating regional directors and the review of credentials. However, the involvement of observers in the work of the regional committees could undermine their intergovernmental nature.

The Board should be permitted to limit the number of draft resolutions only on the basis of agreed criteria. The proposal to make more frequent use of Chairman's summaries where a formal resolution was not deemed essential could restrict participation by Member States in shaping the outcome of the intergovernmental process. A clear distinction between formal resolutions and Chairman's summaries should be respected, and in no case should the latter ever replace the former. Concerning the draft revised terms of reference of the Programme, Budget and Administration Committee, while ways of enhancing its capacities should be explored, it should not be overburdened. He looked forward to the translation into practice of the principles set out in paragraph 46 of document A65/5.

Regarding management reform, he supported enhancing the capacities of country offices; their principal role was to carry out WHO's general programme of work in accordance with the national health development priorities of governments. The proposed reforms to improve financing for WHO should be underpinned by effective mechanisms to ensure the adequacy, predictability and flexibility of funds. In the interests of clarity it would have been helpful if all relevant Board decisions and conclusions had been appended to the draft decision.

Dr AL-TAAE (Iraq) commented that the following elements of reform were particularly important: WHO's engagement in suitable partnerships; strengthening governance at global and regional levels; improving the capacity of WHO representatives; ensuring transparency in the allocation of resources; and increasing management effectiveness while reducing expenditure.

Dr LARSEN (Norway) said that the success of the reform process would depend on whether agreement could be reached on a functional financial model that ensured that the governing bodies set the priorities for the Organization. He supported the establishment of an open, transparent and democratic financing model; the one presented to the Executive Board in January 2012 had provided a good point of departure. The purpose of the financing dialogue should be to ensure financing for priorities agreed by Member States at the Health Assembly. An open meeting of Member States and other donors on how to finance those priorities would provide the Director-General with an indication of the funding potential for the coming biennium. The status of the financing dialogue should be presented to the Programme, Budget and Administration Committee and the Executive Board at the beginning of the biennium. The Board could then mandate the Director-General to mobilize any funds that were lacking in accordance with the agreed priorities and the allocation of funds under the draft proposed programme budget. The Director-General should oversee the Organization-wide mobilization of resources and should be free to refuse contributions that were not in line with the agreed budget.

He supported option (d) under decision point 3, which would link the regional committee meetings with those of the global governing bodies in a single sequence over the calendar year. If that option were chosen, he could support the proposal in paragraph 95 of document A65/5 regarding the timing of the financing dialogue. He endorsed the suggestions regarding the alignment and harmonization of governance processes outlined in paragraphs 22–27. The draft twelfth general programme of work should incorporate the technical categories and the criteria for priority setting agreed by Member States in February 2012. To that end, the word "framework" in subparagraph 1(b) of the draft decision should be replaced with the words "criteria and categories".

Dr HASAN (Bahrain) agreed with the five technical categories detailed in the consolidated report and supported the proposals to align regional and governing body processes. Regional priority setting should take account of national and regional culture and traditions. WHO's engagement with stakeholders should follow the three streams of work defined in paragraph 54 of the report. She welcomed the progress made to tackle conflicts of interest and deal with strategic matters.

DR AL-RAJEHI (Saudi Arabia) said that his Government supported the draft decision. He emphasized the need to include the prevention of blindness and visual impairment, which were prevalent worldwide and would continue to increase as a result of population ageing, as a priority in the draft twelfth general programme of work.

Mr SMIDT (Denmark), speaking on behalf of the Member States of the European Union in respect of programme and priority setting, said that it was important to consider the wider implications of proposals for reform in order to ensure that WHO retained its role as the leading global public health agency. Although important steps had been taken in the reform process, a number of challenges remained, for example in relation to financing, resource allocation, the role of WHO in global health and corporate alignment. Monitoring of results of the reform would be essential, and he welcomed the monitoring framework outlined by the Secretariat in document A65/INF.DOC./6.

Referring to decision point 1, he endorsed the recommendations of the Member State meeting held in February 2012 on programmes and priorities, criteria, categories and timeline, as set out in document A65/40, which should be reflected in the draft twelfth general programme of work and the proposed programme budget. He requested that future documents should refer to the third category for priority setting according to the wording agreed by Member States: "promoting health through the life-course". The figure outlining the draft twelfth general programme of work (document A65/5 Add.1) provided a good overview of the terminology used and the linkages between the different components but required further elaboration, especially with regard to how core functions and criteria had been applied in order to set the priorities, as well as further detail on the priorities themselves. He agreed with the overall structure of the draft twelfth general programme of work. The allocation of funds between and within the technical categories and corporate services should be based on a standardized cost analysis of outputs. He welcomed the use of a results chain, including a transparent approach to the allocation of funds. Accountability should be increased throughout the Organization with a clear focus on realistic targets in line with available funding. Moving from three to two steering documents must not weaken accountability.

He requested guidance from the Chairman regarding the procedure to be followed in relation to the draft decision.

Mr MEIŽIS (Lithuania), speaking on behalf of the Member States of the European Union and addressing the management aspect of reform, expressed support for the principles outlined in the consolidated report to ensure closer alignment of the objectives agreed by Member States and available resources; accurately predict potential income for the biennium, based on dialogue with current and potential donors; and establish a realistic, fully funded budget to be decided by the Health Assembly. The proposed financing mechanism required further elaboration, including additional discussion of the process, risks and gains, practical arrangements and timing, and the involvement of the governing bodies. It was essential to improve financial transparency and accountability so that Member States understood how the overall budget was financed and were made aware of gaps in financing. Coherence between the budget and the general programme of work should be ensured and resources linked to agreed targets. Funds not in line with the agreed programme budget should be refused. The European Union encouraged donors to provide non-earmarked funds. Monitoring and reporting should be conducted on a regular basis throughout the budget period. He requested that the Secretariat should include proposals for consideration by the Executive Board at its 132nd session regarding web-based tools for increasing financial transparency. He would also like information on how the Secretariat planned to strengthen results-based budgeting. The annual cycle of governing

body meetings should be adjusted as proposed in option (d) under decision point 3 in order to give the regional committees a clearer role in the budget process.

Dr TUGSDELGER (Mongolia), noting the prevalence of neglected zoonotic diseases worldwide, requested their inclusion in the list of priorities under the category “communicable diseases” in the draft twelfth general programme of work. She suggested either the creation of an additional category entitled “environmental determinants of health” or the inclusion of environmental determinants of health under the fifth category (“preparedness, surveillance and response”).

Mr OTAKE (Japan) said that, after two years of discussion on reform, the time had come for Member States to provide clear guidance to the Secretariat. He supported the priorities, criteria, categories and timeline agreed by Member States in February 2012. The reform should strengthen WHO’s capacity as a standard-setting agency and build on its comparative advantages. Factors such as burden of disease, morbidity and mortality should be further explored and reflected in future work. Although he supported the five technical categories, he was concerned that they were too broad and might overlap, and therefore recommended a cross-cutting approach to the implementation of activities. The priorities must be clearly reflected in the Twelfth General Programme of Work and the next biennial budget. He supported the idea of a financing dialogue with Member States and donors and looked forward to further discussion with the Secretariat on the subject.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the priority setting process could be simplified by aligning the five categories and criteria identified in the draft twelfth general programme of work with the six core functions defined in the Eleventh General Programme of Work and the Constitution of WHO. Priorities should be established by the governing bodies and not influenced by the interests of donors. Member States should be able to express their views on programmes and priorities during the regional committee meetings and through web-based consultations from August to October, and the Programme, Budget and Administration Committee should meet in November in order to allow sufficient time to transmit the outcome of its deliberations to the Executive Board.

Referring to the phrase “governance needs to be a fully inclusive process, respecting the principle of multilateralism” in paragraph 14(a) of the consolidated report, he requested clarification regarding the term “multilateralism”, emphasizing that governance was the responsibility of WHO’s member governments, not third parties. He also noted that the English version of the draft decision used the term “intergovernmental”, not “multilateral”. The Executive Board should limit the number of draft resolutions on the basis of their alignment with agreed priorities.

Regarding decision point 3, he favoured option (d). Regional committees should not work in isolation, dealing only with regional issues, but should align their activities with global priorities and the WHO general programme of work and programme budget. A cost–benefit analysis should be made before a decision was taken on the proposal to increase the length of the sessions of the Programme, Budget and Administration Committee. He supported the proposal to limit the number of agenda items of the governing bodies, thereby allowing a more in-depth analysis and a possible reduction in the duration of sessions. He also agreed with the proposals to increase the predictability and flexibility of financing and to change the periodicity of the programme budget to three years, given that priorities changed little in the short term. Effort and participation by all Member States would be required to ensure the success of the reform process.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, said that the Organization’s work programmes should reflect the needs of countries. For example, as part of its work to tackle communicable diseases, WHO should undertake research on and development of treatments for neglected tropical diseases, and its activities to prevent and control noncommunicable diseases should focus on the availability of essential medicines and access to technologies for diagnosis and treatment. He welcomed the inclusion of health system strengthening in the categories for priority setting identified in February 2012. Activities in that regard should include health systems

research and promotion of pharmaceutical regulations in order to combat falsified medicines. In order to address the social determinants of health, technical support should be provided on a national level through a multisectoral framework coordinated by national health ministries. Emphasizing the lead role of the Health Assembly among the governing bodies, he expressed support for the conclusions presented in paragraph 14 of document A65/5.

Whichever meeting cycle was chosen, it should begin with an expression of needs by Member States. The effectiveness of the meetings of the Programme, Budget and Administration Committee could be improved if they were held after the year-end financial reports had been produced. The countries of the African Region therefore favoured option (b) of decision point 3. They also supported strengthening of the monitoring and evaluation role of the Programme, Budget and Administration Committee and alignment of governance processes, strengthening of the regional committees, as proposed in paragraphs 24 and 27 of the report, and limitation of regional committee resolutions. It was essential to review the current meeting arrangements and, in particular, to curb the trend towards frequent scheduling of night sessions during the Health Assembly, since they created difficulties for delegations with few participants and for those requiring interpretation services. While streamlining the decision-making of the governing bodies was important, there should be a degree of flexibility to allow the inclusion of new and urgent items on the agenda. Regarding engagement with other stakeholders, the report did not clarify whether Member States would participate in consultations with nongovernmental organizations and commercial private entities; the presence of Member States at those consultations could ensure transparency and credibility.

The African countries supported an effective staff performance management policy that was supported by incentives, rewards and sanctions, and staff learning and development. Linguistic ability should be taken into consideration when recruiting staff and language training should be provided so that staff had a good working knowledge of at least two official languages of the Organization. He noted the efforts made by the Secretariat regarding accountability, risk management, conflicts of interest and ethics, and welcomed the proposal to establish a new ethics office, but adequate funding would need to be provided to ensure its effectiveness and independence.

Further details on the proposed financing dialogue were necessary before the Member States of the African Region could express a view on the subject. His Region would welcome a discussion of the possibility of raising Member States' assessments, which would be the most sustainable solution to the Organization's financing problems. He commended the External Auditor and his team for their work on the first stage of the independent evaluation, but noted that donors did not appear to have been included in the consultations, although lack of flexibility and predictability of funding was one of the Organization's main financing problems. He urged the Secretariat to hold consultations with donors and report back to Member States on the outcomes; to propose an internal resource mobilization strategy; to improve results-based management using clear indicators with and feasible targets; to strengthen the alignment of governing bodies at all levels; and to determine the resources needed to effect reform.

Dr JACOBS (New Zealand) welcomed the work undertaken thus far on WHO reform and expressed his broad support for the proposals and the draft decision. With regard to the annual cycle of governing body meetings, he agreed that sessions of the Executive Board should be held in February, thereby allowing the Board more time to consider the recommendations of the Programme, Budget and Administration Committee. Sessions of the latter should be held in late January or early February in order to enable the Committee to have access to financial and other relevant reports on activities from the previous calendar year. He supported the proposal to enhance the role of regional committees, outlined in decision points 3 and 4 of the report, which would increase the relevance and responsiveness of WHO's activities at regional and national levels. The annual cycle of meetings should begin with the regional committees, the outcomes of those meetings then feeding into the meetings of the governing bodies. However, for practical reasons affecting certain Member States in the southern hemisphere, the regional committee meetings should be held in September, October or November rather than in January. Regional committees could thus develop their programmes of work

based on draft third-quarter or year-end financial reports. He supported increased harmonization between regional governance processes but affirmed the need for WHO to maintain a global overview of health and to continue to develop global norms and standards in order to provide a framework within which Member States could carry out their work, thereby ensuring consistent responses across regions while allowing those responses to be tailored to regional or national needs.

Dr GULLY (Canada) said that progress had been made on WHO reform, but further work was needed. He supported the draft twelfth general programme of work, which should be linked with the draft proposed programme budget, since the priorities of the Organization were reflected therein. In defining its priorities, the Organization should ensure that due consideration was given to social and economic determinants, gender equality and other cross-cutting issues included under “principles, values and fundamental approaches” in the draft programme of work. To that end, the Global Management System might establish a process to ensure that those issues were taken into account, and they might also be included in staff workplans. They should perhaps also be included in an additional column in the draft general programme of work. The involvement of partners from other sectors, especially United Nations agencies, in dealing with determinants of health must be ensured. With regard to the options proposed under decision point 3, (b) or (c) would be acceptable but (b) might be preferable, as it would ensure the regional committee meetings, governing body meetings and financing dialogue took place within a shorter time frame, in line with the financial cycle. Consideration might also be given to changing the financial year. He supported closer collaboration between the Chairmen of the regional committees and the Officers of the Executive Board to ensure an inclusive and functional process.

Mr ROLLIANSYAH SOEMIRAT (Indonesia) said that the five categories identified in the draft twelfth general programme of work constituted the biggest health challenges for the international community. The Organization should further support Member States in building their capacity to address those challenges, in line with country needs and capacities. Transparency should be paramount in any decisions connected to the activities of the Secretariat. Evidence-based and cost-effective interventions should be further implemented. He stressed the importance of linking the activities and functions of regional offices and WHO headquarters in order to maximize their effectiveness. The Organization should work closely with United Nations agencies and relevant stakeholders to avoid the duplication of activities.

Mr HOLM (Sweden), expressing appreciation of the Director-General’s demonstrated commitment to reform, said that the outcome of the process should be a WHO fit to carry out its role as the leading global health agency working in and with countries, contributing knowledge, norms and high-quality technical advice. The unanimous agreement at the Member States’ meeting in February 2012 on categories and criteria had provided a good basis on which to develop a programme of work and a programme budget in line with the objectives set. Of all the items on the reform agenda, the new financing mechanism was the most critical.

The current way of financing WHO had become a fundamental obstacle to the Organization. The financing dialogue suggested by the Secretariat had potential and should be explored. A new mechanism, developed through open dialogue, could bring about a transparent and interactive funding process; an opportunity for donors and non-donors to engage on equal terms in a dialogue with the Secretariat on funding; increased predictability under a unified budget; and increased accountability of both Member States and the Secretariat. The dialogue could include a web-based component, complemented by mission briefings under the guidance of the Programme, Budget and Administration Committee. In preparation for the dialogue, the Secretariat should provide participants with full information on available resources, activities planned in order to reach agreed objectives and funding gaps, which would allow governments and partners to adjust and align funding to the needs of the Organization. It was irresponsible to approve a budget that was 75% unfunded. Member States should take responsibility for fully funding the priorities they had agreed and should be prepared to prioritize

further within the framework of a unified budget. The Secretariat should be authorized to proceed with the development of a financing mechanism.

Mr PRASAD (India) expressed concern that only eight of the 16 decision points in document A65/5 required the specific endorsement of the World Health Assembly and that the Health Assembly was only required to note progress on four important decision points. The Health Assembly would have no role in adopting the draft evaluation policy or the draft revised terms of reference of the Programme, Budget and Administration Committee, as those decisions would be taken by the Executive Board at its 131st session. With regard to the proposal that the Executive Board should limit the number of draft resolutions, the Board's role should be clarified, and the constitutional right of Member States to propose agenda items should not be undermined. In his view, the proposal in paragraph 43 to allow Officers of the Executive Board to screen draft resolutions would compromise that right. Moreover, it was impractical to allow only the submission of draft resolutions relating to the general programme of work, as that document currently seemed limited in scope. Reporting requirements should not be limited to a maximum of six times.

Option (d) under decision point 3 would move the Health Assembly to the last quarter of the year, which could lead to donors, not Member States, setting priorities, since the proposed financing dialogue would take place between the meetings of the Board and the Health Assembly. Moreover, option (d) would limit the time available for the Secretariat to implement Health Assembly resolutions and decisions. He therefore supported option (c). He asked whether the proposal contained in subparagraph 26(b), regarding submission of agenda items by regional committees, would require a change to the Rules of Procedure of the World Health Assembly and requested further clarification on the proposals regarding interaction with stakeholders contained in subparagraphs 14(g) and (i).

With regard to paragraphs 64 to 77 on technical and policy support, a detailed proposal was required. Concerning human resources reform, a policy ensuring quality, accountability and transparency, and a comprehensive policy on conflicts of interest were needed. He requested further information on the proposed evaluation and information disclosure policies.

Dr ST. JOHN (Barbados) said that Member States must remain engaged in the reform process, including through web-based consultations. Regional committees had a role to play in facilitating understanding of documents and providing region-specific analysis. Specific resources should be allocated to the reform process. The draft twelfth general programme of work reflected Member States' calls for priority-based funding and would help to ensure that they played a role in developing transparency and flexibility in financial allocations. The first evaluation report contained in document A65/5 Add.2 was useful, but WHO should develop its own evaluation systems, to ensure true accountability. She supported the draft decision without the amendment proposed by the delegate of Norway because the use of the word "framework" in subparagraph 1(b) was more comprehensive than "criteria and categories". On the question of governance, the Programme, Budget and Administration Committee should be held at a time of year when the most information on the WHO budget was available, while ensuring there was enough time between the Committee and Executive Board sessions to allow the Secretariat to produce appropriate documentation. Any review of the annual cycle should take into account regional committee meeting cycles, in particular when there was a need to approve budgets. The proposed high-level implementation and monitoring framework contained in document A65/INF.DOC./6 was a step in the right direction; she looked forward to a more detailed version of that document with reporting on one-year and three-year milestones, which would enable Member States to assess the impact of the reform process.

Dr GUEVARA CLAVIJO (Plurinational State of Bolivia), referring to the subject of financing, said that reform would enable WHO to return to its original mandate in public health, and an adjustment of the budget was a necessary part of that process. Different financing mechanisms should be investigated to ensure that by 2014 at least 70% of the budget was derived from predictable funding. Furthermore, it was necessary to improve the management and transparency of voluntary

funds, to ensure they were in line with the Organization's priorities as set by its Member States in accordance with its Constitution.

Ms JESSE (Estonia), speaking on behalf of the Member States of the European Union on the subject of governance, supported the decisions of the special session of the Executive Board on reform in November 2011, set out in paragraph 14 of document A65/5. However, WHO's unique role, based on its constitutional functions, should be preserved. Concerning the scheduling of governing body meetings, she strongly supported option (d) under decision point 3. Aligning the meeting cycle and budget year would enable a more informed discussion on the programme and budget during the Health Assembly, based on known rather than forecast funding. It would also give a clearer role to the regional committees and strengthen coherence and efficiency between the governing bodies. She requested that the Secretariat provide information on the logistical and financial implications of transitioning to such an approach.

With regard to governance, the goal of enhancing alignment should include all three levels of the Organization and should enhance organizational effectiveness, alignment and efficiency, as called for in independent evaluation report (document A65/5 Add.2). She welcomed the proposal that the Programme, Budget and Administration Committee should examine the financial, administrative and programmatic implications of proposed resolutions in order to strengthen strategic decision-making and supported a more disciplined agenda for the Executive Board. She requested clarification on the proposals relating to centring debates around the general programme of work.

With regard to engagement with other stakeholders, she supported greater involvement of civil society and nongovernmental organizations, although relations with the private sector would require a coherent framework. She asked for clarification of WHO relationships with stakeholders, including regional economic integration organizations. The 2002 report on the subject¹ should be taken into account during future consultations. Partnerships could benefit WHO if roles and responsibilities were clear, but they should bring added value, and the contribution of each party should be optimal and meet expectations.

Mr KÜMMEL (Germany) said that he was disappointed that Member States would only be allowed to make one three-minute intervention, as they had been advised otherwise at mission briefings. A thorough discussion of reform, and particularly of the draft decision, was essential.

Concerning priority setting, there was no clear indication in the report on how WHO was to maintain its leading role in global health. Its role vis-à-vis other global health actors must be clearly defined. WHO could not do everything and should limit its activities to the areas in which it had a comparative advantage. He supported the draft twelfth general programme of work, but believed that it would be essential to set transparent priorities in order to ensure that Member States and donors had a common understanding of what was expected of WHO. The priorities needed to be more clearly defined and their number limited.

With regard to governance, he supported option (d) under decision point 3. Priorities set by the Health Assembly would never match funding if the budget continued to be adopted seven months before the beginning of the biennium. Corporate alignment should not be limited to the regional committees and headquarters, but should also exist among clusters. A strengthened role for the Director-General, in line with Article 31 of the Constitution, should also be considered within the reform process.

Regarding a new financing mechanism, he welcomed the commitment to increase transparency, accountability, realism and guidance by Member States and to seek a mechanism that would allow priority setting to match resource availability. However, a financing dialogue would not be a magic bullet, and the potential costs and risks of any such mechanism, as well as Member States' perceptions of it, should be carefully considered. It had not been possible to undertake a comprehensive analysis of

¹ *Understanding civil society issues for WHO*. Geneva, 2002, World Health Organization (document CSI/2002/DP2).

the independent evaluation report owing to its late publication, and he was therefore unable to endorse its recommendations at the present meeting.

Mrs ESCOREL DE MORÃES (Brazil) said that the strengths of WHO were derived from its intergovernmental and multilateral nature. The Organization should continue to be guided by the nine principles contained in the preamble to its Constitution. There was no doubt that WHO had to adapt in order to respond effectively, efficiently and coherently to emerging health challenges in an increasingly complex global health framework. The Organization should continue to promote the improvement of nutrition, housing, sanitation, recreation, economic and working conditions, and environmental conditions with a view to improving the health and well-being of all people, which should be the strategic vision guiding reform. The reform process had not yet adequately addressed the inextricable link between health and sustainable development, which should remain one of the Organization's strategic objectives. Greater attention should be given to the principles of equity, social justice, human rights and determinants of health and to the need to promote sustainable development and a "health in all policies" approach, as called for in the Rio Political Declaration on Social Determinants of Health adopted at the World Conference on Social Determinants of Health (2011). The draft twelfth general programme of work should include a further category, which might be entitled "Health, Determinants and Sustainable Development", which would address those issues and provide guidance for WHO, other United Nations agencies and Member States. Further consultations would be needed on the draft decision on WHO reform, particularly the section on programmatic reform.

Dr SILVA DO ROSÁRIO (Sao Tome and Principe), referring to paragraph 33 of document A65/5 regarding the participation of observers, noted that her country cooperated with Chinese Taipei in respect of various health issues and asked that Chinese Taipei be allowed to participate more fully in the activities of WHO.

Ms TYSON (United Kingdom of Great Britain and Northern Ireland) reiterated that reform was vital in order to optimize WHO's success in the twenty-first century, and should create an effective and efficient organization. A clear timeline should be established for the implementation of reform at all levels. The criteria and five categories identified at the intergovernmental meeting in February 2012 should form the basis for more precise priority setting. While she was keenly aware of the importance of social, environmental and other determinants of health, she did not believe it would be wise to reopen discussion on the categories, on which there had been clear consensus in February.

Good governance required a clear definition of roles, accountability and transparency, one aspect of which was timely release of documents for discussion. Enhancing alignment between the regional committees and the Executive Board was a key part of better governance, and she requested more specific proposals as to how that could be achieved. With regard to management reforms, the Director-General should use her authority to implement proposals quickly, on the basis of key principles: rational delegation of functions, clear accountability based on results and outcomes, financial propriety and intelligent financial management, and fair and open recruitment based on merit and transparency.

Mr TOSCANO VELASCO (Mexico) said that reform was essential in order to clearly define the responsibilities of the Organization in order to prevent its decline. The reform process would facilitate programme evaluation; promote sharing of best practices, in particular with the least developed countries; better communicate financial and administrative repercussions across the Organization to facilitate alignment of the programme and budget at all three levels; and ensure that voluntary contributions were transparent and in line with priorities established by Member States. In the row of the strategic overview of the draft twelfth general programme of work entitled 'Impact' (in document A65/5 Add.1), special emphasis should be given to reduction in morbidity as well as

mortality. The success of the reform process would depend on the Organization's ability to enhance its response capacity, planning and use of resources.

Mr KAZI (Bangladesh) said the reform process should remain driven by Member States. The process had developed from a need to ensure predictable, flexible and sustainable financing, and in order for WHO to play its leadership role in global health governance, financing should be brought to the forefront, not hidden behind managerial reforms. He looked forward to further discussions on financial reform when the Committee considered the draft decision. He supported the results-based budget and resource allocation approach contained in the draft twelfth general programme of work. However the categories and criteria identified by Member States should be accompanied by tangible and measurable outputs, aligned with the priorities of the draft proposed programme budget. Financing should be guided by accurate income prediction, based not just on past income but on ongoing dialogue with Member States and donors. He requested more information about the guiding principles and overall objectives of the proposed financing dialogue, the implications of which should be clearly understood before decisions were made. Any mechanism should be transparent and inclusive; he urged Member States to participate in informal consultations prior to the 132nd session of the Executive Board. Member States should retain the right to propose draft resolutions in areas of interest, without the introduction of artificial procedural barriers; and the reform process should not overburden the regional committees.

Mr SEN (Turkey) welcomed the progress made on reform, in particular the democratic, transparent and inclusive nature of the process, which should continue. As proposals had become more specific, there was a need for greater clarity. Regarding priority setting, he welcomed the general framework and timeline, which were based on core functions and categories, in particular health system strengthening and preparedness, surveillance and response. Priorities should be set transparently and address the needs of the most deprived.

Concerning governance, extension of the mandate of the Programme, Budget and Administration Committee could be facilitated by adding a day to its sessions and ensuring sufficient time between its sessions and those of the Executive Board. While that might have cost implications, it would increase effectiveness and efficiency, and would allow the Secretariat more time to prepare appropriate documentation. The Committee should have a role in the new financing dialogue. It might be possible to review the annual meeting cycle in order to allow Member States and regional committees to make specific contributions to discussions on the programme and budget. The proposal regarding the Executive Board's role in limiting the submission of draft resolutions needed clarification and should not undermine the constitutional rights of Member States. He welcomed the proposals to improve communication between regional committees and the Executive Board, but noted the lack of a mechanism to ensure accountability of Executive Board members to their regional committees. He looked forward to further consultations on engagement with other stakeholders, and suggested that the regional committees should discuss the matter.

He applauded the rapid introduction of some management reform measures. Important issues remained to be addressed, however, including a mechanism for more predictable and flexible financing. He welcomed the move towards priority-based financing and results-based budgeting and resource allocation which, together with the proposed financing dialogue and the role of the Programme, Budget and Administration Committee, should be discussed by the regional committees. Evaluation should become an integral element of reform at all three levels of the Organization.

Dr DAHL-REGIS (Bahamas) said that WHO should not relinquish its role as the lead global public health agency to other agencies, groups or partners. Nevertheless, PAHO structures predating WHO had served the Region of the Americas well and should be preserved. Financial accountability should be uniformly ensured across all regional institutions. She welcomed the draft revised terms of reference for the Programme, Budget and Administration Committee of the Executive Board, noting that it would need adequate resources, including additional skill sets, in order to fulfil its expanded

mandate. On management reform, she strongly advocated greater representation of Member States at all levels of the Organization.

Professor HALTON (Australia) agreed that WHO should remain the lead global health agency. Financing was clearly a priority, requiring further work. Efforts made regarding programmes and priority setting provided a good basis for future work, although clarification was needed of the priorities themselves and of how they would be reflected in the programme budget. Regarding governance, further discussion of the timing of regional committee and governing body meetings was needed in order to accommodate the differing needs of Member States in the northern and southern hemispheres. From that perspective, none of the options under decision point 3 was acceptable. The timetable should therefore remain unchanged for the moment, but the structure of individual meetings should be examined. The suggestions of the delegate of New Zealand regarding regional committee meetings merited discussion. She supported expanding the role of the Programme, Budget and Administration Committee and extending its meetings by one day. She also welcomed reforms concerning risk management, conflicts of interest, evaluation and ethics. However, change in the management process was vital to ensure effective and efficient implementation of agreed actions.

Dr LIU Peilong (China) said that the various reports effectively summarized results obtained over the previous year. He supported the proposed reforms in the area of programmes and priority setting and the criteria and categories for priority setting identified in the draft twelfth general programme of work. It was to be hoped that the five criteria would be strictly followed. The supporting explanatory notes contained in document A65/5 Add.1 were insufficient. In each reform category, the way in which core functions were reflected in WHO's key activities should be made clear. Regarding governance, the status quo should be maintained but the schedule of governing body meetings should be modified in line with option (b) under decision point 3. He could not support option (d) as it would prevent ministers of health from fully participating in the Health Assembly and regional meetings. The Executive Board should indeed limit the number of draft resolutions and the Health Assembly should respect the Board's decisions, thus ensuring focused debate on key strategic issues. The proposal to optimize financing within management reform was welcome.

Dr RODRÍGUEZ (El Salvador) said that WHO should return to its 1978 definition of primary health care as a fundamental strategy for achieving health for all. In the context of the global economic crisis, which was affecting health, many multilateral organizations were facing resistance to multilateralism. The major global funds for health should support and reinforce, not compete with, WHO policies and activities. WHO should favour creative forms of cooperation, such as cooperation between countries – especially important for developing countries – and triangular cooperation, in order to optimize resource usage. Finally, in future documents and work on noncommunicable diseases, priority should be given to reducing rates of chronic kidney disease among the populations of Central American countries.

Dr SILBERSCHMIDT (Switzerland) said that his Government fully supported WHO reform and generally welcomed the draft decision. Though progress was being made, much remained to be done to make WHO fit to fulfil its constitutional mandate as the lead global health authority. Much emphasis had been placed on reforms concerning the Secretariat. However, WHO was first and foremost a Member State-led organization, and reforms were also needed in the way Member States worked with the Secretariat. They should guide the Secretariat in revising the first draft of the general programme of work but should not be involved in actual drafting. Overall, the one-page overview of the draft programme of work was excellent and should be maintained as a key feature of the programme. However, care should be taken to avoid focusing excessively on medicine rather than on health. He favoured maintaining the five categories agreed by Member States in February, in the light of the comments made by several delegates, and proposed including a cross-cutting priority that would

cover all five categories, entitled “health determinants and equity”. On governance reform, he proposed adding a new paragraph *7bis* to the draft decision, to read:

“to request the Director-General, in consultation with Member States, to:

- (a) propose options on possible changes needed in the Rules of Procedure of the governing bodies to limit the number of agenda items and resolutions;
- (b) propose options on how to streamline the reporting of and communication with Member States.”

His country had shown its readiness to streamline and strengthen its own collaboration with WHO by becoming one of the first industrialized countries to develop a country cooperation strategy. The strategy would embrace a “whole of government” approach, encompassing all Swiss ministries and entities that interacted with WHO, and all levels of the Organization.

Dr WANEE PINPRATEEP (Thailand) said that, in the interests of time, his delegation would submit more detailed written comments on the decision points. The priorities identified under the draft general programme of work were too broad, and it was not clear whether and how they would apply to the whole budget. The Organization was like a country in which its citizens declined to pay adequate taxes but then demanded more public services, causing it to have to beg for resources from donors in order to provide those services. There had been zero growth in assessed contributions for more than two decades; now was the time to rethink that approach and to take greater ownership by contributing more funds to the Organization or providing more non-earmarked regular funding. It was lamentable that the proposed reforms had not challenged Member States on that serious matter. Likewise, they had not adequately addressed the still graver issue of staffing. The contracts of approximately 300 staff were terminated annually, while the most talented were leaving voluntarily for new jobs.

The most critical component of reform was governance. The present structure reflected the geopolitical landscape following the Second World War and was based on a State-only system. Influential stakeholders, such as academia, civil society organizations and the private sector, were excluded and therefore forced to engage in “under the table” lobbying. A complete overhaul of the Constitution of WHO was required in order to transform the Organization into a real evidence-based, participatory body. Thailand supported all the decision points, but believed that the proposed reforms were mostly cosmetic and would not lead to the needed rebirth of WHO.

Dr DAULAIRE (United States of America) said that he supported the scope of the reforms set out in the various decision points and recognized the need for change in the areas of finance, management and governance, which would help to strengthen WHO and enhance its capacity for normative excellence and technical support. Regarding programmes and priority setting, he supported the agreed outcomes of the Member States meeting in February 2012 on criteria, categories and a timeline for the next step in the development of the draft twelfth general programme of work and draft proposed programme budget. It was critical for the next general programme of work to enable a clear understanding of the roles and responsibilities of all three levels of the Organization. Member States should provide input on how WHO could improve the two-way flow of information, on where global targets and indicators could inform and guide regional and country-based objectives, and on country needs and global efforts. At the February meeting, it had been agreed that, like gender equality, the social determinants of health were principles that should inform all of WHO’s work. It would be inadvisable to reopen consultation on that matter.

On governance, realistic budgeting went hand in hand with transparent and more predictably financed budgets. It could be useful for the Secretariat to engage in additional informal consultations with Member States before the Executive Board meeting in January 2013. The linkage between regional offices and headquarters and the timelines for organizing work were important questions that required more thorough discussion. The United States of America welcomed the commitment to realistic income estimates and plans for a more inclusive and open process for engaging with donors

and all Member States on funding budgets. It supported further dialogue between the Secretariat and Member States on financing and meeting schedules, but was not yet prepared to make a decision on the matter; greater clarity was needed on a number of core elements of the reform, as well as cost and logistical considerations, including at the regional level. Concerning management, his Government supported the proposals relating to harmonization, streamlining the management of resolutions and items, and reforms that strengthened technical and policy support to Member States. Lastly, it gave high priority to human resource reform as a means to ensure a better match between staff skills and job profiles.

Mr BEN AMMAR (Tunisia) observed that one of the main reasons for WHO reform was the present financial crisis. During a comparable crisis in the 1990s, the Executive Board had recommended, *inter alia*, outsourcing technical programmes to countries where costs were lower and conditions good. Many similar recommendations had been made during the present crisis, and it was to be hoped that the decisions taken would reflect that approach. He supported the proposal to include social determinants of health as a fundamental priority in the next general programme of work.

Mr LEE Kyung-yul (Republic of Korea) said that reform was necessary not because WHO had performed poorly but because of expectations that it would perform better in the future as it addressed new challenges. He endorsed the Director-General's focus on clear priorities, delineation of jobs needed, creative division of labour, and transparency and accountability. Reform would be an ongoing process, since the world was continuously changing. Clear guidelines were required for the process of priority setting. That process should not be seen as a means of exclusion, however Member States should be able to exclude issues that they deemed unnecessary. That said, the Republic of Korea supported the draft criteria, categories and road map for priority setting set out in document A65/40, which should be translated into feasible action plans. Regarding decision point 3 on the scheduling of governing body meetings, option (c) was considered the most desirable but would not rule out option (d).

Ms PRIETO ABAD (Colombia) said that WHO reform was important for building a strong and modern Organization, fit to face the challenges of the twenty-first century. The changing situation of global health and its determinants, globalization and economic internalization were creating new challenges for WHO as it strived to ensure human security in its broadest sense. A fundamental objective of the reform was to strengthen Member States' national health systems in the medium and long term. The budget should be transparent, predictable, financed by non-earmarked contributions and in line with programmes and priorities determined by Member States. It would be advisable to add social determinants of health as an additional category in the draft twelfth general programme of work. In addition, equity and social inclusion should be included in the "health systems" category. On governance, she welcomed the focus on strengthening national capacity and public health policies, and on enhancing existing mechanisms before creating new bodies and authorities. It was important to continue discussions that would ensure the wider participation of Member States. Regarding the proposal to improve alignment, careful consideration should be given to the role and contribution of the regional committees with respect to the Executive Board. Consultation on the issues addressed in the draft decision was ongoing, more in-depth dialogue on the proposed priorities was required before approval.

Mr PELLET (France) welcomed the focus on the five priority categories that would clarify WHO's mandate and define its activities. Consultation on the categories should not be reopened, given the significant progress made in the reform process. Governance reforms should enhance the effectiveness of governing bodies and oversight of programme, budget and administration. He acknowledged efforts to manage limited resources effectively in the face of growing health needs. A new performance-based management policy should make full use of modern evaluation and monitoring tools. WHO should have a clear programme of action with a defined timeline that would

allow it to evaluate reform outcomes in relation to initial objectives. It was time for WHO to communicate the rationale and implications of reform to the three levels of the Organization. Regarding stakeholder engagement, the Secretariat could propose a draft general policy outlining WHO's relationship with different types of nongovernmental organization by January 2013, preserving the intergovernmental character of WHO decision-making and the independence of its expertise. For the global population to understand the usefulness of reform, decisions adopted at headquarters should translate into tangible improvements on the ground; in that context, emphasis should be placed on the accountability of WHO offices at country level. Finally, the model for future financing should be transparent and realistic and based on priorities defined by Member States and not by private donors. WHO's ability to attract flexible, predictable and sustainable funding would largely depend on the trust it inspired once reformed, re-focused on its core role and able to benefit from its comparative advantages within the global health architecture.

Dr GUTERRES CORREIA (Timor-Leste) said that since May 2011 three distinct and interconnected objectives had emerged in the process of WHO reform: improved health outcomes; greater coherence in global health, with WHO playing a leading role; and the pursuit of excellence, effectiveness, efficiency, responsiveness, objectivity, transparency and accountability. Reform was essential to help the Organization respond to the changing complexity of public health issues, equipping it to fulfil its lead role more effectively and efficiently. WHO needed to become more flexible to accommodate the differences between regions. South-East Asia, for example, was still behind in ensuring standards of living, tackling poverty and inadequate infrastructure, and addressing education and communication to the public.

Mr MESBAH (Algeria), referring to governance, said that it was essential to reaffirm the role of the Health Assembly as the supreme decision-making body. With regard to programmes and priority setting, he emphasized the need to respect the views of Member States and to apply a bottom-up approach. Concerning management reform, he acknowledged the need to rationalize decision-making, but said that Member States should be able to add new and urgent issues to governing body agendas.

Dr NGOZI AZODOH (Nigeria), noting that financing was critical to the work of WHO, said any financing strategies would be welcome that would ensure WHO's independence in pursuing priorities agreed by the Health Assembly, while also ensuring flexible, predictable and sustainable financing. WHO should remain the lead agency in global health matters, despite the emergence of other players.

Dr ELSAYED (Egypt) said that his country supported the five technical categories in the draft twelfth general programme of work. All countries would need to set their own disease priorities according to prevalence rates at the national level. Communicable diseases should be included among the priorities, as they represented 60% of diseases affecting humans, and neglected tropical diseases should feature in that category. On management reform, it was important to preserve the Organization's intergovernmental nature in any new initiative or priority-setting exercise. Donors should not be allowed to establish priorities, given the risk of conflicts of interest.

Dr ELMARDI (Sudan) said that, without reform, WHO might not survive. The priorities set out in the document were reasonable to the extent that they were largely inclusive and represented real challenges. However, there was some overlap, which should be addressed. Although primary health care was an agreed approach, it had not been given sufficient weight in the reform. The five technical categories would be further strengthened if they incorporated a primary health care component. Social determinants of health should be incorporated as a cross-cutting element in the five categories, but not added as a separate category. Governance issues were context-dependent and should be considered not only at all three levels but also beyond WHO, in health ministries and partner organizations. In-depth situation analysis should be carried out to assess organizational structures, actors, tools, instruments

and culture. In the context of scarcity and shortage of predictable financing, WHO should not restrict itself to its own funds but should consider overall funding for health at the global level, seeking to ensure harmonization, alignment and aid effectiveness. Open dialogue was necessary on that critical matter to enable WHO to lead and guide global health interventions.

Dr SHONGWE (Swaziland) said that, as WHO was an intergovernmental organization, the reform process should be country-driven. With reference to paragraph 33 of document A65/5, on participation by observers, consideration should be given to broadening the participation of Chinese Taipei in the work of WHO, including in the Health Assembly and other meetings. Regarding governance reform, the present schedule of governing body meetings should be maintained until consensus was reached. He therefore favoured option (a) under decision point 3. The Health Assembly should remain the supreme body of WHO, in line with the Constitution. He supported the adoption of the draft twelfth general programme of work, but underscored the need for flexibility to address new and emerging issues. Any steps taken to streamline the management of resolutions should not interfere with, or limit, the constitutional rights of Member States.

The meeting rose at 12:30.

SIXTH MEETING

Thursday, 24 May 2012, at 14:40

Chairman: Dr L.Z. DUKPA (Bhutan)

WHO REFORM: Item 12 of the Agenda (Documents A65/5, A65/5 Add.1, A65/5 Add.2, A65/5 Add.3, A65/40, A65/43 and A65/INF.DOC./6) (continued)

Mr LEATHER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, urged the World Health Assembly to take a clear decision to ensure that the fundamental right to health was fully integrated into the draft twelfth general programme of work (document A65/5 Add.1). That would enable the Organization to reaffirm its commitment to human rights, meet the requirements of the Constitution and promote a rights-based approach to the Organization's work, thereby contributing to the prioritization of health in national policy-making and supporting those most excluded from access to health services.

Ms VERZIVOLLI (Consumers International), speaking at the invitation of the CHAIRMAN, said that reform efforts in respect of engagement with stakeholders should focus on improving relations with public-interest nongovernmental organizations. Relations with nongovernmental organizations with commercial interests should perhaps be restricted. Such organizations had been accepted into official relations with WHO in violation of the 1987 Principles Governing Relations between WHO and Nongovernmental Organizations. Their relations with WHO should be guided by the policy for interaction with the private sector alluded to in paragraph 54 of document A65/5. Consultations on the revision of the 1987 principles should build on the key recommendations of the 2002 review report on WHO's interactions with civil society and nongovernmental organizations¹ and on a thorough assessment of current practices. The proposed review of partnerships hosted by WHO should perhaps cover all partnerships in order to assess whether they enhanced or limited the Organization's ability to fulfil its constitutional mandate.

Dr KAMAL-YANNI (Oxfam), speaking at the invitation of the CHAIRMAN, noted that the Organization was struggling to deliver on its core functions owing to financial constraints and resulting staff losses. She urged the Health Assembly to approve mechanisms to protect the core functions, including an emergency financial package, for the period through to the next programme budget. It was also important to ensure sufficient funding from the regular budget for activities relating to essential medicines, in view of the potential conflicts of interest in that area. Member States had to work together to bring about a significant increase in the proportion of flexible funding, which was essential in a context of increasing demands and decreasing Member State contributions to the regular budget. Longer-term reforms should build on WHO's many successes and enable it to strengthen its leadership role in promoting universal and equitable access to quality health services.

Mr KNIGHTS (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, expressed strong support for WHO collaboration with public-interest

¹ Review report: *WHO's interactions with civil society and nongovernmental organizations*. Geneva, World Health Organization, 2002 (WHO/CSI/2002/WP6).

organizations. However, there was a qualitative difference between the interests of the latter and those of the private sector, and the Secretariat should devise effective ways of maintaining transparency in partnerships with the private sector, whose assistance should be accepted only if in line with agreed priorities.

A more radical approach was required to overcome the current funding crisis. An organization that derived 80% of its funding from earmarked donations could not set its own agenda objectively on the basis of evidence and global health needs. Member States should consider ways of allowing greater flexibility in their voluntary contributions and should also commit collectively to yearly growth in core funding.

WHO must advocate effective global policies to tackle the economic, social and environmental determinants of health. Some of its greatest successes had emerged from its advocacy and implementation work, and it would be regrettable to see those functions diminished by restricting its remit to a narrow biomedical focus. National and personal interests should be set aside in order to reaffirm WHO's core principles, especially the realization of health for all.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, welcomed the reduction in the number of categories for priority setting and programmes, as presented in document A65/40, and stressed the need for systematic programme coordination at a technical level in order to promote a holistic approach. He trusted that the numbering of the categories did not reflect a hierarchy in terms of priority setting and financing.

On the subject of effective engagement with stakeholders, he said that the differentiation of nongovernmental organizations referred to in paragraph 49 of document A65/5 might create more problems than it solved, as only a few of those organizations were potentially likely to introduce bias into WHO's work. The important task of identifying and managing conflicts of interest in the Organization could be facilitated by providing a clear definition of the terms "stakeholder" and "conflict of interest".

The single-page summary of the draft twelfth general programme of work was commendable, but it might be enhanced by clarifying how the Organization would work, making reference, for example, to "transparency", "collaboration" and "broad consultation". "Health technology" should be added to the priorities under category 4 in order to support the illustrative example of WHO's prequalification of medicines, vaccines and diagnostics.

The CHAIRMAN invited the Committee to consider each section of the draft decision contained in document A65/5 Add.3 separately, beginning with "Programmatic reforms".

Dr GULLY (Canada) suggested that, in the interest of expediting decision-making, speakers should confine their comments to clarification of points already raised at the previous meeting.

Mrs ESCOREL DE MORÃES (Brazil) said that the draft decision required further discussion, as some of the text remained in square brackets. Her delegation still had concerns to be addressed before it could agree to endorse the report referred to in subparagraph 1(a).

Dr MARTÍNEZ (Paraguay), speaking on behalf of the members of the Union of South American Nations, joined the delegate of Brazil in calling for further discussion of the draft decision. In particular, it needed to be clarified how the views expressed would be reflected in the text.

Ms POLACH (Argentina) endorsed the comments made by the delegates of Brazil and Paraguay.

The DIRECTOR-GENERAL, responding to the comments on programmes and priority setting, noted that there had been many points of convergence, but that some matters required further guidance and decisions by Member States. Once those matters were resolved, the decision points could perhaps

then be addressed section by section. On the specific matters of blindness and zoonotic diseases raised by the delegates of Saudi Arabia and Mongolia, respectively, both would be addressed under the draft twelfth general programme of work. There had already been important collaborative work with FAO and OIE on zoonoses.

Several delegates had requested the Secretariat to revisit the priorities presented in the draft strategic overview contained in document A65/5 Add.1, so as to provide more details showing the interlinkages between the draft twelfth general programme of work and the draft proposed programme budget 2014–2015, and clarifying the results chain. In addition, Member States had requested greater emphasis on the ways in which WHO was working with health partners in the United Nations system. Both those requests would be addressed. Opinions had differed on the matter of the categories of work. Some delegates had proposed the inclusion of an additional category to reflect the importance of economic, social and environmental determinants of health and of other fundamental principles, such as equity and human rights. Others had opposed the addition of a category, but had agreed on the importance of those principles and had suggested that, in order to reflect their importance, they should be mainstreamed into the categories agreed during the February 2012 meeting. The delegate of Switzerland had suggested presenting them in a new row in the draft strategic overview as cross-cutting priorities covering all five categories. She sought guidance on the Committee's preference for one or other of those options. Another alternative might be to refer to health determinants and equity in each of the five boxes in the existing "priorities" row.

Mrs ESCOREL DE MORÃES (Brazil) said that the delegations opposing the addition of a new category had done so simply because they did not wish to reopen the discussion on the issue. That was not a good argument. Member States had gathered at the Health Assembly to review, endorse and, if necessary, improve on what had been agreed. The Director-General's suggestion was positive in that it would make the various determinants of health a priority in all categories. However, there would still be a need to establish a special unit to prepare the appropriate studies and to interact with staff working in the various programmatic areas. Creating a new category would be one way to address that need. It might be easier to reach agreement if Member States had a clearer understanding of the rationale for and objectives of the various categories.

Ms POLACH (Argentina) said that she did not see how it could be ensured that social determinants of health would be incorporated in the five categories and therefore favoured the addition of a new category, which would enable WHO to place health higher on the sustainable human development agenda. That, in turn, would help to raise awareness of the role of health determinants and ensure that appropriate work programmes and resources were incorporated into national development plans.

Dr GULLY (Canada) requested clarification as to the implications of creating another category. On the one hand, it might constitute a new category of work leading to a programme and a plan with outputs and outcomes, forming part of the results-based management system. On the other, it might take the shape of a programme for monitoring the plans and outputs of all WHO programmes to ensure that the various determinants of health were at the heart of the Organization's activities.

Dr LIU Peilong (China) suggested treating action on the various determinants of health in the same manner as the core functions of WHO established under the Eleventh General Programme of Work, such that considerations relating to health determinants would be included in each category of work, just as the core functions were reflected in each category.

The DIRECTOR-GENERAL explained that the addition of a new category would not affect organizational structure as the categories did not determine future structure nor future funding allocations. Priorities could be addressed either through a dedicated, stand-alone programme, as in the case of malaria and HIV/AIDS, or through a cross-cutting mechanism, as with gender, human rights

and equity. In both cases, work would be overseen by a unit under the responsibility of an Assistant Director-General, but her office would take responsibility for compliance, and monitoring and evaluation. The addition of a category might raise the visibility of the issue, but if the aim was to ensure increased attention to health determinants, they should, in her view, be addressed at the priority level, since financial and human resources would be allocated not to categories but to priorities as articulated in the programme budget. Moreover, she personally would oversee work on mainstreamed priorities.

Dr SUWIT WIBULPOLPRASERT (Thailand), welcoming the Director-General's proposal, suggested that economic, social and environmental determinants, which were the root cause of both communicable and noncommunicable diseases, should be addressed both as priorities under each category and as an additional category.

Dr ST. JOHN (Barbados) noted that the key point in the Director-General's explanation was that resources were to be allocated to priorities. The end results of the work on social determinants of health were more important than the means, and an additional category might not be the best solution.

Ms SHAHNAZ WAZIR (Pakistan) endorsed the Director-General's view on the positioning of the social, economic and environmental determinants of health, as well as equity and human rights, which were fundamental principles that had to cut across all of WHO's work. Welcoming the clarification on the funding of priorities as opposed to categories, she said that the debate should focus on priority setting. In order to measure performance and outcomes in the five categories, it would be essential to consider social determinants of health. They should be mainstreamed and clearly defined as priorities in each category and should be addressed through work programmes and supported through budgets under those categories. She did not support the addition of a sixth category.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that priority setting was crucial. It was a complex process in which the principles, values, approaches and functions of WHO, as well as the categories of work and the criteria for priority setting, had to be taken into account. He supported the addition of a sixth category entitled "Health and sustainable development", which should be taken into consideration when setting priorities for funding. It was the priorities established that would ultimately determine the Organization's general programme of work and its activities at the global and regional levels.

Dr KIMANI (Kenya) stressed the need to give greater prominence to the long-neglected environmental determinants of health, which were of particular concern to many developing countries. Targets and indicators should be developed for those determinants, and they should be dealt with either in a new category or in each of the existing categories. Nutrition was another key cross-cutting determinant that should be prioritized, as it affected all population groups, but health workers often failed to accord it sufficient importance.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, reiterated her view, expressed at the previous meeting, that there was no need for a sixth category, given the broad consensus reached on the five categories of work at the February 2012 meeting of Member States on programmes and priority setting. Although reluctant to reopen the debate on the matter, she was willing to consider the Director-General's proposal in order to find a way forward.

Dr LARSEN (Norway) said that it was more important to focus on the criteria for priority setting than the categories, which had already been the subject of extensive debate at the meeting in February. That debate should not be reopened. He was pleased to see the determinants of health included among the principle values and fundamental approaches in the draft strategic overview presented in document A65/5 Add.1, and was confident that they would be suitably prioritized in the

Twelfth General Programme of Work and the Programme budget 2014–2015. He did not support the addition of another category and endorsed the approach proposed by the Director-General.

Mr MESBAH (Algeria) said that the five categories should be seen as vertical axes and the social determinants of health, together with equity and gender, as cross-cutting, horizontal axes. It would be useful to consider the advantages and disadvantages of the two options – the creation of a new category or the inclusion of health determinants in each of the five categories – in terms of a single criterion: how they would contribute to the Organization's effectiveness.

Dr MAKUBALO (South Africa) said that all relevant factors contributing to good health needed to be taken into account in the continuing drive for universal coverage and equity. The Director-General had provided a useful indication of a way forward; however, details were often lost in the process of mainstreaming. South Africa had initially preferred the option of a separate category of work for social determinants of health, as it would help to ensure that they remained a focus of attention, and if the Committee decided against that option, it would be important to consider a means of monitoring progress on the elements that would have been included in such a category.

Dr SILBERSCHMIDT (Switzerland) said that his delegation, like that of South Africa, had initially been in favour of a separate category for health determinants and equity. However, it had realized that that might lead to their being neglected in the other categories. They had to be mainstreamed into all WHO's work, which called for a change of mindset throughout the Organization. The delegate of Brazil had rightly drawn attention to the need to establish a unit to remind other units of their responsibilities and to provide them with the tools to measure the results of their work, but it was not necessary to have an additional category of work for that purpose. The question of whether to present health determinants and equity in a new row in the draft strategic overview in document A65/5 Add.1 or under each category on the existing "priorities" row was unimportant. What mattered was to ensure that they formed the basis of all work in all five categories.

Dr AGUILAR (Ecuador), supporting the proposal by the delegate of Brazil, said that his Government and those of many other South American countries considered tackling the determinants of health through intersectoral synergies to be of primary importance in health work. A separate category would provide a means of organizing and focusing work on social determinants. A cross-cutting approach risked diluting the focus.

Dr AMMAR (Lebanon) reiterated his position, expressed at the previous meeting on behalf of the Member States of the Eastern Mediterranean Region, on the importance of considering social determinants of health under all five categories. He endorsed the cross-cutting approach proposed by the Director-General.

Ms TYSON (United Kingdom of Great Britain and Northern Ireland), endorsing the views of the delegates of Cuba, Denmark, Norway, Pakistan, South Africa, Switzerland and others, thanked the Director-General for her clarification of the distinction between the categories of work and the priorities. She supported prioritizing determinants of health under each category while also including them among the Organization's principles and values as shown at the top of the draft strategic overview of the draft twelfth general programme of work.

Dr AL-TAAE (Iraq) agreed with previous speakers that attention to the determinants of health was vital. Supporting the cross-cutting approach set out by the Director-General, he stressed the need for integrated performance indicators within each category in order to ensure that the focus on determinants remained undiluted.

Dr SEAKGOSING (Botswana) endorsed the Director-General's proposal of a cross-cutting approach to social determinants of health. The categories should be left as they stood.

Dr DANKOKO (Senegal), recalling his comment at the previous meeting on the importance of emphasizing social determinants of health in the draft twelfth general programme of work, stressed that none of the priorities set out in document A65/5 Add.1 could be tackled without taking those determinants into account. There was clearly a need for a cross-cutting approach, and he therefore supported the proposal by the Director-General.

Mr MAMACOS (United States of America) said that within the architecture proposed in January, social determinants of health should be treated as a principle underlying all WHO's work. The categories of work were baskets of programmatic activities comprising most of that work. It was unclear what activities would be carried out under a new category on social determinants. The categories already agreed should be respected; continued debate on the matter was hindering progress and was not in the Organization's best interests.

Dr TAKEI (Japan) expressed support for the approach suggested by the Director-General and endorsed her view of the cross-cutting nature of the determinants of health. He further endorsed the view of the delegate of Switzerland that those determinants should be regarded as overarching principles to be taken into account in all five categories of work.

Mr PARDO (Monaco), endorsing the comments by the delegates of Denmark, Norway and Switzerland, expressed appreciation for the clarification provided by the Director-General and supported her proposal. The debate on the list of categories, which had been agreed by consensus at the February meeting of Member States, should not be reopened. The determinants of health were clearly of great importance and should be considered priorities, but should not be placed in a separate category.

Mr URQUIDO VELÁSQUEZ (Colombia) said that without a separate category of work and a clear indication of WHO's mandate with respect to social determinants of health, there was a danger of the issue remaining in the realm of rhetoric and good intentions. The matter was of particular importance to developing countries, where stronger action was needed to enable them to achieve their public health objectives.

Ms MARTHOLM FRIED (Sweden) endorsed the views of the many speakers stressing the importance and cross-cutting nature of the determinants of health. That had been highlighted when those determinants had been included, along with gender equality – a principle dear to her delegation – among the principles, values and fundamental approaches at the top of the draft strategic overview contained in document A65/5 Add.1. She supported the way forward proposed by the Director-General.

Dr RODRÍGUEZ (El Salvador) expressed support for the creation of a sixth category of work for determinants of health. Given the increased importance attached to them by WHO, and the conclusion drawn by the World Conference on Social Determinants of Health that they were fundamental to the achievement of health priorities, it would not suffice merely to incorporate them into the five previously agreed categories.

Mr KÜMMEL (Germany) said that while the February meeting of Member States on programmes and priority setting had reached a balanced consensus, which should be respected, it was clear that many delegations saw a need to give greater emphasis to social determinants of health in the draft twelfth general programme of work. He supported the approach proposed by the Director-General, which addressed that need while also preserving the earlier consensus.

Dr MARTÍNEZ (Paraguay), welcoming the Director-General's proposal to include health determinants in all five categories of work, enquired whether it might be possible to raise the visibility of such determinants through a mechanism other than a separate category. Such a mechanism should have adequate resources and technical support and should serve as a liaison with other cooperation agencies. Perhaps the Director-General might suggest a way around the impasse at which the Committee found itself.

The DIRECTOR-GENERAL said that the various meetings on WHO reform and the World Conference on Social Determinants of Health (in Rio de Janeiro, Brazil) had shown that all Member States embraced the importance of social determinants of health. The visual presentation of the draft strategic overview in document A65/5 Add.1 had perhaps exaggerated the importance of the five categories. Resources, as mentioned earlier, would be allocated not to the categories but to priorities, and the Secretariat would be accountable for the results achieved with those resources. She now saw how better to reflect the determinants, and equity, social justice, human rights and gender equality in the chart. She assured Member States that she personally would ensure that they were given greater prominence when the draft was revised, and reiterated that she would oversee all mainstreamed priorities.

Dr SUWIT WIBULPOLPRASERT (Thailand) suggested, as a possible compromise, that the words "social determinants of health" could be inserted into the title of category 3 and added to the respective list of priorities. He further suggested that the Committee should accept the Director-General's pledge to take direct responsibility for ensuring a clearer focus on health determinants.

Mrs ESCOREL DE MORÃES (Brazil) said that she could accept the proposal to revise the draft twelfth general programme of work to reflect the cross-cutting nature of not just social but also economic and environmental determinants of health. However, it also needed to reflect their specific characteristics and the potentially positive or negative effect of each determinant on health. Studies had to be conducted with a view to developing appropriate, evidence-based policies, indicators, goals and plans of action to support countries in adopting sound policies that would foster health and prevent disease.

As for the priorities listed under each category, although they had been suggested by the Secretariat on the basis of the criteria for priority setting agreed at the February meeting, they had not been discussed by Member States at that time. It was important to take the time to consider them carefully in order to arrive at the right decision.

The DIRECTOR-GENERAL acknowledged that the priorities had not been discussed at the February meeting of Member States, but pointed out that they had not been picked at random. They had been developed by the six regional directors, herself and the Deputy Director-General on the basis of contributions from across the Organization, taking into account regional and international priorities, as well as national priorities identified through the 145 country cooperation strategies. The list was neither exhaustive nor set in stone. Member States had agreed in February that the priorities should be reflected in the draft proposed programme budget 2014–2015, which would be developed in line with the comments made at the present Health Assembly. Member States would have three further opportunities to discuss priorities: when the draft proposed programme budget was submitted, together with the draft twelfth general programme of work, to the six regional committees in September and October 2012; during the 132nd session of the Executive Board; and at the Sixty-sixth World Health Assembly. Clearly, more work was required to give greater prominence to social determinants of health. One possible option might be to amend the title of category 3, as suggested by the delegate of Thailand, to read "Promoting health through the life-course and social determinants". She sought guidance from Member States as to how they wished to proceed.

Dr GULLY (Canada) said that health determinants, together with sustainable development, were fundamental to all five categories. He urged the Secretariat to revise the draft programme of work in such a way as to ensure that they were given due attention in all areas of work.

Mr URQUIDO VELÁSQUEZ (Colombia) endorsed the proposal to include health determinants in the title of category 3, which might provide a way of reaching consensus, and suggested amending it to read “Promoting health and action on the determinants of health”.

Professor N’DRI-YOMAN (Côte d’Ivoire), speaking in her capacity as President of the World Health Assembly, recalled that, in plenary, the Health Assembly had stressed priorities and the need for programming and funding to support them. Accordingly, she suggested that health determinants should, as a first step, be included as a priority under one of the categories, preferably category 3, which covered health promotion, as it was through health promotion that the determinants of health would be addressed. The question of whether they needed to be placed in a separate category could be dealt with at a later stage, and the Committee could move on to consider other aspects of reform.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, endorsed the comments made by the delegate of Canada and reiterated her support for the cross-cutting approach proposed by the Director-General.

The CHAIRMAN invited the Committee to provide the guidance requested by the Director-General.

Dr SILBERSCHMIDT (Switzerland) said that the Committee should endorse the Chairman’s report on the meeting of Member States held in February 2012 (document A65/40), as provided in subparagraph 1(a) of the draft decision. In order to highlight the importance that Member States clearly attached to determinants of health and to equity, subparagraph 1(b) might be amended to read: “... guidance provided by the Sixty-fifth World Health Assembly, especially concerning health determinants and equity ...”. The Secretariat could then revise the draft twelfth general programme of work, perhaps reworking the draft strategic overview so as to place less emphasis on the categories, and present a proposal for discussion during the upcoming regional committee sessions and the next session of the Executive Board. Member States could then judge whether the revised draft met their needs.

Dr DAHL-REGIS (Bahamas) endorsed the proposal put forward by the delegate of Switzerland.

Mrs ESCOREL DE MORÃES (Brazil), responding to a question from Dr LARSEN (Norway), said that her delegation remained concerned at the lack of any details on concrete activities by the Organization on determinants of health and sustainable development. Supporting the proposals to include determinants of health as a cross-cutting category and in the title of category 3, she suggested amending the latter to read: “Health promotion and social determinants”. Further to a query by the DIRECTOR-GENERAL regarding whether reference to the life-course should be retained, she said that the exact wording did not matter as long as health determinants were included in the title.

Ms LANTERI (Monaco) noted that the prevailing view was that the Director-General should carry out further work on the draft programme of work, taking into account all of the determinants of health as a cross-cutting priority, as suggested by the delegate of Switzerland. The categories should not be reopened for discussion, and the Committee should move on to other areas of WHO reform.

Dr LARSEN (Norway) said that, while there was clearly consensus on the importance of social determinants of health, there did not appear to be agreement to reopen discussion on the categories.

Mr MESBAH (Algeria) said that it would not be appropriate to include health determinants only under category 3 and reiterated his previous suggestion that the advantages and disadvantages of creating a new category or, alternatively, including health determinants in all categories should be examined in the light of how they might contribute to the Organization's effectiveness.

Dr GULLY (Canada) said that he supported the amendment proposed by the delegate of Switzerland and looked forward to seeing a revised draft programme of work and a proposed programme budget that would reflect Member States' concerns in respect of social determinants of health and would ensure, through the programme budget, that they were included in the activities of all WHO programmes.

Dr RODRÍGUEZ (El Salvador) suggested that a compromise approach encompassing the various options under consideration might be to put health determinants in a cross-cutting category placed across the top of the other five categories of work.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, endorsed the proposed amendment to subparagraph 1(b).

Ms PATTERSON (Australia) said that the text as amended would allow Member States to influence not only the general programme of work but also the programme budget, the means by which the determinants of health would actually be addressed. She therefore supported the proposed amendment.

Mrs ESCOREL DE MORÃES (Brazil), expressing support for the amendment proposed by the delegate of Switzerland, said that further work was required to improve the report of the Chairman of the meeting of Member States on programmes and priority setting; she would therefore suggest that the word "endorse" be replaced with "welcome" at the beginning of subparagraph 1(a).

Dr SILBERSCHMIDT (Switzerland) stressed that the Director-General would require clear and unambiguous guidance in order to produce a revised version of the draft Twelfth General Programme of Work and the Proposed programme budget. In view of the need to adopt a budget at the next Health Assembly, every effort should be made to avoid major differences of opinion. He noted that, while it was agreed that much stronger emphasis should be placed on health determinants and equity, most delegations appeared to want the categories to remain unchanged.

Dr ST. JOHN (Barbados) observed that the proposed amendment to subparagraph 1(b), which she fully supported, carried more weight than the proposed amendment to subparagraph 1(a), as it covered the substantive matter of how work was prioritized and resourced.

Dr SUWIT WIBULPOLPRASERT (Thailand) endorsed the amendment to subparagraph 1(b) and requested clarification of whether the proposal to rename category 3 had been accepted.

The CHAIRMAN said that there was no clear consensus on changing the title of category 3. The majority of delegations appeared to support the cross-cutting approach suggested by the Director-General.

Mrs ESCOREL DE MORÃES (Brazil), asked whether her proposed amendment to subparagraph 1(a) had been accepted and reiterated her view that the report by the Chairman of the meeting of Member States presented some good work but could do with improvement.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, said that the report was comprehensive and fruitful and should be endorsed. She requested clarification from the Secretariat as to whether the amendment proposed by the delegate of Brazil would imply that the discussion might be reopened.

Mr MAMACOS (United States of America) endorsed the amendment proposed by the delegate of Switzerland to subparagraph 1(b) of the draft decision and welcomed the amendment proposed by the delegate of Brazil to subparagraph 1(a).

Mr SEN (Turkey) welcomed the proposed amendments to subparagraphs 1(a) and 1(b) of the draft decision. In view of the Director-General's pledge to give due consideration to determinants of health in revising the draft general programme of work, the discussion could now be brought to a close.

The DIRECTOR-GENERAL, welcoming the comment of the previous speaker, said that the proposed amendment to subparagraph 1(b) of the draft decision would assist the Secretariat in ensuring that the revised version of the draft twelfth general programme of work captured the strong feelings expressed about determinants of health, gender equality, human rights and equity.

Dr DAYRIT (Secretary), in response to a request by the CHAIRMAN, read out paragraph 1 of the draft decision, with the amendments proposed by the delegates of Brazil and Switzerland: "(a) to welcome the Chairman's report on the meeting of Member States on programmes and priority setting and the criteria, categories and timeline set out in its three appendices;¹ (b) to request the Director-General to use the agreed framework² and guidance provided by the Sixty-fifth World Health Assembly, especially concerning health determinants and equity, in the formulation of the draft twelfth general programme of work and the proposed programme budget 2014–2015".

Dr LARSEN (Norway) recalled that his delegation had proposed during the previous meeting to replace the word "framework" in subparagraph 1(b) with "criteria and categories". As he had heard no support for that proposal, his delegation would withdraw it.

Mr TOBAR (Argentina), referring to paragraph 3 of the draft decision, expressed his delegation's preference for the option set out in subparagraph 3(d). He also proposed that the word "draft" should be inserted before "paper" in subparagraph 8(a).

The CHAIRMAN said that the Committee would continue its discussion of the draft decision at its next meeting.

The meeting rose at 17:00.

¹ See document A65/40.

² See document A65/5 Add.2.

SEVENTH MEETING

Thursday, 24 May 2012, at 18:55

Chairman: Dr L.Z. DUKPA (Bhutan)

later: Mr H. BARNARD (Netherlands)

1. WHO REFORM: Item 12 of the Agenda (Documents A65/5, A65/Add.1, A65/5/Add.2, A65/Add.3, A65/40, A65/43 and A65/INF.DOC./6) (continued)

The CHAIRMAN invited the Committee to take up the sections on governance reforms and managerial reforms in the draft decision contained in document A65/5 Add.3.

The DIRECTOR-GENERAL reported that, as requested by the Programme, Budget and Administration Committee, the Secretariat had further explored the various implications of the four governance reform options set out in paragraph 3 of the draft decision, by seeking the views of the Regional Directors and consulting with those responsible for organizing United Nations meetings in Geneva. The option put forward in subparagraph 3(d) of the draft decision would have high cost implications; a minimum additional sum of US\$ 1 million per session would be required. Moreover, moving the Health Assembly to the last quarter of the year would be unlikely to generate goodwill among other United Nations agencies, as it would be necessary to reschedule the meetings of a long list of other bodies that traditionally convened in the Palais des Nations during that period. The Pan American Health Organization would also be faced with a difficult challenge in that its budget was decided at the September sessions of its Directing Council. In the light of those factors, it appeared unwise to pursue option (d).

As to the options outlined in subparagraphs 3(b) and 3(c) of the draft decision, they would provide longer intervals for reflection between meetings, however it would be difficult, for example, for the Regional Office for the Eastern Mediterranean to prepare the report of its Regional Committee, which met in October, and for the final report to be prepared in the six official languages in time for submission to the Programme, Budget and Administration Committee and the Executive Board in January or February. Her recommendation was therefore to maintain the status quo offered by the option set out in subparagraph 3(a), while allowing the Secretariat to explore the feasibility of increasing the interval between meetings of the Programme, Budget and Administration Committee and sessions of the Executive Board, so that the Committee would have more time to complete its enhanced agenda and its work could feed meaningfully into that of the Executive Board.

Dr SUWIT WIBULPOLPRASERT (Thailand), Dr SILBERSCHMIDT (Switzerland) and Ms MATSOSO (South Africa) expressed support for that recommendation.

The DIRECTOR-GENERAL, responding to a question from Dr SILBERSCHMIDT (Switzerland) concerning the possibility of starting the budget year on 1 October, said that timely completion of operational planning following approval of the budget would be very difficult if the budget cycle were to be changed. Aligning a change in the budget year with WHO's Global Management System would also cause major disruption, and was therefore inadvisable.

Mr BLAIS (Canada) said that, irrespective of the option selected, decisions relating to financial matters had to be made on the basis of accurate, reliable, realistic and timely information. Information on what measures the Secretariat envisaged in order to ensure that that occurred would be welcome, as

would a discussion concerning the possibility of adjusting the dates of the fiscal year. Predictability would be improved if the planning and decision-making cycle was shorter and if the budget was approved closer to the end of the fiscal year. In the interests of cost-saving, the meeting of the Programme, Budget and Administration Committee and the session of the Executive Board should continue to be held during the same month, preferably February, as suggested in subparagraph 3(b) of the draft decision. The advantage of additional time for reflection gained by increasing the interval between the two events would most likely be neutralized by loss of the momentum created by holding them in close succession.

The DIRECTOR-GENERAL said that the February option would allow more time for preparation and submission of the report of the meeting of the Regional Committee for the Eastern Mediterranean. On the other hand, it would cut short the financing dialogue. Additional information on that score could be provided in January 2013 after the issue of the financing dialogue had been discussed further. She felt confident about the feasibility of holding the two events in late January or early February and continuing to hold the Health Assembly during the third week of May. As to altering the dates of the budget year, she understood from Regional Directors that doing so would create problems with regard to the implementation of country cooperation strategies and operational plans.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, said that the benefit of the option set out in subparagraph 3(d) of the draft decision was that it would enhance alignment of the meeting cycle with the budget year and enable Member States to have a more informed discussion of programmes and budgets at the Health Assembly. Given the arguments that had been presented for that option, she believed that it should remain on the table until more light had been shed on the financing mechanism.

Mr STUPPEL (United Kingdom of Great Britain and Northern Ireland) said that his delegation had been particularly keen to explore option (d). Additional discussion of that option was needed; the matter could be considered further at the January 2013 session of the Executive Board.

Ms BLACKWOOD (United States of America) proposed that subparagraph 3(a) of the draft decision should be amended to read: "to maintain the present schedule of the governing bodies meetings and return to the issue in January 2013".

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that, in the interests of a satisfactory outcome to WHO reform, it was important to adopt a step-by-step approach and avoid hasty decisions. He therefore concurred with the recommendation of the Director-General to maintain the status quo while considering the possibility of altering the date of the meeting of the Programme, Budget and Administration Committee.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) observed that no decision was needed in order to maintain the status quo and suggested that the Director-General should be requested to continue exploring each of the four options presented with a view to their further discussion by the Executive Board at its next session or by the Health Assembly.

Ms PATTERSON (Australia), endorsing the Director-General's recommendation to maintain the status quo, said that it was clear that views differed and Member States wished to discuss the matter further. She therefore supported the amendment proposed by the delegate of the United States of America.

Dr DAYRIT (Secretary), at the request of the CHAIRMAN, read out subparagraph 3(a) with the proposed amendment: “to maintain the present schedule of the governing bodies meetings and return to the topic in January 2013”.

The CHAIRMAN took it that, in the absence of any objection, the Committee wished to approve the proposed amendment to subparagraph 3(a) of the draft decision.

It was so agreed.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) pointed out that in paragraphs (4), (5) and (7) Member States were asked to endorse sets of proposals. Major parts of some proposals were acceptable, however other parts might not be for some delegations. He suggested that details of the proposals should be added in the form of bullet points in order to clarify what, exactly, Member States were being asked to endorse.

Dr SUWIT WIBULPOLPRASERT (Thailand), noting that the proposals referred to in paragraph (7) were set out in paragraph 43 of document A65/5, said that he could fully support the proposal in subparagraph 43(a) if “the Officers of the Board” meant the Chairman and five Vice-Chairmen. In addition, if subparagraphs 43(a) and 43(b) were approved, he would propose deleting subparagraph 43(c) because under subparagraphs 43(a) and 43(b) the agenda and draft resolutions submitted to the Executive Board would be more substantive and fewer in number, which would obviate the need to limit reporting requirements.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, endorsed the request made by the delegate of the Islamic Republic of Iran for clarification of paragraphs (4), (5) and (7). She proposed that subparagraph (8)(a) should be amended to begin with the words “to present a draft policy paper”.

Dr SILBERSCHMIDT (Switzerland) recalled that during the Committee’s fifth meeting his delegation had proposed the addition of a new paragraph (7)bis, which would leave open the option of adapting the rules of procedure of the governing bodies in order to streamline resolutions and the number of agenda items, and would call for the proposal of options on how to streamline the reporting of Member States and communication with them.

Mr DESIRAJU (India), expressing support for the request for clarification of paragraphs (4), (5) and (7), said that unhurried further reflection on the various proposals was required. Paragraph (8) also contained important proposals that required clarification: delegates needed to know more about how the Secretariat intended to go about forging relationships or partnerships with nongovernmental organizations and private commercial entities.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) asked whether, as he had suggested, bullet points containing details of the proposals referred to in paragraphs (4), (5) and (7) would be inserted in the draft decision.

Dr DAYRIT (Secretary), summarizing, at the request of the CHAIRMAN, the discussion of paragraphs (4), (5) and (7), said that the delegates of India and the Islamic Republic of Iran had sought clarification on what was being endorsed in those paragraphs, and the latter had suggested that the Secretariat should insert bullet points for purposes of clarification. The delegate of Switzerland had proposed the addition of a new paragraph (7)bis, to read: “to request the Director General, in consultation with Member States, to: (a) propose options on possible changes needed in the rules of procedure of the governing bodies to limit the number of agenda items and resolutions; (b) propose options on how to streamline the reporting of and communication with Member States.” In addition,

the delegate of Thailand had proposed the deletion of subparagraph 43(c) of document A65/5, referred to in subparagraph (8)(c) of the draft decision.

Dr SUWIT WIBULPOLPRASERT (Thailand) clarified that his proposal had concerned paragraph (7) rather than paragraph (8)(c).

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), endorsing the view of the delegate of India, said that there was no need to rush the endorsement of proposals that might not be clear. His specific concerns were that paragraph 33 of document A65/5 was too vague; he was not comfortable with paragraph 43(d), which he believed had no legal basis; and paragraph 41 required further reflection, particularly with respect to how emerging issues would be addressed.

Mr DESIRAJU (India), pointing out that his earlier comment in respect of paragraph 8 had not been reflected in the Secretary's summary, said that more details should be given of the procedure to be followed in order to finalize the reports called for in that paragraph.

Ms KRARUP (Denmark) noted that her proposed amendment to paragraph (8)(a) had also been omitted from the Secretary's summary.

The CHAIRMAN said that the reform process was proceeding unhurriedly, having been under way for two years. He appealed to the delegates of India, the Islamic Republic of Iran and Thailand to make concrete proposals for amendment of the draft decision.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that paragraphs (4), (5) and (7) in their current wording could not be fully understood without reference to document A65/6. His delegation had serious concerns with regard to the proposal contained in subparagraph 43(d) of that document, concerning substitution of resolutions and decisions by the Chairman's summaries, which were the prerogative of Member States.

Dr SILBERSCHMIDT (Switzerland) suggested that the Secretariat should be asked to insert the bullet points requested and distribute a revised version of the draft decision for discussion at the next meeting. That would enable readers to understand the draft decision without referring to the report.

Mr DESIRAJU (India) suggested that, in subparagraph 8(c), the four principles by which the Director-General was to be guided in developing the documents described in subparagraphs 8(a), (b) and (c) might be supplemented by a further principle reading: "the need for due consultation with all relevant parties, keeping in mind the principles and guidelines laid down for WHO's interactions with Member States and other parties".

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, endorsed the suggestion of the delegate of Switzerland. With regard to subparagraph (3)(a), she proposed inserting after the amendment proposed by the delegate of the United States of America the words: "and in preparation to present a feasibility study on the possibility of shifting the financing year".

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) proposed that subparagraph 43(d) of document A65/5 should be redrafted to read: "to make better use of the Chairmen's summaries reported in the official records, with the understanding that they do not replace formal resolutions".

The CHAIRMAN invited the Committee to comment on the section of the draft decision concerned with managerial reforms.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States and commenting on subparagraph (15)(b), pointed out that there were a number of outstanding issues relating to the report on the first stage of the independent evaluation contained in document A65/5 Add.2, which had been issued rather late, leaving little time for discussion. One of those issues was the time frame; in addition, it was unclear who would perform the second-stage evaluation. She suggested that a paper providing specific details, including on funding for the second-stage evaluation, should be submitted to the Executive Board in January 2013 and that the draft decision should be amended accordingly. She further proposed amending paragraph (18) to read: “to request the Director-General to report, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly on the basis of a monitoring and implementation framework on progress in the implementation of WHO reform”.

The CHAIRMAN said that the Committee would resume its discussion of the draft decision the following day on the basis of a revised text that would incorporate all proposed amendments to the three sections of the draft decision.

(For continuation of the discussion and approval of the draft decision, see the summary record of the eighth meeting, section 3.)

Mr Barnard took the Chair.

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

Prevention and control of noncommunicable diseases: Item 13.1 of the Agenda (Documents A65/6, A65/6 Add.1, A65/7, A65/8, A65/9, EB130/2012/REC/1 and resolutions EB130.R6 and EB130.R7) (continued)

- **Outcomes of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases and the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control** (continued from the second meeting)

The CHAIRMAN drew attention to a revised version of the draft decision on follow-up to the High-level meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable Diseases, which had been prepared by a drafting group to reflect amendments proposed by various delegations and which read:

The Sixty-fifth World Health Assembly,

PP1 Recalling the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases (A/RES/66/2), in particular paragraph 62, to prepare recommendations, before the end of 2012, for a set of voluntary global targets for the prevention and control of noncommunicable diseases and the commitments made to address noncommunicable diseases, principally cardiovascular diseases, cancers, chronic respiratory diseases, diabetes, and the underlying common risk factors, namely tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol;

PP2 Reaffirming the leading role of WHO as the primary specialized agency for health, as recognized by the United Nations General Assembly in the Political Declaration of the High-level meeting of the General Assembly on the Prevention and Control of Non-communicable

Diseases and its responsibility with the full participation of Member States¹ pursuant to paragraphs 61 and 62 of the Political Declaration toward development of a comprehensive global monitoring framework, including a set of indicators, capable of application across regional and country settings, and a set of voluntary global targets for the prevention and control of noncommunicable diseases, before end 2012;

PP3 Recalling the commitment made in WHA60.23 to achieve the target of reducing death rates from noncommunicable diseases by 2% annually during the period 2006–2015,

1. DECIDED to welcome the report A65/6 on prevention and control of noncommunicable diseases and its addendum 1 and recognized the significant progress made in close collaboration with Member States pursuant to paragraphs 61 and 62 of the Political Declaration;
2. DECIDED to adopt a global target of a 25% reduction in premature mortality from NCDs by 2025;
3. EXPRESSED strong support for additional work aimed at reaching consensus on targets relating to the four main risk factors, namely tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity;
4. DECIDED to note wide support expressed by Member States¹ and other stakeholders around global voluntary targets considered so far including those relating to raised blood pressure, tobacco, salt/sodium and physical inactivity;
5. FURTHER noted that consultations to date, including discussions during the Sixty-fifth World Health Assembly, indicated support from among Member States¹ and other stakeholders for the development of targets relating to obesity, fat intake, alcohol, cholesterol and health system responses such as availability of essential medicines for noncommunicable diseases;
6. NOTED that other targets or indicators may emerge in the remainder of the process established by resolution EB130.R7;
7. URGED all Member States¹ to participate fully in all remaining steps of the noncommunicable diseases follow-up process described in resolution EB130.R7 including regional and global level consultations;
8. REQUESTED the Director-General to:
 - (i) undertake further technical work on targets and indicators and prepare a revised discussion paper on the comprehensive global monitoring framework which reflects all discussions and submissions to date and which takes into account measurability, feasibility, achievability and the existing WHO strategies in this area; and
 - (ii) consult with Member States¹ including through Regional Committees, and where appropriate, regional technical/expert working groups which report to Regional Committees through the Secretariat, on this revised discussion paper;
 - (iii) continue to consult with all relevant stakeholders in a transparent manner on this revised discussion paper;
 - (iv) prepare a report summarizing the results of the discussions in each of the Regional Committees and the inputs from the above-mentioned dialogues with stakeholders;

¹ And, where applicable, regional economic integration organizations.

- (v) convene a formal Member States¹ meeting, to be held prior to the end of October 2012, to conclude the work on the comprehensive global monitoring framework, including indicators, and a set of global voluntary targets for the prevention and control of noncommunicable diseases;
- (vi) submit a substantive report on the recommendations relating to paragraphs 61 and 62 of the Political Declaration through the Executive Board at its 132nd session to the Sixty-sixth World Health Assembly.

Dr ST. JOHN (Barbados), speaking as Chair of the drafting group, said that representatives of some 30 Member States had participated in its work, including representatives speaking on behalf of the 27 Member States of the European Union. Consensus had been sought in two broad areas: defining the process until the end of 2012 and identifying the implications for the Sixty-sixth World Health Assembly and determining which indicators and targets should be included in the draft decision. The group had also considered whether any of the indicators currently proposed could be endorsed by the present Health Assembly. The consensus reached on those issues was reflected in the revised version of the draft decision.

It had been recognized that the process of setting targets for noncommunicable diseases was highly political as well as technical, and it had therefore been considered important to utilize the regional committee meetings and other regional processes, where possible or appropriate, in order to obtain Member States' views prior to a formal global meeting, to be held before the end of October 2012. Further technical work was needed on a range of indicators and targets relating to the four main noncommunicable diseases and risk factors. There had been sufficient agreement and support to recommend that the mortality target should be adopted by the current Health Assembly.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft decision.

The draft decision was approved.²

Nutrition: Item 13.3 of the Agenda (Documents A65/11, A65/11 Corr.1 and A65/12) (continued)

- **Maternal, infant and young child nutrition** (continued from the fourth meeting, section 2)
- **Nutrition of women in the preconception period, during pregnancy and the breastfeeding period:** Item 13.3 of the Agenda (continued from the fourth meeting, section 2)

The CHAIRMAN recalled that discussion of the agenda item had been suspended during the Committee's fourth meeting and invited the delegate of the Bahamas, who had been unable to deliver her statement in full, to take the floor.

Dr BRENNEN (Bahamas) said that his delegation had decided to submit the remainder of its statement electronically to the Secretariat.

Dr DLAMINI (South Africa) expressed satisfaction with the draft comprehensive implementation plan for maternal, infant and young child nutrition, contained in document A65/11, and emphasized the importance of ensuring timely finalization and adoption of the indicators. Improving the nutritional conditions of women in the preconception period remained a challenge. Unplanned pregnancies and delayed care-seeking during pregnancy increased risks for mothers with

¹ And, where applicable, regional economic integration organizations.

² Transmitted to the Health Assembly in the Committee's second report and adopted as decision WHA65(8).

poor nutrition status and for their infants. In South Africa, the problem of low birth weight was further compounded by high rates of teenage pregnancy, lifestyle factors such as alcohol and substance abuse, and HIV infection. Her Government had prioritized the reduction of infant and young child mortality. Nutrition interventions, such as the promotion of exclusive breastfeeding and micronutrient supplementation, together with efforts to ensure food security, were among the key strategies being implemented. In order to enhance country-level activities, she called on the Director-General to increase advocacy and support for countries in preparing legislation and enforcing the International Code of Marketing of Breast-milk Substitutes.

Dr ALMANEA (Bahrain) said that his Government attached great importance to maternal, infant and young child nutrition. It had not only adopted the global strategy on infant and young child feeding, but had improved services in hospitals, encouraged mothers to breastfeed infants during the first six months of life, and produced guidelines on the issue. He echoed the comments made by the representative of the United Arab Emirates on behalf of the Member States of the Eastern Mediterranean regarding the need for information on the scientific basis for the proposed indicators.

Dr SLAMET RIYADI YUWONO (Indonesia) underlined the importance of nutrition for women in the preconception period, during pregnancy and in the breastfeeding period, given its links with noncommunicable diseases later in life. His Government had a comprehensive national policy and a national action plan on food and nutrition, which was updated every five years. Current efforts were focused on reducing the prevalence of malnutrition, in line with the Millennium Development Goals. Since 2008, legislative measures had been taken to ensure that women were able to breastfeed their babies in the workplace, and in 2012 regulations had been introduced to protect and promote exclusive breastfeeding for the first six months of life, encourage mothers to continue complementary feeding for the first two years and ban the marketing of formula milk and other baby food products.

His Government had committed to the “Scaling Up Nutrition” movement. It welcomed the draft comprehensive implementation plan, which provided a framework for solving long-term nutritional problems. He supported the draft resolution put forward by Swaziland and Uganda, but proposed, in view of differences in national circumstances, that subparagraph 2(h) be amended to read: “to encourage countries to set up a national mechanism to deal with conflicts of interest”.

Dr MOTEETEE (Lesotho) said that, in common with other African countries, Lesotho continued to see high levels of malnutrition and low rates of exclusive breastfeeding, a situation exacerbated by the high prevalence of HIV infection. An alarmingly large number of children under five years of age were stunted and, although recent data for obesity rates were not available, the 2001 figures of 43% in urban areas and 33.5% in rural areas were not thought to have decreased significantly. Her Government had adopted guidelines on infant and young child feeding and had trained primary health care workers in the integrated management of acute malnutrition.

Success in improving nutrition would have a positive impact on noncommunicable disease rates, and Lesotho therefore welcomed the draft comprehensive implementation plan set out in document A65/11. She urged WHO to develop both a monitoring and evaluation framework and tools to allow countries to better assess their progress in implementing the plan. Expressing support for the draft resolution proposed by Swaziland and Uganda, she said that, given differences between legal systems on matters such as conflict of interest, WHO should facilitate coordination within regions to ensure the harmonization of legislation.

Dr HEMMATI (Islamic Republic of Iran) said that nutrition for high-risk groups posed numerous challenges worldwide, including those set out in paragraph 17 of document A65/11, and larger-scale action to tackle them was needed. Given the importance of food and nutrition for human health, the Organization’s focus on high-risk groups was welcome. To make further progress, comprehensive programmes should be undertaken, involving all Member States and international stakeholders. Governments should work to improve the nutritional status of communities, taking into

account equity, comprehensiveness, the need to target high-risk groups, effectiveness and acceptability. Reducing micronutrient deficiencies, improving communication and information on healthy diets, and controlling the fast food market could significantly improve nutrition in society.

Mr DEANE (Barbados) welcomed the Organization's work on nutrition of women during the preconception period, pregnancy and the breastfeeding period, which was an important initiative to secure the future development of human capital. Nutrition across the life cycle was firmly embedded in his country's primary health care system. Given the abundance of high-energy foods in Barbados and the challenges women faced in providing appropriate nutrition for themselves and their families, the Government had scaled up nutrition programmes and was promoting the use of dietary guidelines and working to encourage healthy diets among children in schools. Barbados supported both exclusive breastfeeding and the implementation of the International Code of Marketing of Breast-milk Substitutes.

Dr SUNDARANEEDI (Trinidad and Tobago) expressed support for the draft comprehensive implementation plan, which would provide countries with a multisectoral nutrition framework for strengthening maternal and child health service delivery, policies and programme planning. His Government was currently reviewing its draft food and nutrition policy to ensure that it addressed all nutritional challenges throughout the life-cycle. Trinidad and Tobago was a signatory to the International Code of Marketing of Breast-milk Substitutes and had a strong policy and advocacy programme to ensure safe and adequate nutrition through breastfeeding. Good compliance with that policy had been achieved without the need to introduce legislation. Initiatives had been taken to greatly limit the use of infant formula in public hospitals, and the Government had encouraged manufacturers to include a statement on their products indicating that infant formula was not a substitute for breast milk.

The role of civil society had been vitally important to those efforts, and he therefore encouraged countries that might have difficulty in implementing legislation to work with nongovernmental organizations to further the cause. His Government remained committed to achieving Millennium Development Goals 4 and 5 and had adopted a "continuum of care" approach to maternal, neonatal and child health. The optimal strategy for improving the nutritional status of women and children lay in combining specific interventions with a multisectoral approach.

Dr SEAKGOSING (Botswana), commending WHO's placement of nutrition high on its agenda, said that high rates of undernutrition in his country could be attributed, among other things, to poor infant feeding practices. Rates of exclusive breastfeeding remained low. His Government was taking measures to improve feeding practices, such as acceleration of training for health workers on infant and young child feeding, individualized counselling for all mothers and provision of maternity leave and infant-feeding breaks for mothers who worked outside the home. A family health survey had shown that a significant proportion of women of reproductive age were either underweight or obese, thus creating a double burden of malnutrition. Strategies introduced to improve the nutritional status of women of reproductive age included the provision of food baskets, and vitamin and mineral supplements to pregnant women.

Dr Shu-Ti CHIOU (Chinese Taipei) said that the global breastfeeding target would be difficult for Chinese Taipei to meet as a large proportion of women of reproductive age were working women; however, the Act on Gender Equality in Employment required employers to allow women time off for breastfeeding or breast-milk collection, and a law on breastfeeding in public places ensured women's freedom to breastfeed and the availability of breastfeeding and breast-milk collection rooms in public places. Exclusive breastfeeding rates remained low, but had doubled over the previous seven years. They had been found to be higher among women who had given birth in baby-friendly hospitals versus regular health facilities. Chinese Taipei therefore strongly supported the Baby-Friendly Hospital Initiative.

Ms DELTETTO (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that more needed to be done to strengthen the resilience of vulnerable populations and address the underlying causes of that vulnerability, including undernutrition. Undernutrition in pregnant women was responsible for poor fetal growth and reduced biological resilience. As a crucial component of the maternal, newborn and child continuum of care, maternal nutrition must therefore be fully integrated into national and subnational health policies.

Ms SMITH (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that breastfeeding was the key to optimal nutrition and to success in all aspects of the draft comprehensive implementation plan. She urged WHO to ensure that breastfeeding remained a priority issue for the Organization and to recognize the importance of breastfeeding not only for nutrition but for mother-infant bonding and the health of the community. While welcoming the global targets set forth in the draft comprehensive implementation plan, she suggested that their order should be changed so that global target 5, concerning exclusive breastfeeding, became global target 1. The achievement of the other five targets depended to a great extent on whether breastfeeding was continued up to the age of six months. She urged stronger action to ensure compliance with the International Code of Marketing of Breast-milk Substitutes and called for the Baby-Friendly Hospital Initiative to be strengthened worldwide.

Mrs EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, noted that the target date for achievement of the Millennium Development Goals was only three years away, and although the global poverty target was on track, undernutrition remained a significant problem and rapid progress was needed in scaling up nutrition initiatives in Member States. She welcomed the draft comprehensive implementation plan, which built on the positive momentum created by the “Scaling Up Nutrition” movement and presented constructive and specific guidance for Member States. Increasing guidance on multisectoral activity and the development of related indicators was crucial. Her organization supported the proposed global targets for nutrition and urged governments to develop corresponding country-level targets and to incorporate indicators for nutrition into health information systems in order to track progress. A consultative process should be developed to establish national targets, paying particular attention to the unique contexts of fragile States. The draft comprehensive implementation plan should also contain language referring to the fulfilment of the right to food and the right to health as key international covenants that should be central to global and national efforts to improve maternal and child health and nutrition.

Dr GUPTA (Consumers International), speaking at the invitation of the CHAIRMAN, said that the resources available for protection, promotion and support of breastfeeding were not commensurate with the importance of the issue. The draft comprehensive implementation plan appeared to place too much emphasis on micronutrient deficiencies and not enough on the underlying causes of childhood malnutrition. The plan should include indicators for periodic evaluation of policies and programmes and the identification of gaps and provide for the development of action plans to bridge them. The Secretariat should support Member States in combating inappropriate promotion of foods for infants and young children, as mandated in resolution WHA63.23. The plan should also call for independent monitoring and reporting of violations of the International Code of Marketing of Breast-milk Substitutes, and the proposal regarding mechanisms to safeguard against potential conflicts of interest should also cover WHO and international partners, in addition to Member States.

Dr COSTEA (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, welcomed WHO’s focus on nutritional outcomes, the role of maternal nutrition and the need for multisectoral involvement, as well as the emphasis on the need for evidence-based and country-specific interventions. Her organization supported exclusive breastfeeding in the first six months of life and continued breastfeeding with appropriate complementary feeding thereafter. It also supported the emphasis placed in the draft comprehensive implementation plan on social determinants

of health and nutritional counselling for women, including advice on the safe and timely introduction of nutritionally adequate complementary foods. Her organization continued to invest in research and innovation, quality and safety, and worked with public health partnerships to advance nutrition science and standards.

Ms SCHLEIFF (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, welcomed the draft comprehensive implementation plan, but expressed concern that it failed to provide for the building of a framework to regulate transnational agribusiness and food corporations at the global and country levels. New provisions providing transnational corporations with defences against regulation continued to be inserted into preferential trade agreements, and she urged WHO to work with Member States to develop coherent policies to address the relationship between trade and health, in accordance with the provisions of resolution WHA59.26. It was important to consider nutrition within the context of food security and insecurity. The stalemate in the Doha Round at WTO had left in place policies that were detrimental to small farmers in many countries, and she urged WHO to take a proactive stance on trade issues and the regulation of transnational industry, in collaboration with other competent intergovernmental bodies.

Mr BAKER (Helen Keller International), speaking at the invitation of the CHAIRMAN, welcomed the draft resolution and underscored his organization's support for exclusive breastfeeding during the first six months of life. He urged all countries to implement the International Code of Marketing of Breast-milk Substitutes. Recognizing the importance of appropriate complementary feeding practices starting at six months of age, Helen Keller International was concerned that resolution WHA63.23 would significantly limit efforts to produce and appropriately market high-quality, fortified complementary foods. Such foods, including lipid-based nutrient supplements, should form part of a holistic approach to filling gaps in nutrition in children aged six months to two years. The complete prohibition of any nutrition- and health-related claims for such complementary foods would constrain campaigns aimed at informing and educating mothers and other caregivers on nutritious food choices and optimal feeding plans. His organization welcomed the draft comprehensive implementation plan and urged the Secretariat to develop evidence-based guidelines on the appropriate marketing of complementary foods. It also sought clarity on the internal conflict between subparagraphs 1(4) and 1(6) of resolution WHA63.23.

Ms HOLLY (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that progress in combating malnutrition, which could cause the loss of up to 3% of a country's gross domestic product, had been slow. She called on Member States to endorse the draft comprehensive implementation plan, including its proposed targets, which reflected the scale of the required response and would help to sustain political momentum regarding nutrition. Her organization had presented research in May 2012 that indicated that a 40% reduction in the number of stunted children by 2025 in the 36 high-burden countries was possible if key economic and policy issues were addressed, including development of policies aimed at raising the incomes of the poorest households. Targets should be disaggregated to ensure that progress could be measured. National governments should be consulted and supported to ensure that global targets were adapted and implemented at the national level. Partners in the "Scaling Up Nutrition" movement should work closely with Member States, the Secretariat and other stakeholders in increasing efforts to improve child nutrition. A strong monitoring system, including regular data collection, would be crucial for assessing progress. She welcomed the decision by the Government of the United Kingdom of Great Britain and Northern Ireland to host a high-level event on hunger and malnutrition during the 2012 Olympic Games.

Dr CHESTNOV (Assistant Director-General) welcomed the valuable comments made during the meeting as well as those transmitted in writing by Member States and nongovernmental organizations in recent months on the subject of nutrition.

Dr BRANCA (Department of Nutrition for Health and Development) said that the proposed global targets included in the draft comprehensive implementation plan had been developed in response to requests by Member States to identify priority areas for action. The global targets were not intended to replace national targets, but to serve as guidance to be used by governments in developing national targets that reflected national situations. National targets might be more ambitious than the global targets. Hence, countries that had already achieved a 50% rate of exclusive breastfeeding up to the age of six months should consider setting a higher target such as 75%. With regard to the need to scale up nutrition work at country level, the Secretariat had noted the call to develop a national consultative process for national target-setting. The assessment of breastfeeding up to two years and beyond, together with adequate complementary feeding, was included in the proposed monitoring framework.

Agreement by the Health Assembly on the global nutrition targets proposed in the draft plan would also serve as an input to discussions already under way on the post-2015 United Nations development agenda, to be discussed at the forthcoming United Nations Conference on Sustainable Development (Rio+20). Agreement on those targets would also help countries to scale up action to combat malnutrition and to realize the target under Millennium Development Goal 1 of reducing by half the proportion of people suffering from hunger and poverty.

The Secretariat used the best available research to inform decision-making and conducted systematic reviews of the relevant literature. That input had been taken into account in the development of the draft plan, as had best practices observed in countries. The Secretariat had taken note of the request to implement operational research, which would complement recommendations in the draft plan to develop a prioritized research agenda.

If the draft plan was approved, the Secretariat would ensure that it was modified as requested by the representative of the European Union: Tables 1 to 3 would be removed and included in other WHO normative texts on nutrition. WHO monitoring and evaluation procedures would be developed further, as requested by Member States.

The CHAIRMAN noted that both a draft resolution and a draft decision had been proposed, and invited the delegate of Swaziland to take the floor.

Ms CHANESTA (Swaziland) said that the delegations of Swaziland, Canada and other countries had met to discuss a revised version of the draft resolution that would amalgamate the draft decision and draft resolution proposed during the Committee's fourth meeting. The new version, sponsored by Canada, Mexico, Swaziland and the United Kingdom of Great Britain and Northern Ireland, would read:

The Sixty-fifth World Health Assembly,
Having considered the report on maternal, infant and young child nutrition: draft
comprehensive implementation plan (A65/11),

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;
2. URGES Member States, to put into practice, as appropriate, the comprehensive implementation plan on maternal, infant and young child nutrition, including:
 - (a) revising nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding;
 - (b) developing or where necessary strengthening legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes;

(c) establishing a dialogue with relevant national and international parties and forming alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest;

3. REQUESTS the Director-General:

- (a) to provide clarification and guidance on the inappropriate promotion of foods for infants and young children as mentioned in resolution WHA63.23;
- (b) to support Member States to monitor and evaluate policies and programmes, including those of the global strategy for infant and young child feeding;
- (c) to develop risk assessment and management tools to safeguard against conflicts of interest in policy development and implementation of nutrition programmes.

Ms HERNANDEZ (Canada) said that the new draft resolution before the Committee was the product of intensive and constructive negotiations involving a number of Member States. She hoped that it would be fully supported.

Mr KOLKER (United States of America), expressing support for the draft resolution, said that in paragraph 3 it should be made clear that the guidance and risk assessment and management tools to which it referred were designed to support countries in implementing the comprehensive plan.

Mr ÁLVAREZ LUCAS (Mexico) said that he also supported the draft resolution.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, expressed support for the new draft resolution but requested that a footnote be added to paragraph 2 after “Urges Member States”, reading: “And, where applicable, regional economic integration organizations”.

Dr TAKEI (Japan) expressed support for the new draft resolution but suggested that the Director-General should be asked to update Member States as new evidence became available. Accordingly, he proposed adding “with the latest evidence on nutrition” at the end of subparagraph 3(b).

Ms BULLINGER (Switzerland) welcomed the new draft resolution. Referring to subparagraph 3(a), she asked what was the added value of requesting the Director-General to provide guidance on inappropriate promotion of foods for infants and young children, a task that fell within the remit of the Codex Alimentarius Commission.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland), referring to the comments made by the delegate of the United States of America, suggested inserting “country-level” before “policy development” in subparagraph 3(c).

Ms CHANESTA (Swaziland), responding to the question raised by the delegate of Switzerland, recalled that when resolution WHA63.23 had been discussed in 2010, concerns had been expressed about the lack of a precise indication of what was meant by “inappropriate promotion of food for infants and young children”; the new draft resolution sought clarification on that issue and how it should be addressed at the country level.

Dr THITIKORN TOPOTHAI (Thailand) welcomed the new draft resolution, which represented a compromise between the two draft texts presented previously. Before taking a decision on the resolution, however, he would like to see the revised text in writing.

Ms BULLINGER (Switzerland), welcoming the response from the delegate of Swaziland, noted that the Codex Alimentarius Commission was currently carrying out work on the subject and would be releasing its conclusions shortly. She remained concerned at the request made of the Director-General and the responsibility entrusted to her in subparagraph 3(a). She seconded the request of the delegate of Thailand.

The CHAIRMAN said that the draft resolution would be distributed as a conference paper for consideration at the next meeting.

(For continuation of the discussion, see the summary record of the eighth meeting, section 4.)

The meeting rose at 21:30.

EIGHTH MEETING

Friday, 25 May 2012, at 09:45

Chairman: Mr H. BARNARD (Netherlands)

1. SECOND REPORT OF COMMITTEE A (Document A65/54)

Dr MMBUJI (United Republic of Tanzania), Rapporteur, read out the draft second report of Committee A.

The report was adopted.¹

2. ORGANIZATION OF WORK

Dr NABEEL (Pakistan) requested the Committee to discuss agenda item 13.10 on poliomyelitis: intensification of the global eradication initiative, earlier than scheduled, preferably once it had concluded discussions on item 13.4.

The CHAIRMAN took it that the Committee was happy to accommodate that request.

It was so agreed.

3. WHO REFORM: Item 12 of the Agenda (Documents A65/5, A65/5 Add.1, A65/5 Add.2, A65/5 Add.3, A65/40, A65/43 and A65/INF.DOC./6) (continued from the seventh meeting, section 1)

The CHAIRMAN drew attention to the following amended draft decision on WHO reform:

The Sixty-fifth World Health Assembly,
PP1 Having considered the documents on WHO reform presented to the World Health Assembly;²

PP2 Having taken into account the deliberations held and the decisions made on WHO reform during the 129th session of the Executive Board in May 2011, the special session on reform of the Executive Board in November 2011, the 130th session of the Executive Board in January 2012, and the meeting of Member States on programmes and priority setting in February 2012,

¹ See page 275.

² Documents A65/5, A65/5 Add.1, A65/5 Add.2, A65/5 Add.3, A65/40, A65/43 and A65/INF.DOC./6.

DECIDED:

Programmatic reforms

- (1) (a) to ~~endorse~~ **welcome [Brazil: agreed]** the Chairman's report on the meeting of Member States on programmes and priority setting and the criteria, categories and timeline set out in its three appendices;¹
- (b) to request the Director-General to use the agreed framework² and guidance provided by the Sixty-fifth World Health Assembly **especially concerning health determinants and equity [Switzerland: agreed]** in the formulation of the draft Twelfth General Programme of Work and the Proposed programme budget 2014–2015;

Governance reforms

- (2) to endorse the decision of the Executive Board at its special session in November 2011³ to strengthen, streamline and improve the methods of work and roles of the governing bodies;
- (3) (a) ~~{to maintain the present schedule of the governing bodies meetings}~~ **and return to the topic in January 2013 [USA: agreed] and in preparation to present a feasibility study on the possibility of shifting the financing year; [Denmark on behalf of the EU: agreed]**
 OR
 (b) ~~[to move the meeting of the Programme, Budget and Administration Committee of the Executive Board and the session of the Executive Board to early February];~~
 OR
 (c) ~~[to increase the interval between meetings of the Programme, Budget and Administration Committee and sessions of the Executive Board];~~
 OR
 (d) ~~[to revise the annual cycle to start with Regional Committees in January and end with the Health Assembly in the last quarter of the year];~~
- (4) to endorse the **following** proposals for enhancing alignment between the Regional Committees and the Executive Board;
- **that Regional Committees be asked to comment and provide input to all global strategies, policies and legal instruments such as conventions, regulations and codes;**
 - **that the Health Assembly refer specific items to the Regional Committees to benefit from diverse regional perspectives;**
 - **that chairpersons of the Regional Committees routinely submit a summary report of the Committees' deliberations to the Board;**
 - **that Regional Committees consider proposing through their summary reports agenda items to the Board as well as draft resolutions on items on the Board's agenda;**
- (5) to endorse the **following** proposals for increasing harmonization across the Regional Committees in relation to the nomination of Regional Directors, the review of credentials, and participation of observers;

¹ See document A65/40.

² See document A65/5 Add.1.

³ Decision EBSS2(2).

Nomination of Regional Directors

- that **Regional Committees that have not yet done so, in line with principles of fairness, accountability and transparency, establish;**
 - (1) **criteria for the selection of candidates; and**
 - (2) **a process for assessment of all candidates' qualifications;**

Review of credentials of Member States

- that **Regional Committees that have not yet done so appoint credentials committees or entrust the task of reviewing credentials to the officers of the Committee;**

Participation of observers

- that **Regional Committees that have not yet done so ensure that there is an explicit procedure that enables them to invite observers to attend their sessions, including as appropriate, Member States from other regions, intergovernmental and nongovernmental organizations;**
- (6) to note that the revised terms of reference for the Programme, Budget and Administration Committee will be presented to the Executive Board at its 131st session;
 - (7) to endorse the **following** proposals for streamlining decision-making and to improve governing body meetings **according to paragraph 43 of document A65/5, except (c)[Thailand];**
 - (a) **that the Officers of the Board use criteria, including those used for priority setting in the GPW, in reviewing items for inclusion on the Board's agenda;**
 - (b) **that the Board consider amending its rules and procedures in order to manage the late submission of draft resolutions;**
 - ~~(c) that reporting requirements on all resolutions be limited to a maximum of six instances, unless otherwise decided by the Health Assembly; [Thailand: agreed]~~
 - (d) **make ~~more~~ better use of the Chairman's summaries, reported in the official record, in cases where a formal resolution is not deemed to be essential with the understanding that it does not replace formal resolutions; [Iran: agreed]**
 - (7bis) to request the Director General in consultation with Member States to:
 - (a) **propose options on possible changes needed in the rules of procedure of the governing bodies to limit the number of agenda items and resolutions;**
 - (b) **propose options on how to streamline the reporting of and communication with Member States; [Switzerland: agreed]**
 - (8) to request the Director-General:
 - (a) to present a **draft [Argentina: agreed] policy [Denmark on behalf of EU: agreed] paper on WHO's engagement with nongovernmental organizations to the Executive Board at its 132nd session in early 2013;**
 - (b) to present a draft policy paper on the relationships with private commercial entities to the Executive Board at its 133rd session in May 2013;
 - (c) to present a report on WHO's hosting arrangements of health partnerships and proposals for harmonizing work with hosted partnerships to the Executive Board at its 132nd session in early 2013;

And further, in support of the development of the documents described in subparagraphs (8)(a)(b) and (c), that the Director-General be guided by the following principles:

- (i) the intergovernmental nature of WHO's decision-making remains paramount;
- (ii) the development of norms, standards, policies and strategies, which lies at the heart of WHO's work, must continue to be based on the systematic use of evidence and protected from influence by any form of vested interest;
- (iibis) the need for due consultation with all relevant parties keeping in mind the principles and guidelines laid down for WHO's interactions with Member States and other parties; [India: agreed]**
- (iii) any new initiative must have clear benefits and add value in terms of enriching policy or increasing national capacity from a public health perspective;
- (iv) building on existing mechanisms should take precedence over creating new forums, meetings or structures, with a clear analysis provided of how any additional costs can lead to better outcomes;

Managerial reforms

- (9) to note progress made in relation to strengthening technical and policy support to all Member States;
- (10) to note progress made in relation to staffing policy and practice;
- (11) to request the Director-General, based on guidance received from the Sixty-fifth World Health Assembly, to further develop the proposals to increase the transparency, predictability and flexibility of WHO's financing for presentation to the Executive Board at its 132nd session;
- (12) to note progress on developing WHO's internal control framework;
- (13) to note progress made in the areas of accountability, risk management, conflict of interest, and the establishment of an ethics office;
- (14) to note that the draft WHO Evaluation Policy will be presented to the Executive Board at its 131st session;
- (15) (a) to note the findings and recommendations of the Stage one evaluation report presented by the External Auditor;¹
- (15) (b) ~~to proceed with the second stage of the independent evaluation in line with the terms of reference as outlined in the report of the External Auditor~~ **to note the proposed terms of reference of the second stage of the independent evaluation as outlined in the report of the external auditor and to request the Director-General to provide a paper on the specific modalities of this evaluation for consideration of the 132th EB; [Denmark on behalf of the EU: agreed]**
- (16) to note progress made in the area of strategic communications;²
- (17) to endorse the decisions and conclusions reached by the Board at its special session on reform with regard to organizational effectiveness, alignment and efficiency; financing of the Organization; human resources policies and management; results-based planning, management and accountability, and strategic communications;

¹ Document A65/5 Add.2.

² Decision EBSS2(3).

(18) to request the Director-General to report **through the 132nd Executive Board to the Sixty-sixth World Health Assembly on the basis of a monitoring and implementation each year, through the Executive Board, to the Health Assembly [Denmark on behalf of EU: agreed]** framework on progress in the implementation of WHO reform.

The CHAIRMAN recalled that the Committee had agreed most of the text of the draft resolution at its seventh meeting and encouraged delegations to limit their comments to paragraphs 4, 5 and 7(a) and (b).

Mr DESIRAJU (India) proposed adding the words “at the 132nd session of the Executive Board” before the words “January 2013” in subparagraph 3(a).

Dr SILBERSCHMIDT (Switzerland) said that the French version of the first bullet point in paragraph 4 should include a reference to “global strategies” as the English text did. He proposed to add a new bullet point in paragraph 4, after the first two bullet points, one that would draw on paragraph 25 of the report contained in document A65/5 and would read: “That regional committees adapt and implement strategies for which they have provided input instead of developing additional region-specific strategies.”

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) said that the reference to “an explicit procedure” for the participation of nongovernmental organizations in paragraph 5 was too vague and should be replaced with the words “relevant rules within their rules of procedures”. He did not think it necessary to refer to paragraph 43 of document A65/5 in paragraph 7, and proposed that the introductory part of that paragraph should terminate with a colon after the words “governing body meetings”. The words “it does” should be replaced by the words “they do” in the last line of subparagraph 7(d).

Dr DAULAIRE (United States of America) said that he considered that the proposal contained in the last bullet point in paragraph 4 was premature and suggested that it should be removed.

At the invitation of the CHAIRMAN, Dr DAYRIT (Secretary) read out the amendment proposed by the delegate of Switzerland: “That regional committees adopt and implement global strategies for which they have provided input instead of developing additional region-specific strategies.”

Mrs ESCOREL DE MORÃES (Brazil) said that she objected to that wording. It was important that global strategies could be adapted to regional specificities and circumstances as required.

Dr ST. JOHN (Barbados) said that she, too, would have difficulty accepting language that prevented the adaptation of global strategies.

Dr SILBERSCHMIDT (Switzerland) said that the language he had proposed was not his own, but was drawn directly from paragraph 25 of the report: the purpose of his proposal was to encourage regional committees to adapt the existing global strategy rather than to write their own, since that might result in competing strategies.

Dr DAULAIRE (United States of America) sought clarification as to whether the proposal by the delegate of Switzerland used the word “adopt” or “adapt”.

Mr FILLON (Monaco) said that he supported the proposal by the delegate of Switzerland, which was in line with the report and avoided the possibility of having competing strategies.

Mrs ESCOREL DE MORÃES (Brazil) asked to hear the wording of the proposal again. She wished to be certain that the wording would allow regional committees the flexibility and freedom to adapt strategies to the specificities of regions and subregions.

Dr RODRÍGUEZ (El Salvador) said that a number of comments made by her delegation during the fifth meeting, and proposals submitted in writing on multilateralism, primary health care, the need to strengthen WHO's policies and activities and the need for various cooperation strategies, especially cooperation among countries, had not been incorporated into the text. She asked whether changes were still to be made to the document or whether it was considered to be final.

The DIRECTOR-GENERAL assured the delegate of El Salvador that the comments made by her delegation would be included in the next draft of the twelfth general programme of work.

Dr SILBERSCHMIDT (Switzerland) said he concurred with the delegate of Brazil on the need to allow for the possibility of adaptations and clarified that his proposal contained the word "adapt", not "adopt".

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) expressed concern that the phrase "for which they have provided input" might give rise to a disincentive to provide input, since regional committees that failed to do so might claim the freedom to develop their own strategies.

Ms KRARUP (Denmark), speaking on behalf of the Member States of the European Union, expressed support for the proposal by the delegate of Switzerland, which was also linked to paragraph 24 of the report. Encouraging regional committees to adapt existing strategies was a good way of avoiding duplication and overlap, which was a goal of the reform process, and would also strengthen alignment between the three levels of the Organization.

The CHAIRMAN suggested that the proposal by the delegate of Switzerland might be shortened to read: "That regional committees adapt and implement global strategies."

Dr ST. JOHN (Barbados) welcomed the proposal from the Chairman.

Mr KÜMMEL (Germany) said that he strongly supported the proposal but wished to add the words "as appropriate".

Dr DAYRIT (Secretary) said that the proposal would be to add a new bullet point to paragraph 4, positioned after the first two bullet points, which would read, "That regional committees adapt and implement global strategies, as appropriate."

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to adopt the draft decision, as amended.

The draft decision, as amended, was approved.¹

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as decision A65(9).

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

Nutrition: Item 13.3 of the Agenda (Documents A65/11, A65/11 Corr.1 and A65/12) (continued)

• **Maternal, infant and young child nutrition** (continued from the seventh meeting, section 2)

The CHAIRMAN drew attention to a revised version of the draft resolution proposed by Canada, Mexico, Swaziland and the United Kingdom of Great Britain and Northern Ireland, which incorporated amendments proposed during the previous meeting:

The Sixty-fifth World Health Assembly,

PP1 Having considered the report on maternal, infant and young child nutrition: draft comprehensive implementation plan,¹

1. ENDORSES the comprehensive implementation plan on maternal, infant and young child nutrition;
2. URGES Member States,² to put into practice, as appropriate, the comprehensive implementation plan on maternal, infant and young child nutrition, including:
 - (1) revising nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding [paragraph 31(a), (b), (c) from the comprehensive implementation plan];
 - (2) developing or where necessary strengthening legislative, regulatory and/or other effective measures to control the marketing of breast-milk substitutes [paragraph 38(d) from the comprehensive implementation plan];
 - (3) establishing a dialogue with relevant national and international parties and forming alliances and partnerships to expand nutrition actions with the establishment of adequate mechanisms to safeguard against potential conflicts of interest [paragraph 31(e) from the comprehensive implementation plan];
3. REQUESTS the Director-General:
 - (1) to provide clarification and guidance on the inappropriate promotion of foods for infants and young children as mentioned in resolution WHA63.23;
 - (2) to support Member States to monitor and evaluate policies and programmes, including those of the global strategy for infant and young child feeding with the latest evidence on nutrition;
 - (3) to develop risk assessment and management tools to safeguard against conflicts of interest in country level policy development and implementation of nutrition programmes.

Dr LARSEN (Norway) proposed that the words “country level” be removed from subparagraph 3(3), as conflicts of interest were not limited to country level.

Dr AL-TAAE (Iraq) proposed that subparagraph 3(3) be deleted in its entirety.

¹ Document A65/11.

² And, where applicable, regional economic integration organizations.

Dr BOODAI (Kuwait) proposed adding the words “strategies to tackle childhood obesity that could project into the future as noncommunicable diseases in adulthood” after the words “and young child feeding” in subparagraph 2(1).

Ms CHANESTA (Swaziland), speaking also on behalf of the other sponsors of the draft resolution, said that she could not agree to the deletion of subparagraph 3(3), but she concurred with the delegate of Norway that the words “country level” must be removed, as they entirely changed the intended meaning of the subparagraph. The version of the subparagraph proposed during the seventh meeting should remain.

Dr AL-TAAE (Iraq) said that the subparagraph seemed to belong in paragraph 2, as it referred to an action required of Member States rather than of the Director-General. However, if the words “country level” were deleted, he could agree to the subparagraph.

Ms BULLINGER (Switzerland) proposed an addition to subparagraph 3(1), which would read “taking into account the ongoing work of the Codex Alimentarius”.

Mr DESIRAJU (India) said that the deletion proposed by the delegate of Norway would result in a text that better reflected the intended meaning of subparagraph 3(3).

Dr DAULAIRE (United States of America) expressed support for the proposal by the delegate of Norway, noting that safeguards against conflicts of interest would also be covered by the broader reform process under way. He also supported the proposed inclusion of a reference to the Codex Alimentarius Commission.

Ms WISEMAN (Canada) expressed support for the amendment by the delegate of Switzerland and suggested that for clarity it might be useful to include the words “to support countries” at the beginning of subparagraph 3(3).

Dr MMBANDO (United Republic of Tanzania) said that he supported the draft resolution and the position of Swaziland on subparagraph 3(3).

Dr THAKSAPHON THAMARANGSI (Thailand) said that his country wished to cosponsor the draft resolution, to which he proposed four amendments. In subparagraph 2(1), he proposed to replace the word “revising” with “developing and strengthening”. He proposed the addition of two new subparagraphs in paragraph 2, which would read, “to develop national targets in accordance with the global targets contained in the comprehensive implementation plan, taking into account national priorities and contexts” and “Strengthening national and local capacity, including the competency of the health workforce, in developing nutrition actions”. Lastly, he proposed a new subparagraph in paragraph 3, which would read “to report to the Sixty-seventh World Health Assembly through the Executive Board on progress of this resolution together with the report on progress in implementing of the Code of Marketing of Breast-milk Substitutes and related Health Assembly resolutions”.

Ms CHANESTA (Swaziland) thanked the delegate of Canada for her proposed amendment, but said that she would prefer to leave the subparagraph as it was drafted, excluding the words “country level”. She could accept the amendments proposed by the delegates of Switzerland and Thailand.

Dr DAULAIRE (United States of America), noting that the delegate of Thailand had objected during the Committee’s seventh meeting to the consideration of amendments that were not available in written form, said that, although he could accept the proposal to substitute the words “developing and strengthening” for the word “revising”, he could not agree to the addition of three new subparagraphs without seeing them in writing.

Dr THAKSAPHON THAMARANGSI (Thailand) said that he would submit his proposals in writing. The proposals were important, but he did not believe that they affected the main content of the comprehensive implementation plan; they would help to ensure that it was put into action effectively.

Ms WISEMAN (Canada) said that her hope from the outset had been to have a simple endorsement of the plan. While she appreciated the amendments put forward by the delegate of Thailand, she was concerned by the addition of new paragraphs to the carefully negotiated text. Since many of the elements that he proposed to add were included in the comprehensive implementation plan, she saw no need to include them in the resolution.

Ms BENNETT (Australia) expressed support for the positions taken by the delegates of Canada and the United States of America. She wished to see the draft resolution adopted that day, and therefore advocated sticking as closely as possible to the compromise text. She agreed that the words “country level” should be deleted from subparagraph 3(3), as their inclusion changed the original intent of the text. She could accept the amendment proposed by the delegate of Switzerland as all Member States seemed to agree on the need to avoid replicating the work of the Codex Alimentarius Commission.

Dr JACOBS (New Zealand), endorsing the comments made by the delegates of Canada and Australia, said that it was time to move forward and reach agreement.

Dr ST. JOHN (Barbados) said that she, too, wished to see the draft resolution adopted without further delay. Arguments over nuances of language in the draft resolution must not stand in the way of endorsement of the comprehensive implementation plan. She could accept the proposal by the delegate of Norway to remove “country level” and the reference to the Codex Alimentarius proposed by the delegate of Switzerland.

Ms SCHJØNNING (Denmark), speaking on behalf of Member States of the European Union, said that she was willing to consider the amendments proposed by the delegate of Thailand but tended to agree that it was important to move forward and to adopt the draft resolution that day. She could accept the proposal to use the words “developing and strengthening” in subparagraph 2(1).

Dr THAKSAPHON THAMARANGSI (Thailand) pointed out that the text of the current draft of the resolution had not been available to him until shortly before the present meeting. He requested time for his delegation to engage in informal discussions with other interested delegations.

Ms WISEMAN (Canada) said that she wished to take action on the draft resolution without delay. She could accept the proposal to use the words “developing and strengthening” in subparagraph 2(1), but she did not think it appropriate to refer to strategies to tackle childhood obesity in that subparagraph, as the plan focused specifically on children under the age of five years.

The DIRECTOR-GENERAL said that, as she saw it, the Committee could either decide to take the time to hold informal discussions or proceed to approve the draft resolution as amended. She noted that it had been pointed out that most of the amendments proposed by the delegate of Thailand were included in the draft comprehensive implementation plan.

Mrs ESCOREL DE MORÃES (Brazil) said that, even if the text proposed by the delegate of Thailand were in the implementation plan, it might be desirable to highlight certain concepts in the resolution. It was difficult to decide, however, without seeing the proposals in writing. The Committee should do the delegate of Thailand the courtesy of looking at whether his proposals should be incorporated.

Ms CHANESTA (Swaziland) said that she supported the proposal by the delegate of Thailand to request the Director-General to report back to the Health Assembly. Such a provision was standard. She was concerned that the addition of the phrase “with the latest evidence on nutrition” in subparagraph 3(2), as proposed by the delegate of Japan in the previous meeting, might mean that support for monitoring and evaluation would not be provided if there was no new evidence.

Dr TAKEI (Japan) explained that his proposal had been intended to ensure that policies were evaluated using evidence; to clarify, the words “based on the evidence available” might be inserted after “policies and programmes”.

Ms TYSON (United Kingdom of Great Britain and Northern Ireland) said that it was regrettable that substantive amendments had been proposed at such a late stage. She supported the proposal regarding reporting, but stressed that reporting arrangements should be aligned with those set out in resolution WHA63.23. She urged the Committee to come to a decision during the present meeting so that it could turn its attention to other agenda items.

Dr THAKSAPHON THAMARANGSI (Thailand) said that he could withdraw his amendment on developing national targets as it was contained in the draft comprehensive implementation plan, which the draft resolution endorsed. He had heard support for his proposal to use the words “developing and strengthening” in lieu of the word “revising”, and for the proposal to request the Director-General to report back, and had heard no objection to the content of his proposal to include a paragraph on strengthening local and national capacity. He hoped therefore that those three amendments would be judged acceptable by the Committee.

Dr DAULAIRE (United States of America) said that he could accept the amendment to subparagraph 2(1), but urged the delegate of Thailand to withdraw the proposed additional subparagraphs. He was prepared to take part in informal discussions, but in that case he would not be in a position to take a decision on the draft resolution before the following day.

Ms BENNETT (Australia) agreed that Member States would need to see the text of the proposed amendments in writing before taking a decision on the draft resolution. She could accept the proposed amendment to subparagraph (2)1 with the addition of the words “as appropriate”.

Dr THAKSAPHON THAMARANGSI (Thailand) said that his delegation had not been notified of the informal discussions that had produced the current draft of the resolution and therefore had been unable to put forward its amendments at an earlier stage. He stood ready to engage in informal discussions with a view to reaching consensus.

The CHAIRMAN suggested that the discussion on the item should be suspended and a small drafting group convened to formulate a text that would be acceptable to all.

It was so agreed.

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

Early marriages, adolescent and young pregnancies: Item 13.4 of the Agenda (Document A65/13)

Mr LASKAR (Bangladesh) welcomed the report, noting the in-depth description it provided of the links between early marriage and early pregnancy and the associated maternal health risks. Although improved access to education for girls, women’s participation in the job market, empowerment programmes and legislative measures had contributed to a reduction in early marriage

and adolescent pregnancy in Bangladesh, both remained common among less-educated and socially conservative families. The Government planned to introduce an online marriage registration system that would help to prevent the marriage of girls and boys below the permissible age. WHO should continue to support countries in social advocacy and health education activities in order to discourage early marriages and adolescent pregnancies.

Dr QIN Geng (China) supported the recommendations of the report, which addressed an important topic that was closely linked to the achievement of the Millennium Development Goals. The Government of China took a multisectoral approach to the important issue of adolescent reproductive health that included sexual health education and the regulation of health care services. China stood ready to take part in international cooperation and exchanges of experience. He called on WHO to mobilize the global community to accord higher priority to issues relating to early marriage and pregnancy, support Member States in choosing the interventions best suited to their situations and provide technical and financial support, particularly to developing countries.

Dr DLAMINI (South Africa) said that the report provided a platform for strengthening the reproductive and sexual health and rights of adolescent girls. While early marriage was not a significant problem in South Africa, adolescent pregnancy was, as was HIV infection among young women. Adolescents were at high risk of complications during pregnancy, regardless of their marital status, and it was essential that they be provided with information on pregnancy prevention, sexual and reproductive health and rights, and prevention of HIV infection and other sexually transmitted infections. They must also have access to reproductive health services.

Dr AL-TAAE (Iraq) noted the importance of the topics of early marriage and adolescent pregnancy, particularly with regard to the Millennium Development Goals relating to gender equality and maternal health. It was important to raise awareness of the health risks associated with early marriage and early pregnancy, including the increased risk of maternal mortality. Action should be taken at the primary health care level to address the health of the newborn. Family planning centres should also address the issue.

Ms ERSHADI (Islamic Republic of Iran) affirmed the importance of access to maternity services as a means to reducing maternal mortality and rates of HIV/AIDS and other infectious diseases. Successful intervention to prevent early marriage and pregnancy required an understanding of the various moral, religious, social and cultural contexts in which they occurred; a one-size-fits-all approach might not be appropriate and that should be reflected in the report. She highlighted the decisive role of family integrity in addressing the difficulties of early marriage and adolescent pregnancy.

Mr URQUIDO VELÁSQUEZ (Colombia) said that adolescent pregnancy was both a social problem and a public health issue. Addressing the issue required a multisectoral approach that addressed its various social determinants. Services must be adapted to the particular needs of adolescents. Sexual education programmes should begin in early childhood and continue throughout the school cycle and should focus less on the physiological aspects of reproduction and more on communication, self-esteem and negotiation and decision-making skills. Policies to encourage young people to stay in school and social support networks to help them to find employment were needed. It was also important to work to eliminate gender inequalities in childhood and adolescence. Adolescents' opinions should be sought and they should be involved in creating intervention strategies.

He urged the Health Assembly to accord the issues of early marriage and adolescent pregnancy the importance they deserved and to call on the Director-General to promote relevant policies and strategies. There was an urgent need to invest in preventing adolescent pregnancy in developing countries in order to break the cycle of poverty.

Mr DELGADO (Cape Verde), speaking on behalf of the Member States of the African Region, said that, while early marriage existed throughout the world, it particularly affected girls in Africa and South-East Asia. Early marriage led to social exclusion of young women and increased their risk of early pregnancies and sexually transmitted diseases; it also interrupted girls' education, reduced their opportunities for occupational training and served to entrench gender-based poverty, and was thus a violation of young women's human rights. Pregnancy in adolescent girls was often linked to factors beyond their control, such as abuse, the absence of parents and poverty. It was also linked to lack of access to information on sexuality and to contraceptive methods and services. An improved understanding of sexuality and family planning, coupled with higher levels of educational attainment among adolescents, would contribute to the achievement of the Millennium Development Goals. He called on all Member States to support and implement the measures recommended in the report.

Mrs REITENBACH (Germany) said that the report clearly showed the interdependence between early marriage and pregnancy and progress towards Millennium Development Goals 2 to 6. Early marriages and pregnancies had severe consequences for girls, including termination of education, inability to plan family size, complications linked to pregnancy at a young age and vulnerability to HIV infection. A rights-based family planning initiative introduced by her Government aimed to provide information, education and access to modern contraceptive methods. Low rates of adolescent pregnancy in her country could be attributed to formal comprehensive sexuality education starting in primary school. The Federal Centre for Health Education, a WHO collaborating centre, in cooperation with the Regional Office for Europe had developed standards for sexuality education based on the common understanding that children and adolescents had the right to age-appropriate information to support their development and help them to make healthy choices. The standards had been used as an advocacy tool to gain support for the introduction or improvement of sexuality education.

Dr RODRÍGUEZ (El Salvador) said that children as young as 11 years of age were sexually active in her country and there were cases of 12-year olds who were expecting a second child and 14-year olds who were pregnant and infected with HIV. She welcomed the report, but would have preferred that it focus more on sexual relations among adolescents than on adolescent marriage. El Salvador had launched an intensive public awareness campaign on the subject of adolescent pregnancy, which should be treated as a public health issue and a serious social problem and addressed through a multisectoral approach. The high rate of suicides among pregnant adolescents in her country underscored the need for a mental health approach, as well.

Dr DJIGUIMDE (Burkina Faso) said that, in his country, one fifth of girls were married when they were between 10 and 14 years of age, over 47% were married between 15 and 17 years of age, and girls as young as nine years of age were removed from school for marriage. The number of adolescents undergoing abortions was rising steadily, presumably because they had little access to contraceptives, information about sexuality and family-planning services. Campaigns to prevent early marriage, to distribute contraception, promote literacy and schooling among girls and raise awareness had been launched. He thanked those partners involved in improving the health of adolescents in Burkino Faso for their support.

Ms BADJIE (Gambia) observed that many parents encouraged the early marriage of their daughters in the hope that it would benefit the family financially and socially. However, child marriage was a violation of human rights that compromised the development of girls and often resulted in early pregnancy and social isolation. In her country it was prohibited for girls to be withdrawn from school for the purpose of marriage. Most adolescents in her country had limited access to sexual and reproductive health information because the subject was surrounded by taboos. Her Government had taken a number of measures to address the problems associated with early marriage and early pregnancy. A programme on reproductive and child health implemented in

partnership with Chinese Taipei had yielded very positive outcomes. The Gambia had a huge unmet need for emergency obstetric care, which was critical in the reduction of maternal and newborn mortality and morbidity. She endorsed the recommendations contained in the report.

Dr BLUMENTHAL (Finland), speaking also on behalf of Denmark, France, Iceland, the Netherlands, Norway and Sweden, said that healthy and educated young people could serve as motors of economic and social development and it was therefore important to meet their education, health and employment needs. WHO had a crucial role to play in coordinating efforts, establishing guidelines and recommendations and monitoring progress with respect to sexual and reproductive health and rights. Millennium Development Goal 5 (Improve maternal health) was the goal on which the least progress had been made. It was to be hoped that the review of the International Conference on Population and Development in 2014 would be an opportunity for progress.

Access to youth-friendly services, modern contraceptives and safe abortion was key to the welfare of young people, since it helped them to make informed choices and avoid early pregnancy and remain in school. Many young people failed to access such services because those services targeted married women. The needs of lesbian, gay, bisexual and transgender youth, groups that were often marginalized, should not be forgotten and their access to youth-friendly services should be safeguarded. Men and boys had a significant influence on women's and girls' sexuality and access to contraceptives; sexual health education programmes should therefore target boys from a young age and promote responsible and non-violent sexual relationships.

She commended the report and the guidelines on preventing early pregnancy and unsafe abortion, noting that further research on effective interventions was required. Experience showed that promoting gender equality, equal education opportunities and developing youth-friendly health-care systems and access to contraceptive methods resulted in low levels of unintended pregnancies, abortions and sexually transmitted infections. When adolescent sexuality was not condemned or stigmatized and appropriate services were provided, adolescent sexual health could be improved at low cost.

Dr PRASAD (India) said that it was important to take a multisectoral approach to early marriage and adolescent pregnancy and essential to target interventions on health, nutrition, education and life skills. In India, health clinics were being established to provide sexual health guidance and treatment. Evidence suggested that the age of marriage was rising and the birth rate among young girls falling, factors which should contribute to the achievement of the Millennium Development Goals.

Dr KAZIHISE (Burundi) said that the subject of the report was of great significance for the African Region and for his country, where early marriage and early pregnancy were significant concerns. By the age of 19 years, 24% of girls in Burundi had given birth to at least one child. Research indicated that adolescent fertility rates were linked to educational attainment. His Government endorsed the recommendations made in the report, with the exception of those relating to promotion of access to safe abortion services in cases other than when there was a medical need.

Dr SLAMET RIYADI YUWONO (Indonesia) noted the importance of focusing on adolescent health in order to work towards the achievement of the Millennium Development Goals. His Government had adopted a life-cycle approach to maternal and child health encompassing the neonatal period, childhood and adolescence and the childbearing years. Since education helped to prevent early marriage and pregnancy, the Government had designed a national programme that provided information and counselling on reproductive health issues and encouraged young people to take responsibility for their reproductive health. He drew attention to the need to respect the diversity of regulations, religions, cultures and social backgrounds that could lead countries to embrace diverse policies.

Ms PEREIRA MAGNO (Timor-Leste), speaking on behalf of the Member States of the South-East Asia Region, said that the Region experienced elevated levels of adolescent pregnancy, mostly as a result of early marriage, low rates of contraception use and the influence of cultural and social values. Many strategies had been developed to deal with the issue, particularly the development of national standards and guidelines on confidential health services and better maternity care for married and unmarried adolescents. Challenges to be addressed included lack of data on unwanted pregnancies and unsafe abortions among unmarried adolescent girls, an unsupportive policy environment for providing contraception and access to safe abortion services, and poor enforcement of minimum age requirements for marriage. WHO technical support and advocacy to enable Member States to meet those challenges were appreciated and should continue.

Mrs PARANEE SAWASDIRAK (Thailand) said that technical support should continue to be provided to Member States to foster the development of policy and programmes relating to access to contraception, safe abortion and adolescent-friendly health services. Highlighting six concerns regarding the report, she said that the policy development process should not rely solely on national figures, since they concealed discrepancies across social classes within countries, but rather on data disaggregated by socioeconomic characteristics. More research was needed on vulnerable groups, such as school dropouts, minority groups and homeless youth. Policy should be evidence-based. The evidence to date had indicated that encouraging self-esteem, promoting educational opportunity and teaching communication skills for sexual relationships were effective approaches. Sociocultural and religious contexts should be taken into account when developing policy. Social determinants that affected adolescents' behaviour should also be considered; for example, research in Thailand had shown a strong correlation between drinking alcohol and teenage pregnancy. Social media should be used to promote healthy behaviour. Legislative and social barriers that prevented pregnant adolescents from accessing reproductive health services and education should be eliminated.

Recognizing that the report's guidelines would significantly contribute to progress towards Millennium Development Goals 4 and 5, her Government was committed and ready to put that guidance into action.

Dr NIK RUBIAH ABDUL RASHID (Malaysia), acknowledging the link between early marriage and pregnancy and the health-related Millennium Development Goals, said that her country had seen a decline in the adolescent fertility rate in recent years, thanks in part to the adoption of a multisectoral approach that included a national adolescent health policy, the introduction of sexuality education in both primary and secondary schools, development of educational materials on sexual and reproductive health, and universal access to maternity services, regardless of marital status.

Ms SHAHNAZ WAZIR (Pakistan) said that her Government recognized the personal, social and economic consequences of early marriages and early pregnancies and the link between early pregnancy and health indicators, in particular low birth weight and maternal and infant mortality, and its impact on women's opportunities for work and education. Her Government had recently enacted legislation criminalizing early or forced marriage, sexual harassment and violence against women and had enhanced educational and vocational training opportunities for girls. It was committed to the achievement of the Millennium Development Goals and urged continued commitment from WHO to develop programmes focusing on the links between the goals for education, gender equality and health. Noting that reference was made in the report to access to contraception for unmarried couples, she stressed that account must be taken of the diversity of societal, cultural and gender norms when promoting policies on access to contraception. Her Government had expanded access to contraceptives and was promoting reproductive health practices such as delayed marriage and pregnancy and adequate birth-spacing that recognized the needs of adolescents and young married couples.

Ms LÓPEZ DE LLERGO CORNEJO (Mexico), noting that many countries lacked effective sexuality education, highlighted the right of all couples to access safe, effective and affordable family planning methods. She welcomed the report's integrated approach and encouraged the Secretariat to disseminate the guidelines on preventing early pregnancy and poor reproductive health outcomes among adolescents¹ in order to support national efforts. Her country had recently put in place a specific programme on adolescent sexual and reproductive health and stood ready to share its experience with other Member States.

Dr THIMOTHÉ (Haiti) said that, while early marriage was not common in Haiti, early pregnancy was a social and public health problem with significant economic consequences; an education programme had been introduced to prevent sexually transmitted infections and adolescent pregnancy, and a bill on paternal responsibility was before parliament. Haiti supported the recommendations in the report and would further its efforts in the areas of sexual health and family planning.

Mr KOLKER (United States of America) said that forced marriage could be an extreme form of gender-based violence, since it was imposed with community and family support and could last a lifetime. He applauded the report's focus on the social and economic vulnerabilities of young women and adolescent girls and welcomed the information that many countries were enforcing laws and policies to prevent early marriage. He urged Member States to address the social and community norms, and in particular the gender equality, that encouraged early marriage and pregnancy. Women faced far fewer health risks if they delayed childbearing and were better prepared for motherhood if they were allowed to complete their education. WHO had an important role to play in compiling and disseminating evidence on the age-related risks of pregnancy and in supporting Member States in introducing and adapting evidence-based sexuality and reproductive health education for young people, and strengthening their commitment to ending the practice of early marriage, and to preventing adolescent pregnancies.

Dr BRYANT (Australia), noting the report's findings, particularly the disproportionate risks of giving birth during adolescence and the low levels of access to and use of contraception by adolescents, said that her Government remained committed to the United Nations Secretary-General's Global Strategy for Women's and Children's Health. It also recognized the importance of addressing sexual and reproductive health needs in order to achieve Millennium Development Goals 4 and 5, and supported equitable access for women and girls to sexual and reproductive health services. The birth rate among teenaged women in Australia had fallen by more than half between 1975 and 2010. The reduction was the result of a wide range of social, economic and educational forces, including improved sexuality education and access to contraception and family planning services.

Ms NÚÑEZ (Chile) said that the protection of adolescents' health and prevention of adolescent pregnancy were being addressed under the national health strategy and an integrated adolescent health programme, which sought to improve access to youth-friendly services at the primary health care level and an increase in sexual and reproductive health coverage for young people between 10 and 19 years of age. It also sought to improve the competencies of professionals in the field of adolescent health and promoted the participation of young people in provincial and regional councils as a means of ensuring that interventions were tailored to their needs, bearing in mind their developmental stage, sex, psychosocial vulnerabilities and cultural diversity. Chile stood ready to share its experience with other Member States.

¹ *WHO Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries*. Geneva, World Health Organization, 2011.

Dr PHOLSENA (Lao People's Democratic Republic), welcoming the report, said that early marriage and adolescent pregnancy were key risk factors in maternal mortality. His Government had introduced a national strategy and a package of integrated maternal, neonatal and child health services and offered family planning and reproductive health education at the community level. Midwives and other health workers were being trained and deployed. His country looked forward to working with development partners to tackle the problems associated with early marriage and pregnancy.

Dr LANGA (Mozambique) said that early marriage had a significant impact on the vulnerability and health outcomes of young people, especially young women, in her country. Although child marriage was prohibited in Mozambique, data collected in 2008 showed that some 11% of girls aged 12–14 were married or living in a stable union and 41% of girls between 15 and 19 years of age were or had been pregnant. Nevertheless, some important progress had been made in protecting the rights of children and to improve the situation of girls and women subjected to violence, including girls forced to marry early.

Dr RUSIBAMAYILA (United Republic of Tanzania) said that her Government had developed a strategy to increase adolescents' access to and use of sexual and reproductive health services and to improve the quality of those services, and the country's First Lady had advocated against early marriage. Increased funding was needed to address adolescent reproductive health issues and to leverage funding that was available for action on HIV/AIDS, including funding for the prevention of mother-to-child transmission of HIV. Adolescent health should be prioritized through a multisectoral approach that sought to prevent early marriage and adolescent pregnancy.

Dr ALI (Maldives) said that high levels of antenatal care attendance and skilled birth attendance, together with the launching of a life skills programme, had helped to reduce adolescent pregnancies and their consequences in her country. The lack of data on adolescent pregnancy rates, a decrease in contraceptive use and widespread drug use and gender-based violence among young people were all challenges faced by the Maldives that required continued support from WHO and other partners.

Dr WAMAE (Kenya) said that early marriage and adolescent pregnancy affected girls physically, emotionally, economically and academically and posed a risk to the lives of newborn infants. Measures were in place in her country to prevent early marriage and pregnancy, and Kenya had enacted legislation in keeping with the Convention on the Rights of the Child, which protected children from the negative cultural practices that could lead to early pregnancy. She commended the report and expressed the hope that it would lead to greater attention to adolescent health and the allocation of more resources.

Dr DOUA (Côte d'Ivoire) said that women from the poorest backgrounds were the most vulnerable to adolescent pregnancy and early marriage, and that the consequences of early marriage identified in the report were visible in Côte d'Ivoire. Effective strategies were needed to respond to the reproductive and sexual health needs of young people, including the provision of access to reproductive health services and HIV prevention programmes, a reduction in inequalities between men and women and enforcement of laws on harmful traditional practices.

He welcomed the recommendations contained in the report and affirmed his Government's commitment to take action to prevent early marriage and adolescent pregnancy; however, in conformity with its legislation, it would limit the practice of abortion to cases where there was a medical need.

Dr Shu-Ti CHIOU (Chinese Taipei) said that Chinese Taipei had recently seen a fall in birth rates among adolescents despite increased adolescent sexual activity; at the same time there had been a rise in contraception use and a significant increase in the numbers of girls completing higher education, which suggested that better opportunities for women in formal education probably played a more significant role than other factors in reducing adolescent pregnancy. A recent attempt to raise the age of marriage for girls in Chinese Taipei had failed, since allowing girls to marry at the age of 16 enabled those who became pregnant early to have a legal marriage if they wanted one. That experience raised questions as to whether the recommendation to raise the legal age of marriage to 18, contained in paragraph 16 of the report, could be universally applicable or effective. Improving educational and employment opportunities and access to contraception might be better strategies for supporting women's development. Any strategy for preventing early pregnancy should take differing cultural and social contexts into account.

Monsignor VITILLO (Holy See), speaking at the invitation of the CHAIRMAN, said that his delegation understood the serious risks incurred by young women and men who entered into marriage before reaching the required affective and physical maturity. It also recognized the need to influence family and community norms and stereotypes that were harmful to women, girls and their communities. However, it wished to register its serious concern with regard to recommendations in the report that promoted access to so-called emergency contraceptives and so-called safe abortion care. Human life began at the moment of conception and must be protected, and the Holy See could never condone abortion or policies that favoured abortion. Abortion services were not a dimension of reproductive health services, and his delegation could not endorse any legislation that recognized abortion, which was the antithesis of human rights.

Ms UPLEKAR (International Alliance of Women), speaking at the invitation of the CHAIRMAN, said that lack of effective sexuality education meant that adolescent girls did not know that they had choices and lacked information about contraception. All too often, desperate adolescents decided to have an abortion. The United Nations Special Rapporteur on the Right to Health in his report to the United Nations General Assembly in October 2011 had recommended that States decriminalize abortion and facilitate access to a full range of modern contraceptive methods and full, complete and accurate information on sexual and reproductive health. Implementing those recommendations would benefit women's health by removing barriers created by national criminal law or other legal restrictions. A survey by her organization had shown that laws establishing the father's responsibility for the welfare of his children within and outside marriage were of little help if cumbersome procedures and a non-supportive environment discouraged women from turning to the courts. Changes in legislation and societal attitudes were needed to pave the way for sexual and reproductive health rights, as well as educational opportunities for all girls.

Mr LEFEBVRE (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, said that continued support of sexual health education and services were the means to ensure that the health-related Millennium Development Goals highlighted would be met, in particular Goals 2 and 3 on universal education and gender equality, which were connected with reproductive rights. Member States should continue to encourage access to education for both girls and boys, since it was the lynchpin in the prevention of early pregnancy. Sexuality education should aim to promote changes in attitudes and instil in boys the idea that they shared responsibility for preventing pregnancy. The assurance of reproductive rights would provide a strong foundation for the achievement of gender equality.

Ms BERGER (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that a family planning summit to be held in London in July 2012 would be an opportune moment for Member States to demonstrate their commitment to remedying the unmet need for family planning services, which were among the most effective of public health measures. They helped to prevent

unwanted pregnancies, empower women and girls and reduce the health risks associated with unplanned pregnancies. She emphasized the need to make access to modern methods of family planning more equitable, so as to ensure that poorer adolescents and those living in rural and remote areas or marginalized communities were not excluded. Married adolescent girls should be specifically targeted in community-based family planning initiatives. All young people should have access to quality, youth-friendly health services provided by skilled health workers who were sensitive to their particular needs, and adolescents should always give birth in a health facility staffed by skilled birth attendants owing to their increased risk of complications. Sexuality education should begin early in adolescence, as it was easier to form positive norms at that stage than to change them later on. National legislation and policies should protect girls from harmful practices such as early marriage and guarantee the equal status of women and girls in the home, the community and the workplace.

Ms TEN HOOPE-BENDER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, said that adolescents were a particularly vulnerable group in terms of sexual and reproductive health outcomes. Early marriage was a significant factor in adolescent pregnancy, which denied girls their right to education and their right to the highest attainable standard of health, and was part of a cluster of harmful cultural practices that included female genital mutilation. Millennium Development Goals 4 and 5 on the reduction of maternal and child mortality were in danger of being missed unless such harmful practices were addressed in a coordinated and systematic manner, including scaling up and strengthening nursing and midwifery services, which would help to reduce maternal and newborn mortality. She called on the Secretariat and Governments to combat harmful cultural practices including early marriages and to improve access to reproductive health services, including family planning and antenatal care for adolescents.

Mrs EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, said that the lack of effective measures to prevent early pregnancy and provide adequate care to pregnant adolescent girls constituted an enormous barrier to achievement of the health-related Millennium Development Goals, especially Goals 4 and 5. Adolescent pregnancy constituted a fundamental threat to the realization of children's and adolescents' right to health and was a multidimensional problem that reflected health inequities both between and within countries. It should be seen as a public health challenge that required an integrated multisectoral response. Access to family planning services tailored to the needs of different stages of adolescence was crucial to avoiding early pregnancy and unsafe abortions that resulted in premature and unnecessary deaths. Health systems should provide prenatal and postnatal services, through multidisciplinary teams, to pregnant adolescent girls and their families. It was to be hoped that WHO would allocate the necessary human and financial resources to support Member States in dealing with the problem of adolescent pregnancy, and make tackling it a priority.

Dr MASON (Maternal, Newborn, Child and Adolescent Health) acknowledged the many supportive comments and requests for WHO to continue raising awareness about the problems associated with early marriage and early pregnancy and their consequences for the health of adolescent girls and for their children. She noted also the importance placed on laws and policies. In addition to the guidelines on preventing early pregnancy and poor reproductive outcomes already available, WHO would develop a policy document that would set out in detail suggested policy options for countries. Workshops were being planned in various regions and countries in order to facilitate the necessary policy dialogue requested by many countries.

The Secretariat was aware that a "one-size-fits-all" approach would not work and would work with regional offices to adapt the guidelines to the realities of different countries. She had noted the call for WHO to continue to work on improving evidence and collecting and highlighting data on the numbers and risks of adolescent pregnancies. She drew attention to the recent adoption of a resolution on reproductive care for adolescence and youth by the United Nations Commission on Population and Development, which fitted into the multisectoral approach required to address early marriage and

pregnancy. She assured Member States that adolescent pregnancy was high on WHO's agenda. The health of adolescents must be promoted and protected, as they were a resource for now and for the future. Parents must be enabled to assist them. A multisectoral response was vital to the reduction and prevention of adolescent pregnancy.

The CHAIRMAN took it that the Committee wished to note the report.

It was so agreed.

Poliomyelitis: intensification of the global eradication initiative: Item 13.10 on the Agenda (Documents A65/20 and EB130/2012/REC/1, resolution EB130.R10)

Dr LARSEN (representative of the Executive Board) said that, at its 130th session, the Board had congratulated India, which had not reported a case of poliomyelitis caused by wild poliovirus since January 2011. The Board had noted that cases had declined in countries with re-established polio transmission and that seven of the eight new outbreaks in 2011 in previously polio-free countries had been stopped. However, continued polio transmission anywhere posed a serious risk to the world until transmission was interrupted globally. The Executive Board had adopted resolution EB130.R10, in which it recommended a text to the Health Assembly for adoption. Since the Board's adoption of the resolution, the Global Polio Eradication Initiative had launched an Emergency Action Plan for 2012 and 2013, with a particular emphasis on providing greater support to the remaining Member States with endemic transmission so that they could increase vaccination coverage to the levels needed to interrupt transmission of all poliovirus by the end of 2012.

Ms SHAHNAZ WAZIR (Pakistan), expressing support for the draft resolution contained in resolution EB130.R10, said that Pakistan had already taken several steps in line with the provisions of the resolution and the recommendations of the report. Although Pakistan was one of the three countries in the world in which poliomyelitis was still endemic, it had made significant progress since launching its eradication plan in 1994, when polio cases had been estimated at around 20 000 per year. Immunization of 33.9 million children under five years of age and interruption of transmission were among the Government's top priorities. It was aware of where the virus was circulating and why children in those areas were not being vaccinated. In view of the alarming polio situation seen in 2010 and 2011, Pakistan had launched a national emergency action plan in January 2011 and an augmented plan in 2012. The plan focused on ensuring greater ownership, oversight and accountability at federal, provincial, district and local levels, with the aim of vaccinating every child under five years of age, including those in security-compromised areas and in mobile and transient populations. It also focused on identifying high-risk areas with low vaccination coverage. The reasons for lack or refusal of vaccination were evaluated, and specific strategies were devised to address the problems. District commissioners were held responsible for implementation of the emergency plan.

Her Government recognized that the health sector alone could not implement the plan successfully and had mobilized large-scale efforts involving a variety of actors, including the education sector, law enforcement and military officials, parliamentarians, religious leaders and the national and local media. There were several areas in the Federally Administered Tribal Areas where vaccination teams still did not have access. The populations in those areas were being mapped, as were mobile and transient populations, and there was ongoing cross-border collaboration between Pakistan and Afghanistan, including synchronized vaccination campaigns. Between January and April 2012 more than 175 000 children had been vaccinated in border areas. As a result of those efforts, the Government had been able to confine poliomyelitis cases to 10 districts out of 140; it had only reported 16 cases in 2012, as compared to 40 cases in 2011; and 80% of districts were reporting 95% vaccination coverage of the target population compared to 42% in 2011.

Pakistan was committed to providing financial resources for its polio eradication plan, but required additional resources in order to implement it fully. She urged the international development community to continue to provide technical, operational, financial and non-financial support.

The meeting rose at 13:00.

NINTH MEETING

Friday, 25 May 2012, at 14:40

Chairman: Dr L.Z. DUKPA (Bhutan)

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

Poliomyelitis: intensification of the global eradication initiative: Item 13.10 (Documents A65/20 and EB130/2012/REC/1, resolution EB130.R10) (continued)

Mrs BAMIDELE (Nigeria), speaking on behalf of the Member States of the African Region, said that, although there had been a resurgence of paralytic poliomyelitis due to wild poliovirus in some African States, progress had been achieved in many other countries of the Region. The African Region viewed completing the eradication of poliomyelitis as a global health emergency. It called on Member States to hold local authorities of key infected areas accountable for the performance and quality of supplementary immunization activities. It welcomed the efforts of countries to halt and reverse endemic and re-established transmission and encouraged them to take further measures, including strengthening accountability, evaluating eradication plans and promoting innovation, in order to interrupt transmission by the end of 2012. Continued global support should be provided to Member States where the disease remained endemic and to countries with transborder transmission. WHO and other partners should support national efforts to accelerate routine immunization and service delivery and to ensure a sustainable supply of vaccines. The African Region supported the draft resolution contained in resolution EB130.R10.

Dr MOHAMMED (Nigeria) said that the actions called for in the draft resolution were already being undertaken by his Government in the framework of its revised national poliomyelitis emergency plan. Resources would be deployed to ensure oral poliovirus vaccine coverage of all eligible children within 24 hours of crossing the border. Nigeria was committed to stopping the transmission of wild poliovirus, which had increased in 2011 as compared with 2010. A task force on poliomyelitis eradication had been established; vaccination strategies were being scaled up in high-risk areas; vigorous risk assessment methods had been developed; a revised national poliomyelitis emergency plan had been drawn up after consultation specifying the accountability of all tiers of Government, stakeholders and partners; and domestic funding for poliomyelitis eradication initiatives had been increased from US\$ 17 million to US\$ 30 million annually for the coming two years. Strategies had also been put in place to improve the performance of vaccination teams in order to ensure high-quality supplementary immunization. The Government was working with community, traditional and religious leaders to address population resistance to vaccination. Efforts were also being made to improve routine immunization, particularly in areas at highest risk for wild poliovirus transmission, and to ensure an uninterrupted supply of vaccines. Every effort was being made to document correctly the surveillance of acute flaccid paralysis.

He thanked WHO and other development partners for their continued support for implementation of Nigeria's emergency plan for poliomyelitis and assured Member States that his country remained committed to discharging its responsibilities.

Dr MASHAL (Afghanistan) welcomed intensification of the Global Polio Eradication Initiative and agreed that transmission of poliomyelitis should be declared a national public health emergency.

Although the number of confirmed cases in his country had been reduced in 2012, challenges remained before poliomyelitis would be eradicated. Innovative strategies tailored to the needs of populations in remaining disease-endemic areas were the key to success, and he called on national and international organizations to take appropriate action. His Government was currently preparing a national emergency action plan and working to strengthen routine vaccination, on which particular emphasis should be placed. Countries with endemic transmission should ensure an efficient link between routine vaccination and the Global Polio Eradication Initiative.

Mr FILLON (Monaco), speaking on behalf of the Member States of the European Region, said that the increasing number of cases recorded in 2011 in countries with endemic transmission was of serious concern. All children, including those in poliomyelitis-free countries and regions, would remain at risk until the disease had been eradicated. The Member States of the European Region remained committed to ensuring the immunity of populations of all ages through certified surveillance programmes, together with routine, and if necessary mass, immunization campaigns. Prevention of the importation of new cases of poliomyelitis was as important as interruption of transmission in countries where poliomyelitis remained endemic. If eradication, which was within reach, was to be achieved, systematic intervention strategies and strong national surveillance and accountability mechanisms should be established in areas where transmission persisted. Noting the financing shortfall with respect to the Global Polio Eradication Initiative, he said that the results achieved so far would be eroded if the necessary funds and human resources were not forthcoming. The Member States of the European Region supported the draft resolution.

Dr PRASAD (India), speaking on behalf of the Member States of the South-East Asia Region, said that the Region had been free of wild poliovirus for some time. India had succeeded in halting endemic transmission of wild poliovirus through a number of initiatives, including political commitment at the highest level and deployment of adequate resources. His Government had introduced the bivalent oral poliovirus vaccine in 2010 and, despite periodic shortages, had been able to procure sufficient quantities for national and regional supplementary immunization rounds. Special attention had been given to ensuring the vaccination of children, migrants and populations in low-coverage areas. Social mobilization, monthly village health and nutrition days and the involvement of community and religious leaders had helped to dispel fears and increase acceptance of vaccination.

Nevertheless, risks remained, and the Government was taking steps to maintain high population immunity, strong surveillance, vaccination of travellers at border crossings, preparation of an emergency preparedness and response plan and regular risk assessment. An endgame strategy, including the switch from trivalent to bivalent oral poliovirus vaccine, would also be prepared. He urged WHO to continue providing technical support at the same level until eradication of poliomyelitis had been achieved. With regard to the draft resolution, he proposed deletion of the phrase “that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines” from subparagraph 4(3).

Dr PORNTHIP CHOMPOOK (Thailand) congratulated India for its success in halting virus circulation. India’s experience showed that a high level of routine vaccination coverage coupled with high-quality supplementary immunization activities were essential, as were a sound cold chain and community engagement. Evidence showed that eradication was compromised by lack of commitment of leaders and shortages of funding. Although the inactivated poliovirus vaccine would have an increasing role to play, particularly in the post-eradication era, its high cost and limited supply were obstacles to its use in developing countries. She asked the Director-General, the vaccine industry and development partners, including the GAVI Alliance, to take concrete steps to ensure that inactivated poliovirus vaccine was affordable.

She supported the draft resolution contained in resolution EB130.R10, as amended by India. She also proposed the addition of a preambular paragraph 6bis reading: “Concerning the current high cost and limited supplies of inactivated vaccine that are hampering the introduction and scaling up of

inactivated poliovirus vaccine, resulting in major programmatic and financial implications to developing countries”. Subparagraph 4(4) should be amended to read “to coordinate with all relevant partners, including vaccine manufacturers, to promote the research, production and supply of vaccines, in particular inactivated polio vaccine, to enhance their affordability, effectiveness and accessibility”.

Dr DECOCK (United States of America) said that the eradication of poliomyelitis was feasible, but if countries in which the virus was endemic and WHO did not make eradication a priority, a tremendous investment in public health would be wasted. The challenges faced by countries experiencing outbreaks required more attention, and countries in which the disease was endemic must make eradication a national priority and ensure accountability for eradication activities. Member States should work together to mobilize the necessary human and financial resources to achieve global eradication. Poliomyelitis was a disease requiring immediate notification under the International Health Regulations (2005), and he urged all Member States to adhere to that reporting requirement and to remain vigilant for cases caused by imported wild poliovirus.

WHO was proposing a comprehensive approach for reducing to the lowest possible level the risk associated with ceasing use of oral poliovirus vaccine and for managing residual risk. It was in the interest of all Member States to support that effort and to coordinate implementation of the medium-term and endgame strategy being prepared by the Strategic Advisory Group of Experts on immunization. Turning to the draft resolution, he proposed replacing the term “epidemic” in subparagraph 3(4) with “epidemiologic”.

Dr CORTEZ (Philippines) expressed strong support for the intensification of poliomyelitis eradication efforts. Eradication of poliomyelitis and other vaccine-preventable diseases remained the highest public health priority in his country, and a comprehensive, mandatory, sustainable immunization programme had been approved in 2011. The Philippines had remained poliomyelitis-free for the previous 12 years; however, a risk of reintroduction of wild poliovirus through importation persisted, because of increased local and international travel and low population immunity in some areas. The Government was seeking to strengthen surveillance and oral poliovirus vaccine coverage. A national poliovirus importation preparedness and response plan had been drawn up to encourage the preparation of subnational plans for sustaining poliomyelitis-free certification and ensuring that the country met its goals for the elimination of other vaccine-preventable diseases. Sustainable financial assistance was needed to support active surveillance.

Dr HIRAOKA (Japan) said that further effort would be needed in order to ensure effective implementation of the Global Polio Emergency Action Plan 2012–2013 and asked why proven new strategic approaches for eradicating poliovirus were not being fully applied. It was essential to reach unvaccinated children and to strengthen outreach strategies. Immunization and seroprevalence rates should be monitored carefully in designated pilot areas over the crucial next few years. His Government supported the draft resolution and would continue to provide technical and financial support and collaborate with international partners such as WHO and UNICEF in order to achieve eradication.

Dr HUSAIN (Bahrain) said that her country had taken a number of steps to control vaccine-preventable diseases and had been free of poliomyelitis since 1994. A programme was in place for the detection of suspected new cases, and national campaigns to increase vaccination against poliomyelitis had resulted in over 90% coverage. Vaccination strategies were continuously evaluated, and introduction of bivalent oral poliovirus vaccine was foreseen. She was confident that, as a result of local, regional and national activities, Bahrain would remain free of the disease. She emphasized the importance of the strategies recommended by WHO for completing the eradication of poliomyelitis and expressed support for the draft resolution.

Dr AL-TAAE (Iraq) said that his country had remained free of poliomyelitis for 12 years. He emphasized the importance of comprehensive coverage with services at primary, secondary and tertiary health care levels in order to reach populations in remote areas; the active participation of all sectors; and partnerships with other countries. Afghanistan, the Islamic Republic of Iran, Iraq and Pakistan, in collaboration with WHO, were promoting cooperation with neighbouring countries for the eradication of poliomyelitis, including the use of active surveillance as recommended by WHO.

Mr LASKAR (Bangladesh) said that significant progress had been made towards eradication of poliomyelitis in the South-East Asia Region over the previous 24 months and that the Region hoped to be certified as poliomyelitis-free in January 2014. India had succeeded in halting endemic transmission as a result of concerted efforts, including strong government ownership, close partnerships, a focus on quality, and programme accountability. Member States of the Region recognized the importance of achieving a high level of population immunity in order to remain free of poliomyelitis and to mitigate the risk of importation. A careful review of the use of oral and inactivated poliovirus vaccines, including adequate regional consultations, would be needed as part of the endgame strategy.

Bangladesh had been free of poliomyelitis since 2006, and current vaccination coverage stood at 95%. National poliomyelitis immunization days were held each year and would continue until the Region had been certified as poliomyelitis-free. Bangladesh supported the draft resolution.

Dr MELNIKOVA (Russian Federation) said that poliomyelitis remaining endemic in some countries demonstrated that the measures being taken were insufficient, and additional action plans were needed. The Russian Federation supported implementation of the Global Polio Emergency Action Plan 2012–2013 and welcomed the efforts of WHO to raise awareness of the issue among the leaders of all countries. Financing was essential, and her Government was committed to meeting its international obligations under the Global Polio Eradication Initiative. It was also providing additional support to countries of the Commonwealth of Independent States to strengthen their network of laboratories and had provided vaccines for supplementary immunization of children. Further steps to build capacity and improve epidemiological surveillance in the Region would be taken in 2012. Her Government had provided financial resources for diagnosis of cases at the WHO Regional Polio Reference Laboratory. It welcomed WHO's initiative to devise new strategic approaches, including to prevent cases due to vaccine-derived poliovirus, and would be willing to participate in those efforts. She endorsed the draft resolution.

Dr ALLENDE (Paraguay), noting that circulation of wild poliovirus had last been recorded in his country in 1985, said that the delay in achieving global eradication of the disease was seriously compromising the actions taken in some regions, necessitating the continuation of vaccination and epidemiological surveillance for an indefinite period. The increase in incidence of cases due to vaccine-derived poliovirus in areas with high HIV prevalence was especially worrying. Steps should be taken to accelerate the administration of inactivated poliovirus vaccines to all affected age groups in such areas. Teams of international health workers had played an important role in reducing the number of cases in countries where poliomyelitis remained endemic, and the Health Assembly should promote such horizontal cooperation. The threat of resurgence of poliomyelitis was a matter of global security, and WHO and related organizations and agencies must adopt a strong position to tackle the problems standing in the way of eradication. He endorsed the draft resolution.

Ms GOLBERG (Canada) said that Canada remained firmly committed to poliomyelitis eradication and had made significant technical and financial contributions to that end. Her Government supported the proposed Global Polio Emergency Action Plan 2012–2013 and believed that it was critical to intensify collective activities in the three countries in which poliomyelitis remained endemic. She praised the commitment of those countries to pursue aggressive eradication campaigns. A stronger communication strategy was needed under the emergency action plan to

increase the engagement of different constituencies and sustain momentum. The financial gap must be bridged to eradicate poliomyelitis, and Canada urged all Member States and funding partners to consider contributing to eradication efforts. Her Government also called on countries involved in the Partnership for Maternal, Newborn and Child Health to consider supporting immunization activities under that initiative.

Dr RAFEEG (Maldives) said that India's success was a landmark in global efforts to eradicate poliomyelitis. Maldives had remained free of indigenous poliomyelitis since 1982, a significant achievement for a nation with such a widely dispersed population and frequent foreign visitors. Vaccination had begun in 1967; high coverage had been achieved and maintained with the use of mobile vaccination teams, mandatory vaccination for school entry and advocacy and awareness-raising. Considerable effort, including continued surveillance, was being made to maintain the status of Maldives as poliomyelitis-free. She highlighted the importance of improved cross-border collaboration among neighbouring countries and called on WHO to continue to support the countries of the South-East Asia Region in order to ensure that the gains they had made were not lost. Maldives fully supported the draft resolution.

Mrs REITENBACH (Germany) observed that poliomyelitis was endemic in only parts of three countries and that the number of cases due to wild poliovirus type 3 was at its lowest level ever. Global eradication of poliomyelitis was therefore within reach, but only with continued financial, political and technical support from all governmental and nongovernmental bodies concerned. The Global Polio Emergency Action Plan 2012–2013, which Germany supported, was essential in order to complete poliomyelitis eradication. The considerable financing shortfall remained a serious concern, however, and could be bridged only by concerted effort from all partners of the Global Polio Eradication Initiative. Germany remained actively engaged in the Initiative and would fulfil its commitment to make available €100 million for the fight against poliomyelitis between 2009 and 2013.

Dr MOHAMED (Oman) said that, despite the tireless efforts of the Director-General, the Regional Director for the Eastern Mediterranean and the technical and financial support provided to countries for poliomyelitis eradication, cases in the three countries in which wild poliovirus remained endemic had increased in 2011 and there was a danger that transmission could spread to other countries. It was unclear from the Arabic translation of the report whether the situation constituted a global health emergency and what time frame for global eradication was being proposed. Oman welcomed the transparent reports provided by the Independent Monitoring Board and thanked the Strategic Advisory Group of Experts on immunization for its work.

Dr WU Liangyou (China) agreed that poliomyelitis was a global health emergency. Although eradication was possible, the Global Polio Eradication Initiative was facing severe challenges; China therefore supported the draft resolution. The persistence of wild poliovirus in some countries posed a threat to their neighbours. His Government had responded rapidly to importation of wild poliovirus in August 2011 by conducting intensive immunization programmes and strengthening surveillance. No further cases had been recorded since August 2011, and China had been removed from the list of countries in which poliomyelitis remained endemic.

He called on Member States to devise mechanisms for rapidly sharing information and urged the countries in which the disease was endemic to implement prevention and control activities with their neighbours. A staged plan should be prepared to promote technology transfer for the production of inactivated poliovirus vaccine, and special attention should be given to the use of that vaccine in developing countries. The Director-General should coordinate support to the countries in which the disease was endemic to prevent transmission, conduct risk assessment to identify areas with weak immunization coverage, and take steps to rectify the situation.

Professor BAGGOLEY (Australia) said that his Government strongly supported the global eradication of poliomyelitis and had committed to provide 50 million Australian dollars for the purchase and delivery of poliovirus vaccines. He congratulated India on remaining poliomyelitis-free for more than one year and welcomed the emergency action plans prepared by Nigeria and Pakistan. His Government urged all Member States to embrace the Global Polio Eradication Initiative, strengthen their immunization systems and support WHO in eradicating the disease. Australia endorsed the draft resolution.

Dr SLAMET RIYADI YUWONO (Indonesia) welcomed the draft resolution, which would increase global activities for poliomyelitis eradication. His Government was encouraged by the 99% decline in cases of paralytic poliomyelitis due to wild polioviruses since the Global Polio Eradication Initiative had been launched. It also recognized the need for a comprehensive endgame strategy as well as the importance of a post-eradication strategy. His country's success in eradicating poliomyelitis was attributable to the effectiveness of the trivalent oral poliovirus vaccine, and use of bivalent vaccine would complement eradication activities. The introduction into routine immunization programmes of inactivated poliovirus vaccine, however, would have financial implications and could undermine programme delivery. He therefore strongly supported the amendment proposed by the delegate of India to subparagraph 4(3) of the draft resolution.

Professor TRAORÉ (Mali) said that Mali remained at risk of wild poliovirus importation from Nigeria and the security situation in the northern part of the country could decrease the momentum of poliomyelitis eradication efforts. After a period of interruption in the circulation of the virus in 2004, one case of poliomyelitis due to wild poliovirus had been reported in 2008 and others between 2009 and 2011, demonstrating the persisting threat of international transmission. Repeated outbreaks of poliomyelitis in Mali were due not only to population movements but also to poor vaccination coverage, which had been estimated at only 74% in 2009.

Mali had carried out 16 rounds of supplementary immunization activities in 2009 and 2010, which had been synchronized with those in 19 countries, resulting in vaccination of 85 million children under five years of age. New approaches had been introduced to reduce the number of children missed during such campaigns. Despite those efforts, seven cases had occurred in 2011, the last case in October. In order to consolidate the progress made so far, five national poliovirus vaccination days had been planned for 2012. The major challenge for his country was to synchronize supplementary immunization activities in 2012 with those of other countries of West Africa, despite the security situation.

Dr DÍAZ (Chile) said that eradication of poliomyelitis was indeed a global public health emergency. Significant progress had been made under the Global Polio Eradication Initiative Strategic Plan 2010–2012, despite the difficulties encountered. He welcomed the Global Polio Emergency Action Plan and its emphasis on the need for new diagnostic tests for vaccine-derived polioviruses, the availability of bivalent oral poliovirus vaccine and the use of inactivated poliovirus vaccine. Careful planning for phased achievement of the Plan's objectives would be key to its success. His Government was considering changing its immunization strategy by replacing the oral vaccine with inactivated poliovirus vaccine, probably before global eradication had been achieved. Member States should take into account the risks associated with the use of oral poliovirus vaccine, particularly after eradication, when all oral vaccine should cease to be used. Meanwhile, a switch from trivalent to bivalent oral poliovirus vaccine would make vaccination more effective. Wild poliovirus type 2 was no longer circulating and was therefore unnecessary in vaccine used for routine immunization. His Government urged the Secretariat to design an integrated strategy to complete the eradication of poliomyelitis and endorsed the draft resolution.

Mr LAHLOU (Morocco) said that his country had recorded its last case of poliomyelitis in 1998. It had continued to carry out vaccination campaigns, and coverage in 2009 had been well over 90%. A national plan for the eradication of poliomyelitis had been submitted in 2010. To mitigate the risk of importation and re-establishment of transmission of poliovirus, his Government was working with neighbouring countries to strengthen their vaccination campaigns. It urged the Regional Office for the Eastern Mediterranean and the Regional Office for Africa to work together to draw up a plan for reducing the risk of cross-border transmission. The countries in which the disease was endemic should be given greater support in order to prevent the virus from spreading to neighbouring countries. Social, economic and political factors should be taken into account in designing immunization campaigns in those countries. Technical and financial support was essential to enable all countries to prepare national strategies, undertake surveillance and ensure that the achievements made thus far were not eroded. Countries that were poliomyelitis-free must invest the resources needed to prevent re-emergence of the disease. To that end, more effective resource mobilization policies were needed.

Dr GONÇALVES (Mozambique) said that any cases of acute flaccid paralysis in children under 15 years of age in her country were detected by passive surveillance in national health facilities or by active surveillance at community level. Surveillance performance indicators had improved between 2009 and 2011. Despite increased coverage with trivalent oral poliovirus vaccine, there remained health areas with low coverage. In 2011, four cases caused by vaccine-derived poliovirus had been detected, and the Government, with the support of partners, had instituted a mass emergency vaccination campaign. In order to be certified as poliomyelitis-free, Mozambique had to enhance surveillance and improve immunization coverage with trivalent oral poliovirus vaccine. Substantial efforts were being made to strengthen its immunization programme, despite financial constraints, and a national campaign would be conducted later in the year targeting susceptible groups.

Dr KIMANI (Kenya) said that an outbreak of wild poliovirus type 1 in his country in 2011 had been detected and investigated within four days. Six rounds of supplementary immunization had been conducted in selected districts within the year, some synchronized with those of neighbouring countries. A high-level coordination committee had been appointed to monitor poliomyelitis eradication activities and to mobilize resources. Kenya was not yet ready to switch from the oral to the inactivated poliovirus vaccine, as wild poliovirus was still circulating. In addition, the switch would entail logistics problems and have budgetary implications. His delegation therefore supported the amendment proposed by the delegate of India to subparagraph 4(3) of the draft resolution.

Mr KLEIMAN (Brazil), noting that use of oral poliovirus vaccine had been one of the keys to his country's success in achieving poliomyelitis-free status, said that his delegation also supported the proposed amendment to subparagraph 4(3) of the draft resolution. His Government stood ready to collaborate on initiatives for poliomyelitis eradication in the framework of South–South cooperation.

Dr HEMMATI (Islamic Republic of Iran) pointed out that cross-border traffic could adversely affect the poliomyelitis-free status of countries such as his own, which had borders with two of the countries in which poliomyelitis remained endemic. In his country, more than one million people were vaccinated each year, while no significant increase in vaccination rates had occurred in the neighbouring countries. His Government was willing to provide those countries with technical support for vaccination and surveillance, especially in border areas. The support of other neighbouring countries and the Regional Office for the Eastern Mediterranean in those efforts would be much appreciated. His country had achieved close to 100% coverage with routine vaccination and conducted supplementary immunization, had improved its system for surveillance of acute flaccid paralysis and had instituted a national poliomyelitis laboratory proficiency test. All stored specimens of infectious and potentially infectious materials in the national poliomyelitis laboratory had been destroyed in 2006. He endorsed the recommendations in the draft resolution and supported the proposed amendment to subparagraph 4(3).

Dr WILLIAMS (Jamaica) said that her country had eradicated wild poliovirus in 1982 and had been certified as free of poliomyelitis in 1994. Vaccination coverage was high and the Government conducted active surveillance for cases of acute flaccid paralysis. In order to lower the risk for re-importation of wild poliovirus, developed countries should share best practices and provide technical cooperation. Technical guidance from WHO would be needed as countries prepared for the shift to bivalent oral poliovirus vaccine and then from oral vaccine to inactivated vaccine. She endorsed the draft resolution.

Ms MEDINA (Ecuador) observed that her country had been free of poliomyelitis for 19 years. Vaccination coverage for the country as a whole had been above 95% since 2005, and most municipalities had achieved about 80% coverage. A national campaign had been carried out to ensure immunization of all children under seven years of age, concentrating on areas without adequate coverage. Laboratories in which wild poliovirus was stored had been assessed, and active surveillance of acute flaccid paralysis continued. She supported the draft resolution.

Dr MMBANDO (United Republic of Tanzania), expressing support for the draft resolution, said that his country continued to implement poliomyelitis eradication initiatives, with emphasis on regions and districts with low vaccination coverage and those at risk for wild poliovirus importation. Routine immunization was a core strategy, and 91% coverage with three doses of oral poliovirus vaccine had been achieved nationally. The “reaching every district” approach had contributed to that result. The last poliomyelitis case had been detected in 1996, but acute flaccid paralysis surveillance continued nationally. He drew attention to the cost and logistical implications of switching from oral to injectable poliovirus vaccine and expressed support for the amendment to the draft resolution proposed by the delegate of India. He welcomed the support provided by WHO, the GAVI Alliance and UNICEF and urged WHO to continue mobilizing resources to support the required response to outbreaks of poliomyelitis.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) agreed with the conclusion of the Strategic Advisory Group of Experts on immunization that failure to eradicate poliomyelitis would lead to a public health emergency of global proportions and was not acceptable. Cuba had eradicated wild poliovirus in 1962, but a vaccination campaign was still conducted every year. WHO was conducting research on the circulation of vaccine-derived polioviruses in Cuba, in collaboration with the Instituto Pedro Kouri. Cuba had started using inactivated poliovirus vaccine, as recommended by WHO. He supported the draft resolution.

Dr SIA (Brunei Darussalam) expressed concern over the recent outbreaks of poliomyelitis in regions and countries that had previously been free of the disease. Although there had been no poliomyelitis cases in her country since 2000, surveillance for acute flaccid paralysis continued, as maintaining high-quality, case-based surveillance and ensuring that a high proportion of the population was immunized at an early age were key strategies for controlling and eradicating poliomyelitis. In line with global recommendations, Brunei Darussalam had begun using inactivated poliovirus vaccine. She welcomed the work of the Global Polio Eradication Initiative and WHO towards the goal of eradication, which was achievable, and congratulated India on its success in combating poliomyelitis.

Dr BROU (Côte d’Ivoire) said that, despite the progress made towards the eradication of poliomyelitis, 36 cases due to imported poliovirus type 3 had been recorded in Côte d’Ivoire in 2011. Given the mobility of populations and the upheavals in his country and elsewhere in West Africa, maintaining surveillance in accordance with international recommendations was crucial. Nine supplementary vaccination campaigns, synchronized with campaigns in other countries, had been carried out in 2011 and 2012, and no cases of poliomyelitis had been recorded since July 2011. The use of different types of poliovirus vaccine by neighbouring countries was a problem in cross-border

vaccination campaigns, and he asked whether individuals vaccinated with bivalent poliovirus vaccine who entered a country in which the trivalent vaccine was used should be re-vaccinated. Despite the technical difficulties, the goal of poliomyelitis eradication had been shown to be achievable. He called for renewed efforts and adequate financing from Member States and local and international partners, and welcomed the new strategies proposed in the report. His country had recently experienced a serious political crisis and needed WHO support in order to strengthen its health system, particularly for routine vaccination.

Mr ÁLVAREZ LUCAS (Mexico) said that universal vaccination was essential and agreed that completing poliomyelitis eradication should be recognized as a global health emergency. The establishment of eradication strategies and effective surveillance were crucial. As long as poliovirus continued to circulate and the risk of importation persisted, oral poliovirus vaccine should continue to be used in regular immunization campaigns; surveillance for acute flaccid paralysis should be maintained and the capacity of laboratories to analyse samples, particularly from mobile populations, should be strengthened.

Dr SEAKGOSING (Botswana) said that his country had remained free of poliomyelitis since certification in 2005; it continued to conduct surveillance for wild poliovirus through reporting and laboratory confirmation of all suspected cases of acute flaccid paralysis and quarterly risk assessments. Botswana had achieved routine poliomyelitis immunization coverage of over 90% and had used numerous strategies to ensure that all children were immunized. In response to the outbreak in Angola in 2011, Botswana had conducted a house-to-house campaign to strengthen immunity among children under five years of age. He endorsed the draft resolution.

Ms KOBELA (Cameroon), noting that her country bordered Nigeria, said that her Government had recently implemented a contingency plan to scale up its poliomyelitis eradication activities and interrupt transmission, including increasing routine vaccination coverage to at least 88% and accelerating vaccination against other vaccine-preventable diseases, strengthening communication about the benefits of vaccination and ensuring the availability of oral poliovirus vaccine. Despite the burden they represented, Cameroon continued to conduct vaccination campaigns, particularly against poliomyelitis.

Professor Shan-Chwen CHANG (Chinese Taipei), commending the draft resolution, said that the introduction of a system to monitor the immunization status of all children in Chinese Taipei had contributed to poliomyelitis eradication. He recognized the importance of documenting vaccination, of surveillance for acute flaccid paralysis and of strong political commitment in order to ensure that countries remained free of poliomyelitis and supported the recommendation by the Strategic Advisory Group of Experts on immunization to remove Sabin polioviruses from immunization programmes. Chinese Taipei stood ready to share its experience as part of ongoing efforts to eradicate poliomyelitis.

Dr TOURE (UNICEF) welcomed the progress made globally in eradicating poliomyelitis. Millions of children were now protected against the threat of death or paralysis as a result of effective vaccination initiatives. The threat of poliomyelitis would, however, continue until eradication was complete. The number of cases reported globally was now at its lowest level, and it was essential to eliminate remaining pockets of poliomyelitis transmission. She welcomed the draft resolution and said that UNICEF was committed to continuing to work with WHO and other partners to support governments and communities in eradicating poliomyelitis globally.

Dr BELL (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation was committed to working closely with its partners in the Global Polio Eradication Initiative. She fully supported global endeavours to eradicate wild poliovirus in the three countries that remained endemic and support certification activities

thereafter. The Federation would sustain such efforts through its global network of national societies and over 13 million community-based volunteers.

Mr STENHAMMAR (Rotary International), speaking at the invitation of the CHAIRMAN, expressed support for the draft resolution. Eradication was closer than ever, but ongoing transmission in Afghanistan, Nigeria and Pakistan continued to threaten children and adults everywhere. Interruption of transmission in India was proof that eradication strategies worked when fully implemented, and the Global Polio Emergency Action Plan should therefore be fully implemented and progress reviewed by the Executive Board at its 132nd session. He noted that activities in 24 countries had been reduced or cancelled in 2012 because of a shortage of funds. Therefore, in addition to increased efforts by the countries concerned, financial support was required from the global community, including the G8 and G20 groups of countries, the European Commission and development banks, and through innovative funding mechanisms.

Dr AYLWARD (Assistant Director-General), replying to points raised by delegates, apologized for the lack of clarity in the Arabic version of the report referred to by the delegate of Oman and assured delegates that the current situation indeed constituted an emergency. After 20 years of eradication efforts, the situation had reached a tipping point. It was clear that failure would have horrific consequences for both children and adults, as had been demonstrated when outbreaks had occurred in areas that had long been free of the disease; mortality rates in those cases had been extremely high in recent outbreaks. At the same time, India's success had demonstrated that poliomyelitis could be eradicated. A timeline had been agreed with the countries in which transmission remained endemic and the Global Polio Emergency Action Plan 2012–2013 prepared, although it was recognized that activities would have to continue through 2018. The Emergency Action Plan had already been implemented in all countries. Under the Plan, responsibility for eradication programmes would extend beyond the health sector to include governments and society as a whole in the effort to ensure that all children in all countries were immunized. The approach involved innovative tools and strategies, with emphasis on improving routine immunization and on enhanced accountability and monitoring frameworks.

The heads of Government in the countries with ongoing transmission of wild poliovirus were regularly updated on the progress of the initiative. At the request of the governments of those countries, WHO was deploying nearly 2500 additional people to subdistrict level to support implementation and monitoring of activities, while UNICEF was recruiting more than 5000 additional community mobilizers to improve communication. Regular risk reviews in poliomyelitis-free areas were included in the Emergency Action Plan. The Director-General and the Regional Directors regularly discussed the poliomyelitis programme during Global Policy Group meetings and had made cross-regional coordination a priority. Thousands of hours of technical support had been provided by the regional offices. He thanked delegates for their offers of additional support.

Availability of the bivalent oral poliovirus vaccine would be somewhat limited initially, but the situation should stabilize within six months as new suppliers began production. Clearly, international spread would remain a threat until poliomyelitis had been eradicated everywhere. The goal was to conduct additional campaigns in areas at highest risk, although financing continued to be a problem. Despite the progress achieved and the evidence that the consequences of failure would be horrific, campaigns in 24 high-risk countries had had to be abandoned already in 2012 because of lack of funding. The financing prospects for the second half of 2012 were even worse, and activities would have to be curtailed in some affected areas if the funding gap could not be filled. Indeed, the availability of sufficient financing would make the difference between success and failure. Implementing the Emergency Action Plan would require at least an additional US\$ 150 million in 2012 alone.

With regard to the poliomyelitis endgame strategy and barriers to use of inactivated poliovirus vaccine, there was strong collaboration with countries, including Cuba, India, Indonesia and Oman, and with vaccine manufacturers to ensure that the problems were addressed. Research was under way

on reducing the number of doses needed, optimizing the antigen content, fractional dosing and technology transfer. Major breakthroughs had been made that would bring product costs down, probably by more than 50% or in some cases 75%. Nevertheless, inactivated poliovirus vaccine would always be more expensive than the oral vaccine. WHO, with the GAVI Alliance, UNICEF and other partners, was exploring potential financing options to ensure a smooth transition from trivalent to bivalent oral poliovirus vaccine for routine immunization in countries using oral poliovirus vaccine, coupled with the use of inactivated poliovirus vaccine in countries that deemed it necessary to vaccinate against type 2 poliovirus. Those issues would be addressed in the 2014–2018 endgame strategy, which was being prepared for consideration in regional consultations before being submitted to the Strategic Advisory Group of Experts on immunization in November 2012 for an initial review. He thanked all partners for their technical and financial support and commended the efforts of countries with endemic transmission of wild poliovirus to achieve eradication.

The DIRECTOR-GENERAL said that progress in eradicating poliomyelitis had been made thanks to the combined efforts of countries with endemic transmission of wild poliovirus, partners and experts, in particular the Independent Monitoring Board, the Strategic Advisory Group of Experts on immunization, the United States Centers for Disease Control and Prevention, and the Bill & Melinda Gates Foundation. Political commitment to, and ownership of, eradication efforts in countries with endemic transmission of wild poliovirus was encouraging and was essential to eradication, as had been demonstrated in India. Poliomyelitis eradication had reached a point where failure was not an option, as the cost in human terms would be disastrous, and the credibility of public health would be undermined. She therefore urged all partners to ensure that lack of funding did not lead to failure. All those concerned must redouble their efforts and their accountability for delivering results. It was to be hoped that declaring the situation a programmatic emergency would tip the scales towards success.

The CHAIRMAN invited the Secretary to read out the proposed amendments to the draft resolution.

Dr DAYRIT (Secretary) said that the delegate of Thailand had proposed an additional preambular paragraph 6bis, which would read: “Having noted the current high cost and limited supplies of inactivated polio vaccine that are hampering the introduction and scaling-up of inactivated polio vaccine, resulting in major programmatic and financial implications to developing countries”. In subparagraph 3(4), the delegate of the United States of America had proposed that the word “epidemic” be replaced by “epidemiologic”.

In subparagraph 4(3), the delegate of India had proposed deletion of the phrase “that exploits new developments in poliovirus diagnostics and inactivated poliovirus vaccines”. Lastly, the delegate of Thailand had proposed two amendments to subparagraph 4(4), which would thus read: “to coordinate with all relevant partners, including vaccine manufacturers, to promote the research, production and supply of vaccines, in particular inactivated polio vaccines, to enhance their affordability, effectiveness and accessibility”.

Dr KIMANI (Kenya) observed that much of the progress achieved towards the goal of eradication was due to use of the trivalent oral vaccine. A switch to the injectable inactivated vaccine would be more expensive for developing countries, with no guarantee that it would be as effective. The live attenuated oral vaccine had many advantages in countries where environmental sanitation conditions were poor. Member States should be made fully aware of all the implications before making the switch. He supported the amendment proposed by the delegate of India.

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

The draft resolution, as amended, was approved.¹

Nutrition: Item 13.3 of the Agenda (continued)

- **Maternal, infant and young child nutrition** (Documents A65/11, A65/11 Corr.1) (continued from the eighth meeting, section 4)

Ms WISEMAN (Canada) said that, following informal consultations, it was proposed to amend the draft resolution presented during the previous meeting such that subparagraph 2(1) would read: “developing or, where necessary, strengthening nutrition policies so that they comprehensively address the double burden of malnutrition and include nutrition actions in overall country health and development policy, and establishing effective intersectoral governance mechanisms in order to expand the implementation of nutrition actions with particular emphasis on the framework of the global strategy on infant and young child feeding.”

A new subparagraph 2(4) would read: “implementing a comprehensive approach to capacity building, including workforce development.”

Subparagraph 3(1) would read: “to provide clarification and guidance on the inappropriate promotion of foods for infants and young children as mentioned in resolution WHA63.23, taking into consideration ongoing work of the Codex Alimentarius.”

Subparagraph 3(3) would read: “to develop risk assessment, disclosure and management tools to safeguard against possible conflicts of interest in policy development and implementation of nutrition programmes consistent with WHO’s overall policy and practice.”

A new subparagraph 3(4) would read: “to report to the Sixty-seventh World Health Assembly through the Executive Board on progress in the implementation of the comprehensive implementation plan together with the report on implementation of the Code of Marketing Breast-milk Substitutes and related WHA resolutions.”

Dr ZWANE (Swaziland), speaking as a cosponsor of the draft resolution, thanked the Committee for its enthusiastic response and urged Member States to continue to support the Secretariat in its work.

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

The draft resolution, as amended, was approved.²

Monitoring of the achievement of the health-related Millennium Development Goals: Item 13.5 of the Agenda (Documents A65/14, A65/15 and EB130/2012/REC/1, resolution EB130.R3)

- **Progress in the achievement of the health-related Millennium Development Goals, and global health goals after 2015**
- **Implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health**

Dr LARSEN (representative of the Executive Board), introducing the item, said that the Board at its 130th session had adopted resolution EB130.R3 on monitoring of the achievement of the health-related Millennium Development Goals: implementation of the recommendations of the Commission

¹ Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA65.5.

² Transmitted to the Health Assembly in the Committee’s third report and adopted as resolution WHA65.6.

on Information and Accountability for Women's and Children's Health, which recommended a resolution for adoption by the Health Assembly.

Ms STIRØ (Norway) said that, although the Millennium Development Goals and targets had not yet been fully achieved and progress was uneven, many were on track. The United Nations Secretary-General's Global Strategy for Women's and Children's Health had given new impetus to efforts to achieve Goals 4 and 5. The Strategy had had significant mobilizing power, and more than US\$ 40 billion had been committed so far. The main goal was to save 16 million lives by 2015. The need to track commitments had led to establishment of the Commission on Information and Accountability for Women's and Children's Health. The aim of the draft resolution contained in resolution EB130.R3 was to build on the recommendations in the Commission's final report for effective institutional arrangements for national and global reporting, oversight and accountability on women's and children's health. With regard to the post-2015 development agenda, the formidable task of eradicating extreme poverty, hunger and maternal and child mortality would require intensified efforts. In view of the growing epidemic of noncommunicable diseases, the focus should be on prevention and on health system strengthening. Health challenges were closely linked to food security, nutrition, energy, clean air, sanitation and safe drinking-water. The new agenda should therefore include the security aspects of development, linked to the rule of law, human rights and good governance. Changing geopolitical and economic realities that affected the political balance between countries should also be taken into account. Most importantly, the future development agenda must be clear and retain the mobilizing power of the present Goals.

Dr HUSAIN (Bahrain), noting that the draft resolution did not mention the threat posed by chronic noncommunicable diseases, said that health systems should have the capacity to provide high-quality services to everyone. The existence of a health infrastructure providing health care services at various levels had contributed towards the progress made by Bahrain in achieving the health-related Millennium Development Goals. For example, the country had seen a decrease of more than two thirds in infant mortality and rates of HIV infection and tuberculosis had fallen. The country had been free of malaria since 1988. The Millennium Development Goals could not be achieved without cooperation between governments and nongovernmental organizations. The WHO reform process should enable the Organization to face the numerous challenges and also undertake the actions required.

Dr McMILLAN (Bahamas) said that uneven progress among and within countries suggested that much remained to be done, both before and after 2015. While childhood malnutrition was not a serious problem in her country, overweight and obesity were increasingly prevalent among children. A multisectoral initiative was addressing the problem. To further progress in reducing child mortality, five new antigens would be introduced into the national immunization programme within two years. In that connection, she wished to highlight the need for urgent attention to the issue of vaccine availability for developing countries that were not eligible for support from the GAVI Alliance but did not have the means to introduce expensive new vaccines on their own.

The small island States of the Caribbean remained concerned about the method used to calculate maternal mortality ratios. A denominator of 100 000 was too large for countries with small populations and yielded ratios that were higher than the true values. Small nations were often able to report actual numbers, which might better reflect the current situation. Her Government supported the recommendations contained in document A65/14 and looked to the Secretariat and to the Regional Office for the Americas for continued support of Member States' efforts to achieve the Millennium Development Goals.

Mr SMIDT (Denmark), speaking on behalf of the European Union and its Member States, the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process

and potential candidates Albania and Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia, said that those countries welcomed the progress made towards the health-related Millennium Development Goals and in implementing the United Nation's Secretary-General's Global Strategy for Women's and Children's Health. They were concerned, however, that many developing countries, particularly in sub-Saharan Africa, were unlikely to achieve Goals 4 and 5. Major efforts were therefore required to close the gaps in access to reproductive health services between regions and between and within countries. The Secretariat should analyse the uneven progress in order to identify the factors responsible and possible solutions. Health systems should be further strengthened and actions to prevent child and maternal mortality enhanced through, inter alia, programmes aimed at removing obstacles to women's health, including discriminatory laws and practices. Attainment of the health-related Millennium Development Goals depended on enhancing gender equality and the empowerment of women.

It was of particular concern that most young people had limited access to sexual and reproductive health programmes that provided gender-specific information, including comprehensive sexuality education, as well as contraceptives and social support. Access to treatment for sexually transmitted infections was also inadequate. He welcomed the momentum created by the Political Declaration of the United Nations High-level Meeting on HIV/AIDS in 2011 and emphasized the pressing need to eliminate mother-to-child transmission of HIV and achieve universal access to interventions for prevention and treatment of HIV infection.

A more comprehensive approach to global health goals after 2015 should be encouraged, one that emphasized the right to health, universal coverage, social protection and social determinants of health. WHO should highlight the role of health not just as a goal in itself but as an indicator of sustainable development. He urged Member States to engage in discussions before the global consultation on the health-related Millennium Development Goals with a view to establishing a coordinated, coherent review. The European Union was pleased to have been one of the cosponsors of the draft resolution contained in resolution EB130.R3 and looked forward to its adoption.

Dr NOZAKI (Japan) expressed support for the various strategies and initiatives aimed at achieving the Millennium Development Goals, including the Global Strategy for Women's and Children's Health and the 2011 Political Declaration on HIV/AIDS. He welcomed the recommendations of the Commission on Information and Accountability for Women's and Children's Health and the recently developed accountability framework. He emphasized the role of intersectoral collaboration in maximizing the effectiveness of interventions. His Government had undertaken studies of cooperation between the health, water and social security sectors in several countries and had found the intersectoral approach useful in identifying vulnerable groups requiring support. The discussions on global goals after 2015 should not adversely affect the momentum towards achieving the current Goals. There should be continuity between the new goals and current ones. He encouraged WHO to continue its leadership role after 2015.

The meeting rose at 17:30.

TENTH MEETING

Friday, 25 May 2012, at 18:40

Chairman: Mr H. BARNARD (Netherlands)

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

Monitoring of the achievement of the health-related Millennium Development Goals: Item 13.5 of the Agenda (Documents A65/14, A65/15 and EB130/2012/REC/1, resolution EB130.R3) (continued)

- **Progress in the achievement of the health-related Millennium Development Goals, and global health goals after 2015** (continued)
- **Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health** (continued)

Dr NOUR ELDIN (Egypt), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the numerous inequities caused by the global economic crisis would continue to prevent many countries, even those that had made significant progress, from meeting their health-related Millennium Development Goal targets. The impact on the poor of increasing unemployment was severe and, while under-five child mortality in the Region might have fallen by 38% by 2010, some countries would be unable to meet Target 4.A (Reduce by two thirds, between 1990 and 2015, the under-five mortality rate) if the crisis continued. Stronger partnership between countries could help those that were lagging behind to introduce into their national strategies the necessary measures to accelerate progress.

Dr HEMMATI (Islamic Republic of Iran) stressed that a more efficient approach to the challenges posed by economic hardship and health inequities was needed in order for countries to achieve the health-related Millennium Development Goals. Those already making progress could improve their performance through better programming at the local and district levels, which called for political commitment and a comprehensive national plan. A strong health system was also important, and his Government was willing to share its experience in developing and strengthening primary health care. Consistent monitoring of indicators, such as noncommunicable disease rates and conditions in so-called "hidden cities", had been crucial to his country's progress towards attaining the Goals. Performance levels in different regions could be improved through collaborative efforts to establish an interregional monitoring system.

Mr DEANE (Barbados), noting that his Government had prioritized poverty reduction and established an interministerial committee to strengthen the social safety net, said that Barbados had made reasonable progress towards attaining the health-related Millennium Development Goals. Rates of child and maternal mortality, HIV/AIDS-related deaths and mother-to-child transmission of HIV had remained low, and continuous research on levels of awareness, attitudes and practices in vulnerable groups ensured that behavioural change and communication strategies were based on empirical evidence. Close partnerships were considered pivotal to development at the national, regional and international levels. Given the gaps within and between countries, WHO needed to work with development partners to ensure that social determinants of health and equity were taken into

account in all decision-making, and that the global health goals for the period beyond 2015 included action to tackle noncommunicable diseases. His delegation supported the draft resolution contained in resolution EB130.R3.

Dr GOPEE (Mauritius), speaking on behalf of the Member States of the African Region, said that too little progress had been made towards the achievement of the health-related Millennium Development Goals. There had been improvements over the previous ten years, with declines in under-five child mortality, maternal mortality and HIV/AIDS prevalence. But significant disparities persisted between and within countries. The biggest reductions in child mortality, for instance, had been recorded in wealthy urban areas. Poor countries lacked essential medicines and technologies, domestic resources were often ignored in favour of external resources unsuited to local priorities, and national health systems were too weak to ensure access to affordable, quality services. Strengthening those systems, developing comprehensive community-based primary health care, and mainstreaming gender and human rights into health programmes remained major challenges, as did addressing the health effects of unplanned urbanization, population ageing, climate change and the current food and financial crises. Without robust monitoring and evaluation frameworks to provide the appropriate evidence, good intentions could not be converted into effective action to improve people's lives.

Countries needed to learn from past successes and failures, assess their performance and set targets in line with their needs and priorities, with an emphasis on actions likely to have a multiplier effect on growth and prosperity, such as increasing access to drinking-water and energy, boosting agricultural production and expanding opportunities for women and girls. Existing structures and mechanisms needed strengthening for more efficient and sustainable mobilization and use of resources. In view of the continuing health inequities throughout the Region, it was essential for African countries to place the Rio Political Declaration on Social Determinants of Health high on their political agenda. With few likely to achieve the health-related Goals by 2015, all existing policies and strategies must be reviewed without delay, and accountability must be a core principle of all activities aimed at achieving the Goals.

Mr KLEIMAN (Brazil) said that his country had made significant progress towards meeting the health-related Millennium Development Goal targets. Some, such as the target for the under-five child mortality rate, would be met before 2015. His Government, backed by a strong partnership with civil society, had been the first in a developing country to provide free universal access to HIV/AIDS treatment. Despite a 50% fall in maternal mortality, however, Target 5.A (Reduce by three quarters the maternal mortality ratio) remained a major challenge. The Government had adopted a policy of tackling the preventable causes and setting priorities in accordance not only with maternal and child health needs but also with women's needs and rights.

With regard to post-2015 global health goals, any new proposals should be examined with caution and the emphasis should remain on meeting the existing targets. In addition to the progress review by the United Nations General Assembly in 2013, his Government would support the idea of holding another event in 2015 or 2016 to assess progress and plans for the post-2015 period. Any decisions regarding follow-up on the Millennium Development Goals should be taken by Member States.

Mr CRUZ TORUÑO (Nicaragua) suggested that a range of measures were needed to support developing countries in meeting the health-related Millennium Development Goal targets, covering areas from nutrition through cheaper vaccine and generic medicine production to climate change adaptation, risk management and disaster response. His Government had invested heavily in human development and appreciated the technical and financial assistance provided by international health partners and other countries. Chinese Taipei, for instance, had participated in many cooperation programmes to improve the quality and coverage of health services, especially in emergency situations, and had made a valuable contribution to the prevention and control of epidemics and the fight against HIV/AIDS, malaria, tuberculosis and noncommunicable diseases. Nicaragua therefore

supported its continued participation in the Health Assembly and its wider involvement in other WHO bodies and meetings.

Dr SAENGNAPHA UTHAISAEANGPHAISAN (Thailand), referring to the report contained in document A65/14, requested the Secretariat to provide more details on condom use, which was a key indicator for Millennium Development Goal 6 (Combat HIV/AIDS, malaria and other diseases). The information on multidrug-resistant and extensively drug-resistant tuberculosis should also be expanded. In view of the number of countries unlikely to attain Goals 4 (Reduce child mortality) and 5 (Improve maternal health), her delegation welcomed the efforts made to accelerate progress within the framework of the United Nations Secretary-General's Global Strategy for Women's and Children's Health, and the recommendations of the Commission on Information and Accountability for Women's and Children's Health. The Director-General and development partners should follow up on the first recommendation by providing developing countries with capacity-building support for national health information systems. Generating local information was essential in order to fulfil commitments to achieve universal health coverage, and a particular emphasis should be given to the strengthening of vital statistics systems. It might take time for the "Every Woman Every Child" movement to produce tangible results but, with strong leadership and the commitment of Member States, a substantial improvement could be seen by 2015.

Dr GONG Xiangguang (China) said that his country expected to meet health-related Millennium Development Goal targets 6.B (Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it) and 4.A by 2015. Others, such as Target 5.A, however, were more challenging. Improved monitoring and information sharing were essential to accelerating progress. It was important to take stock of experience gained and lessons learnt, to consider the imbalances between countries and regions when setting goals, and to establish a platform for international cooperation. WHO should strive to increase the visibility of the health-related Goals within the United Nations system in order to secure more resources.

Mr URQUIDO VELASQUEZ (Colombia) noted that his country had made significant progress towards meeting the health-related Millennium Development Goal targets through its efforts in areas such as immunization, nutrition, access to antenatal care and institutional delivery, malaria control and rural sanitation. The child mortality target would certainly be met, however significant subnational disparities remained with regard to maternal mortality and adolescent birth rates, which would make achieving the related targets difficult. Those disparities also constituted a real challenge in terms of equity. Colombia supported the Global Strategy for Women's and Children's Health and the draft resolution contained in resolution EB130.R3.

Dr SLAMET RIYADI YUWONO (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, reported that they had all made a great deal of progress towards achieving the health-related Millennium Development Goals, especially since 2005. Some targets would be met before 2015, but others might be hard for countries with large populations to meet without an upsurge in capacity. A recent study had shown glaring disparities that suggested a need for a sustained focus at the subnational level. Given the importance of access to reliable data for monitoring progress at both the national and regional levels, the Member States of the Region supported the Regional Office's plans to strengthen the regional health information system for the collection, analysis and use of such data. They appreciated the technical support of the Health Metrics Network and urged it to support the mobilization of further resources.

With regard to the draft resolution, the Member States of the Region suggested that subparagraph 2(2) should be amended to read: "strengthening their capacity to monitor, including utilizing local evidence, and evaluate progress to improve their own performance".

Ms CAMERON (Canada) expressed her country's continued commitment to accelerating progress towards the achievement of the health-related Millennium Development Goals with particular regard to child, newborn and maternal health, and an emphasis on investment in child education and gender equality. Canada welcomed WHO's efforts to mainstream gender, equity and human rights into all policies and programmes. It was an approach that should also be encouraged at the country level. Member States and partners should consider how to use the United Nations International Day of the Girl Child to raise awareness of the challenges and vulnerabilities faced by girls and to advocate for further progress towards attainment of the Goals. The number of cosponsors of the draft resolution demonstrated the global momentum behind the issue. Her Government welcomed the report presented in document A65/15 and acknowledged the efforts of Member States and partners to honour their commitments to the Global Strategy on Women's and Children's Health. It looked forward to the findings of the independent Expert Review Group referred to in paragraph 8 of the document.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) affirmed that the Millennium Development Goals had been key to the unprecedented global political consensus on development. It was crucial to maintain progress on the health-related Goals. To that end, her Government, together with the Bill & Melinda Gates Foundation, would be hosting a summit in July 2012 aimed at generating global commitments to improve access to family planning. The post-2015 framework needed to build on strengths, improve on weaknesses and support an ambitious new agenda relevant to different challenges.

Dr PRASAD (India) said that his country had achieved a steady decline in maternal and child mortality through a policy of promoting universal access to maternal, newborn and child health care, with a particular emphasis on feeding, immunization and the treatment of diarrhoeal and acute respiratory diseases. Its success in reducing the prevalence of HIV/AIDS, malaria and tuberculosis, however, had been offset by an increase in multidrug-resistant tuberculosis. That was a matter of great concern that required serious attention and guidance from WHO.

With regard to post-2015 health goals, it was essential to build on the progress to date and to set targets aimed at tackling health inequities within countries, taking action on the risk factors for noncommunicable diseases, promoting universal access to quality health care, and strengthening health systems. Political commitment would be of the utmost importance.

Dr GUILLÉN (Paraguay) drew attention to the progress that her country had made as a result of improvements in its national health system, the development of an integrated health services network, and the expansion of primary health care coverage to underserved populations. Infant and under-five child mortality had dropped by 50% and 53%, respectively, between 1990 and 2010, and maternal mortality had fallen by 40% over the previous 10 years, although the figures varied for different parts of the country. An estimated 10%–20% of the reduction in under-five mortality had been due to an increase in measles immunization coverage, and the addition of new vaccines to the routine immunization programme was expected to result in further declines. Although the incidence of HIV/AIDS in the 15–24-year age group had risen, antiretroviral treatment had been extended to 60% of those infected. Tuberculosis incidence had declined significantly since 1990, but the target of 50% reduction had not yet been achieved. Only five cases of malaria had been reported in 2011, and the relevant target had thus been achieved three years before 2015.

As for the post-2015 agenda, the challenge was to build on progress to date by strengthening the integration of health services networks, promoting intersectoral efforts to tackle social determinants of health and social protection, and highlighting the role of health in social, economic and environmental development.

Mr DE SANTIS (Switzerland), welcoming the progress reported in document A65/14, emphasized the importance of health system strengthening for sustaining the gains made and attaining the health-related Millennium Development Goals, especially in the areas of malaria control and child and maternal mortality. His Government remained committed to working with partners to strengthen health systems. With regard to the post-2015 development agenda, new health challenges called for a comprehensive, intersectoral approach aimed at achieving universal coverage and tackling social determinants of health. WHO should take advice from Member States in formulating health goals that would contribute to sustainable development.

Dr YEARWOOD (Trinidad and Tobago) said that her country had made great progress towards attaining the health-related Millennium Development Goals. Significant reductions in infant, under-five and maternal mortality had been achieved as the result of, inter alia, the provision of free pre-natal, post-natal and paediatric care. Antiretroviral therapy was being provided at public health facilities, including to children, and mother-to-child transmission of HIV had been reduced. Steps were being taken to strengthen preventive activities and enhance laboratory capacity. As to the post-2015 agenda, experience had shown the need for a holistic “health in all policies” approach.

Dr PHOLSENA (Lao People’s Democratic Republic), affirming his Government’s commitment to meeting the health-related Millennium Development Goal targets by 2015, said that his country was on track to achieve Goals 4 and 6, as well as Target 7.C (Halve, by 2015, the proportion of the population without sustainable access to safe drinking water and basic sanitation). However, it still faced many challenges in tackling maternal mortality, malnutrition and health inequities. The Government had therefore increased the health sector budget to 9% of total expenditure and was considering a programme to provide free care for all mothers, and all children under five years old.

Dr YANG Sung-hoon (Republic of Korea) said that his country regarded maternal and child health as a priority for its official development assistance for health, which was allocated, inter alia, to projects providing specialist training for midwives and assisting in the construction of primary health care infrastructure. His Government welcomed the draft resolution and looked forward to full implementation of the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health.

Dr MMBANDO (United Republic of Tanzania) welcomed the progress made in implementing the recommendations of the Commission on Information and Accountability for Women’s and Children’s Health. Among the key stages to date, he drew particular attention to the elaboration of the workplan to develop tools and actions; a regional workshop for 10 African countries; and a meeting of national stakeholders to refine his country’s road map. The support of development partners had been greatly appreciated. With the 2015 deadline approaching for the Millennium Development Goals, annual reporting by the Secretariat and the independent Expert Review Group was essential. He supported the draft resolution.

Dr MAKUBALO (South Africa), expressing concern that many countries would be unable to meet the Millennium Development Goal targets by 2015, said that her country was making good progress. There had been a significant reduction in infant mortality; over 20 million people had been tested for HIV/AIDS and 1.7 million were receiving antiretroviral treatment; and there had been a 50% drop in mother-to-child transmission of HIV. Tuberculosis, however, remained a major concern, and the Government was working with national and international development partners on a programme to tackle high rates of the disease among miners. New technology for the detection of multidrug-resistant tuberculosis had recently been introduced.

It was essential to follow up on the hard work done to date, to invest in the post-2015 agenda and to consider how best to mainstream social determinants of health into programmes in order to

accelerate progress and achieve expected outcomes. Continued reporting and accountability would be crucial. South Africa supported the draft resolution.

Dr WILLIAMS (Jamaica) said that her country, despite steady improvement, was unlikely to meet the target for reduced infant mortality. Neonatal deaths accounted for the vast majority of infant deaths. The maternal mortality ratio currently stood at 86.3 per 100 000 live births; a 49% decrease in deaths from direct causes such as haemorrhage had been negated by an 83% increase in deaths from indirect causes related to chronic noncommunicable diseases. About 1.7% of the adult population was infected with HIV, and about half were unaware of their status; the majority of cases in the 10–25-year age group were known to be girls and young women. Increased access to antiretroviral treatment had helped to reduce mother-to-child-transmission to less than 5%.

She encouraged the Secretariat to support countries in taking stock of lessons learnt and to help to document proven strategies for the completion of the current agenda. Her Government, for its part, was seeking to overcome its challenges by mainstreaming health into its medium-term national development plan. She supported the draft resolution.

Mrs MEBRAHTU (Ethiopia), welcoming the recommendations of the Commission on Information and Accountability for Women's and Children's Health, said that Ethiopia was on course to meet the health-related Millennium Development Goal targets but still needed coordinated support from partners in order to accelerate progress on maternal mortality and mother-to-child transmission of HIV. Such support had already helped to reduce under-five mortality by almost 58% by 2011. Best practices should be consolidated and bottlenecks removed in areas where progress was slow in order to focus on the key issues and come up with practical solutions.

Regarding implementation of the Commission's recommendations, robust monitoring and evaluation systems were needed to track progress and take corrective measures. They should build on existing systems and mechanisms and contribute to the strengthening of national health systems. The use of information and communication technology and eHealth systems would provide accurate data for decision-making and accountability, but it called for appropriate infrastructure and human resources. The technologies must be simple, affordable and tailored to each country's needs. The budget support pledged for implementation of the Commission's recommendations should also be aligned with country-led initiatives.

Mr ÁLVAREZ LUCAS (Mexico), recognizing the progress made towards the achievement of the health-related Millennium Development Goals, emphasized the need for continued monitoring until all targets had been met and for the promotion of integrated policies to combat social and economic inequities. His Government endorsed the measures recommended by WHO and other intergovernmental agencies to accelerate reductions in maternal mortality and to prioritize adolescent reproductive health with a view to preventing HIV/AIDS and eliminating violence against women. He urged the Health Assembly to support national programmes aimed at countering the threat of drug-resistant tuberculosis, and to encourage the relevant institutions to reconsider the eligibility criteria for beneficiaries of international funding. As for malaria, significant progress had been made in Mexico and the number of new cases reported was currently the lowest in the history of its national programme. He called on Member States to promote regional collaboration in border areas so as to prevent a resurgence of transmission as a result of cross-border movements in areas where the disease had been brought under control.

Dr AL-TAAE (Iraq) said that his Government had decided to approach the health-related Millennium Development Goals as a whole rather than individually, which had helped to promote effective intersectoral partnership. Health was not the sole responsibility of the health sector, and the principle of active partnership had been incorporated into the strategies of other ministries as well as into the overarching national development plan. That approach had resulted in some significant successes, such as a 70% reduction in child mortality. His Government had further decided to combine

action on noncommunicable diseases with efforts to combat HIV/AIDS, malaria and other diseases (Goal 6), and had set itself a ninth goal: achieve human security and human rights.

Dr SEAKGOSING (Botswana) said that his Government's actions in respect of child mortality had centred on combating diarrhoea through education on oral rehydration therapy and through the involvement of community health workers. It had also revised the national immunization schedule to include new vaccines; while the coverage rate stood at well over 90%, however, there were still pockets of resistance to immunization and areas that were hard to reach. With regard to maternal health, the recommendations of the country's maternal mortality audit system had led to improved emergency obstetric and newborn care delivered by trained health workers, and family planning had been integrated into reproductive health programmes. The national antiretroviral treatment programme had contributed to significant reductions in HIV/tuberculosis coinfection. Great progress had also been made in reducing the incidence and impact of malaria.

Dr BELO (Timor-Leste) reaffirmed her Government's commitment to achieving the health-related Millennium Development Goals and expressed gratitude for the support it had received for that purpose from United Nations agencies, nongovernmental organizations and community groups. While fertility rates and infant mortality had fallen in Timor-Leste, other indicators gave cause for concern. The Government had therefore launched a range of initiatives to improve standards of care, including the education and training of midwives and nurses, the recruitment of staff from Indonesia to fill posts in remote areas, improved monitoring of maternal and child health, and the establishment of maternity clinics in all community health centres. A new coordination and communication mechanism had been established for integrated resource allocation, with the assistance of several external partners. WHO's support remained crucial to the country's efforts to attain the Goals by 2015.

Dr NGOZI AZODOH (Nigeria) said that, despite significant improvements in women's and children's health, Nigeria was unlikely to meet all the Millennium Development Goal targets by 2015. The increasing burden of noncommunicable diseases on the national health system was of particular concern, and her Government urged WHO to support the inclusion of relevant indicators under Goal 6. Her delegation commended the Director-General on her input in the discussions on the post-2015 development agenda and urged her to ensure continued attention to the goals for child mortality and maternal health, as they were still of vital importance to her subregion.

Professor Shan-Chwen CHANG (Chinese Taipei), expressing support for the Global Strategy for Women's and Children's Health, noted that some significant progress had been made towards child and maternal mortality targets, but progress across countries had been uneven. The key, in Chinese Taipei's experience, was a health system with universal coverage. Chinese Taipei's active participation in promoting maternal and child health in Africa, Central America and the South Pacific region had yielded remarkable results. It had already proposed a post-2015 action plan on women's and children's health and would be pleased to continue offering support and sharing its experience with the international community.

Mr LEFEBVRE (International Federation of Medical Students' Associations), speaking at the invitation of the CHAIRMAN, commended the emphasis placed by the Secretariat on the United Nations Conference on Sustainable Development (Rio+20) and acknowledged the efforts of governments, civil society and WHO to ensure that health had a place in the debate. Public health and sustainable development were closely interconnected and the Organization was to be congratulated for having linked the latter to its own reform process. To ensure that the "health in all policies" approach was reflected more adequately in the Conference outcome document, the Secretariat should consider highlighting the health benefits, among others, of sustainable development policies and the links between climate change, air pollution and respiratory diseases; advocating the use of health indicators as a measure of sustainable development policies; and ensuring that the institutional framework for

sustainable development included a mechanism for long-term international policy assessment. Member States should make a voluntary commitment to ensuring the sustainability of their national health systems.

Ms TEN HOOPE-BENDER (International Confederation of Midwives), speaking at the invitation of the CHAIRMAN, noted that little or no progress had been made towards meeting the maternal mortality reduction target in one quarter of the countries with the highest maternal mortality ratio. Less than 50% of births were attended by skilled health professionals in three WHO regions; just 55% of women received four or more antenatal visits; and standards of equally important postnatal care were low. In view of the key role of midwives in providing care before, during and after delivery, including their role in detecting noncommunicable diseases and ensuring referrals to other health providers, WHO should take immediate steps to scale up midwifery services. More funding was needed for the attainment of Millennium Development Goals 4 and 5.

Mrs EARDLEY (World Vision International), speaking at the invitation of the CHAIRMAN, welcomed the progress made in implementing the recommendations of the Commission on Information and Accountability for Women's and Children's Health. However, while a significant amount of funding had been pledged, more than half of the US\$ 88 million required had yet to be disbursed. The independent expert review group established with the support of WHO had spent the previous year actively reaching out to a wide range of stakeholders. WHO and its partners should use the review group's transparent and inclusive approach as a model for securing civil society participation in developing a road map of priority activities for implementing the Commission's accountability framework. Further investment would be needed in strong accountability mechanisms at the local level to enable communities to contribute to local and national reviews. World Vision International stood ready to provide support to strengthen civil society engagement.

Ms KUSANO (International Council of Nurses), speaking at the invitation of the CHAIRMAN, applauded the progress made on a number of the health-related Millennium Development Goal targets, such as reducing maternal and child mortality and combating HIV/AIDS and tuberculosis. Investment in tested measures was needed in order to accelerate progress towards the other Goals. Major challenges included weak health systems and migration and shortage of health professionals. In view of the key role of those professionals, WHO and its partners must give high priority to addressing the human resources for health crisis through effective recruitment and retention strategies.

Dr KIENY (Assistant Director-General), thanking delegates for their comments on the reports, said that it had been encouraging to hear how much progress had been made towards the achievement of the health-related Millennium Development Goals. At the same time, several delegates had stressed the need to strengthen health systems, to achieve universal health coverage, and to reduce inequities within and between countries as well as the importance of social determinants of health in meeting those needs. The Secretariat welcomed the support of Member States for implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health. The Commission's accountability framework provided a unique opportunity to strengthen the monitoring of results and tracking of resources for national and global reviews, which should lead to more effective actions for health in general and for women's and children's health in particular. WHO was working with other United Nations agencies, global health partnerships, parliamentarians, civil society and many other stakeholders around the world to implement the framework, which was relevant to the entire health sector. An independent expert review group had begun its work on the implementation and on examining the ways in which all stakeholders were fulfilling their promises to support the goals of the Global Strategy for Women's and Children's Health. It would deliver its report in September 2012, and the Secretariat would report to the Health Assembly the following year on the progress made.

The Secretariat had noted delegates' comments on the importance of health to the post-2015 development agenda. A background paper on the subject, prepared in collaboration with UNICEF, UNFPA and UNAIDS, would be published as part of a report by a United Nations task team assigned to support the development of that agenda. The report would be provided to the United Nations Secretary-General, who planned to establish a high-level panel after the Rio+20 Conference. Many country and global consultations would take place on the post-2015 agenda in the year ahead. WHO would take the lead in organizing a global thematic consultation on health and looked forward to the active participation of Member States.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB130.R3, as amended by the delegate of Indonesia on behalf of the Member States of the South-East Asia Region.

The draft resolution, as amended, was approved.¹

Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011): Item 13.6 of the Agenda (Documents A65/16 and EB130/2012/REC/1, resolution EB130.R11)

Dr LARSEN (representative of the Executive Board) reported that the Executive Board, at its 130th session in January 2012, had reviewed the outcome of the World Conference on Social Determinants of Health, including progress on implementation of resolution WHA62.14. It had adopted a resolution recommending that the Sixty-fifth World Health Assembly endorse the Rio Political Declaration on Social Determinants of Health, which expressed a global commitment to the implementation of a social determinants of health approach to reducing health inequities and promoting development. The Health Assembly was invited to consider the draft resolution contained in resolution EB130.R11.

Mr LASKAR (Bangladesh), commending WHO for having organized the World Conference on Social Determinants of Health, stressed the importance to least developed countries of its support in integrating health into their social, economic and environmental policies through the training of managers, health sector workers and national policy-makers. In view of the need to reduce inequities in global health, WHO should continue to support policy-making and standard setting aimed at ensuring equitable access to health services and to high quality, safe and effective generic medicines. Research on the factors influencing the health care-related decisions of households should help to frame policies for improving health equity in rural and urban areas. He urged the Health Assembly to recommend that the Rio+20 United Nations Conference on Sustainable Development pay particular attention to the economic, social and environmental determinants that threatened to undermine efforts to achieve universal health care coverage and sustainable financing. He supported the draft resolution.

Mr KLEIMAN (Brazil) said that his Government had been honoured to host the World Conference on Social Determinants of Health. The outcome document, the Rio Political Declaration on Social Determinants of Health, called for the promotion of health equity through intersectoral action in the five priority action areas outlined in paragraph 6 of document A65/16. Work in those action areas should begin immediately at the global, regional and national levels. The Health Assembly should consider the recommendation in the Declaration that the social determinants of health approach be duly considered in the WHO reform process. Through action to address the social determinants of health, the Organization could demonstrate its authority in the field of health and fulfil its mandate. WHO should champion the "health in all policies" approach and apply its technical

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.7.

expertise in advising Governments on how to prevent disease by applying that approach and mainstreaming health into social, environmental and economic policies in areas such as sanitation, transportation, pollution prevention and access to clean water. He urged the Health Assembly to adopt the draft resolution and to closely monitor and contribute to its implementation at all levels.

Dr GONG Xiangguang (China) commended the report and the action taken in connection with social determinants of health. In principle, his delegation supported the draft resolution. Drawing on its research and experience in the area, WHO should continue working to identify health determinants, to consolidate its global leadership and coordinating role, and to formulate a global framework of norms, standards and action plans. Social determinants of health should be incorporated into all areas of the Organization's work and into that of other international organizations. The financial and administrative implications of the adoption of the draft resolution should be considered within the context of WHO reform.

Dr GUILLÉN (Paraguay) said that the Rio Political Declaration on Social Determinants of Health marked a decisive stage in efforts to tackle the underlying causes of ill health, as it recognized the link between health and people's living conditions. Key to Paraguay's progress had been social protection with primary health care at its core; implementation of the healthy communities and healthy schools approach; and improved access to clean water, basic sanitation and food, particularly for children, pregnant women and indigenous populations. She called on the Secretariat and Member States to continue striving to address social determinants of health and thus to overcome health inequities and promote quality of life for all.

Dr HJALSTED (Denmark) said that she was speaking on behalf of the European Union and its Member States. The acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia, aligned themselves with her statement. WHO and the Government of Brazil were to be congratulated on having organized the World Conference on Social Determinants of Health, which had provided an opportunity to share experiences in taking stronger action on those determinants with a view to promoting good health and reducing inequities within and between countries. Such inequities existed in all Member States, regardless of their level of development. The first steps to tackling them were to strengthen public health policies; to address differences in living and working conditions, with a focus on equity in all policy areas; and to ensure universal access to comprehensive quality health services, social protection and education. The impact of the current financial turmoil on health had to be taken into account in all decision-making across all sectors.

The European Union was committed to a "health in all policies" approach. That would be the theme of the 8th Global Conference on Health Promotion in Helsinki in June 2013, which would take stock of progress and identify what remained to be done. She welcomed the Health Assembly's decision to include social determinants of health as a fundamental cross-cutting priority in all WHO programme areas, a decision that would need to be matched by additional staff and resources. Guidance was required to identify effective policies, set targets and monitor progress in tackling health inequities at the national and global levels. The European Union supported the draft resolution.

Dr AL-TAAE (Iraq) said that, following the World Conference on Social Determinants of Health, his Government had set up a committee composed of representatives of the various ministries dealing with health determinants. Work was also being done to strengthen the health system in conjunction with action on the health-related Millennium Development Goals. Social equity was a goal for other sectors besides the health sector and every effort was being made to ensure access to health care for all, including the isolated and vulnerable. Global partnerships should be regarded as a pillar of WHO reform.

Dr HEMMATI (Islamic Republic of Iran), speaking on behalf of the Member States of the Eastern Mediterranean Region, endorsed the commitments made in the Rio Political Declaration on Social Determinants of Health, noting that the social determinants of health approach was fully in line with the primary health care strategy. He called on WHO to ensure that the commitments made in the Rio Political Declaration were translated into concrete action. Determinants such as poverty, illiteracy, unemployment and a lack of access to safe water and sanitation had led to increased vulnerability and inequity, and had undermined development, especially in low-income countries. In the Eastern Mediterranean Region, nearly half of the population were experiencing complex emergency situations that were adversely affecting health. The Secretariat and health ministries could play a lead role in tackling health determinants by promoting a “health in all policies” approach. The Region endorsed the five priority action areas outlined in document A65/16.

Mr HAFED (Algeria), speaking on behalf of the Member States of the African Region, observed that the Rio Political Declaration on Social Determinants of Health reflected the principles laid down in the preamble to the WHO Constitution and could foster greater equity in health by improving socioeconomic conditions for poor and vulnerable people in developing and developed countries alike. Achieving health equity called for action on social determinants at the national and, above all, international levels. Such action would help to uphold the right to health enshrined in several legal instruments, which should guide WHO’s work and its reform process. Governments, which, in his Region, were still the leading guarantors of public health, must see the determinants of health within their socioeconomic, cultural and environmental contexts in order to strengthen their health systems, protect underprivileged and vulnerable groups, and attain the health-related Millennium Development Goals by 2015. Concerted efforts were needed to ensure that health finance policy-making and planning provided for equitable resource allocation at every level and that all policies were intersectoral and complementary, with a view to promoting the social and economic development needed to reduce inequities. It was also necessary to strengthen health information systems; strike the right balance between health promotion, prevention, care and rehabilitation; introduce health insurance schemes to make health care affordable, expand the coverage and quality of health care and ensure social security and solidarity; and build public-sector capacity in terms of human resources and logistics.

To reduce the health inequities between developed and developing countries, in particular, it was essential to accompany action at the national level with international cooperation and, hence, to strengthen the capacities of international actors through better global governance backed by adequate technical and financial support. Multilateral organizations must fulfil their role of setting standards, preparing guidelines and sharing good practices, in keeping with the provisions of the Rio Political Declaration. They must respond to the long-standing call of developing countries for a genuine transfer of knowledge and technologies, and for capacity building in the field of health. Developing countries in Africa looked to the rich countries to honour their pledge to commit 0.7% of their gross national product to official development assistance for health. Strengthening countries’ capacity through international cooperation was the most effective means of arriving at sustainable solutions. The African Member States reaffirmed the great importance that they attached to implementation of the United Nations Declaration on the Right to Development.

Dr KO KO NAING (Myanmar), speaking on behalf of the Member States of the South-East Asia Region, expressed appreciation to the Secretariat for having organized the Conference on Social Determinants of Health and endorsed the Rio Political Declaration and its five key action areas. Action on the social determinants of health called for intersectoral partnership to address health and development issues at the national, regional and global levels, and to promote access to comprehensive and affordable care for all, especially the vulnerable. There was a clear need to prioritize such action and to incorporate it into WHO’s programmes and country cooperation strategies. Technical and financial support would be required to strengthen national capacity to assess health inequities and take the appropriate action, especially in low-income countries.

His Region was committed to implementing the “health in all policies” approach. Regional and country offices had a key role to play in providing technical guidance, and their continued support must be included in the overall process of WHO reform. Support was also required for research on effective policies and interventions beyond the health sector. The Member States of the Region supported the draft resolution.

Mr URQUIDO VELASQUEZ (Colombia) congratulated the Government of Brazil on the success of the World Conference on Social Determinants of Health and expressed strong support for the draft resolution.

Mrs POPPLEWELL (Trinidad and Tobago) said that health was more than a biomedical issue, that it permeated all of society and was affected by every policy shaping the social and economic environment. Many of her country’s public health programmes set out to reduce inequity, and a number of successes had been achieved through its robust primary health care system, including reductions in infant mortality and the eradication of poliomyelitis. In view of the need for a more multifaceted and coordinated approach to tackling health inequities, her Government had established a multisectoral committee to implement the Rio Political Declaration. Working in close collaboration with the public health community to examine the determinants of health, and building on national and international expertise, it would produce an action plan to expand the knowledge base on the impact of those determinants in the country; explore opportunities for collaborative action; and advocate a “health in all policies” approach to improving health outcomes at the national level.

The Rio Political Declaration did not include any commitments regarding resources or formal monitoring and accountability mechanisms. The draft resolution, which her delegation supported, sought to address those shortcomings by calling on the international community to facilitate access to financial and technical support. Trinidad and Tobago supported the setting of targets to tackle the social determinants of health and health inequities.

Mr MADER (Switzerland), expressing support for the draft resolution, encouraged the Secretariat to step up efforts to mainstream the social determinants of health into all programmes, to give health equity its place in all policies, and to promote genuine intersectoral dialogue. His Government supported a vision and goal for health in sustainable development beyond 2012, and expected the outcome document of the Rio+20 United Nations Conference on Sustainable Development to include a focused approach that underlined the link between health and sustainable development. Switzerland welcomed the support that WHO was providing to Member States to enable them to improve health equity and appreciated the formulation of strategies and establishment of platforms for the exchange of best practices. Real changes and concrete results had to be achieved for vulnerable and deprived groups. His Government intended to do more at the national and international levels to promote research on the social determinants of health and to tackle health inequities and their causes. In the follow-up to the World Conference on Social Determinants of Health, clearly defined benchmarks should be provided to facilitate the monitoring of results.

His delegation had taken note of the financial and administrative implications of the draft resolution and welcomed the willingness to invest resources, especially at the level of regional and country offices. It looked forward to working in close partnership with the Secretariat and other Member States in addressing the unequal distribution of health resources and the conditions undermining health at the global, national and local levels.

Dr RODIN (Canada) said that her Government supported formal endorsement of the Rio Political Declaration on Social Determinants of Health, as proposed in the draft resolution. It commended Brazil on the successful outcome of the World Conference and looked forward to working with others to help sustain momentum on the issue.

Dr IWATA (Japan) noted that actions on the social determinants of health had gathered pace in 2011. Her Government was actively engaged in tackling the important issue of health inequities, and was evaluating effective measures to deal with those determinants, in particular in rural communities. A recent study on income inequality and lifestyles in Japan had concluded that the number of smokers and rates of obesity were higher in low-income households. The social determinants of health and noncommunicable diseases were closely interrelated and effective intersectoral approaches should be adopted in order to address them. A social determinants of health approach would be crucial to meeting all future global challenges.

Dr YUTTAPONG WONGSWADIWAT (Thailand) noted the lack of any significant progress in implementing resolution WHA62.14 or any tangible positive health outcomes resulting from the recommendations of the Commission on Social Determinants of Health on market responsibility, health in all policies and health-damaging commodities. Universal health coverage was the best tool for reducing poverty and health gaps, and it was not the sole preserve of rich countries. Her Government welcomed the strong commitment of Member States, the Director-General and the United Nations Secretary-General to discussing the subject in international development forums, including the General Assembly. Transparent, accountable and participatory public health policies were crucial to action on the social determinants of health, and the innovative mechanisms and processes being tested in some countries were to be welcomed.

Evidence had shown that effective policies to protect public health and well-being were constantly challenged by bilateral, regional and international trade policies. It was increasingly difficult to balance the protection of global health against influential commercial interests. Indeed, her delegation was concerned that trade might speak louder than health in the Health Assembly. Addressing social determinants of health should be a priority in the WHO reform process and in the policy-making of Member States.

Ms MEDINA (Ecuador) thanked the Government of Brazil and WHO for having convened the World Conference on Social Determinants of Health, which had been a key forum for discussion and analysis. Integrated, intersectoral action on social determinants of health was crucial to improving the health of populations and ensuring health equity. She therefore supported the draft resolution.

Mr SKOTHEIM (Norway) said that the Rio Political Declaration was consistent with the core principles of the WHO Constitution and presented a new opportunity for progress in global action to reduce health inequities. Fairness and equity were at the heart of common challenges for a socially and economically stable and sustainable future. WHO needed the capacity and resources to play a strong role in advancing the social determinants of health agenda in Member States and across the United Nations system. His Government strongly supported that work and the draft resolution.

Dr DÍAZ (Chile), voicing support for the draft resolution, said that his Government had launched several initiatives to foster a more equitable society, the main one being the national health strategy for 2011–2020, which sought to reduce health inequities by mitigating the effects of the social and economic determinants of health. The draft resolution and the report contained in document A65/16 gave a clear indication of the direction that public policy should take to achieve an optimum standard of living. Chile urged Member States and the international community to meet the commitments made in the Rio Political Declaration on Social Determinants of Health, and called on the Director-General to give Member States every measure of support for that purpose.

Dr PRASAD (India), welcoming the Rio Political Declaration, said that every citizen was entitled to universal health care coverage, which would be hard to achieve without addressing the social determinants of health and disparities linked to class, caste, gender and geographic region. Concrete action to that end called for the support of WHO and other international organizations in the areas of standard-setting, providing guidelines and identifying best practices. It also relied on the

development of mechanisms for the collection of data on health system performance. His delegation urged the Regional Office for South-East Asia to commission a study of the health discrepancies in the Region in order to develop a regional strategy to tackle the key determinants of health.

The Rio+20 Conference would provide an opportunity to reassess the relationship between health and sustainable development, in line with the Rio Declaration on Environment and Development and the Johannesburg Plan of Implementation; to review progress on the sustainable development objectives and commitments; and to define new goals for the future.

Dr RONSE (Belgium) expressed his country's gratitude to the Government of Brazil for hosting the World Conference on Social Determinants of Health, and to WHO for advancing work on those determinants. He pointed out that an accessible and equitable health-care system did not automatically mean an absence of health inequities. Belgium had a widely accessible health care system, yet there was a five-year difference in "healthy life years" between people from high and low socioeconomic groups. Nevertheless, health inequities were unlikely to be eliminated without such a system in place. WHO should therefore continue to act as an advocate for health equity. His delegation was pleased to note that the social determinants of health would receive appropriate attention as a cross-cutting priority in the draft twelfth general programme of work 2014–2019 and welcomed the draft resolution.

Dr YEHYA ELABASSI (Sudan) said that action on the social determinants of health was an ethical, human and political responsibility and vital to health promotion. Drawing attention to the detrimental effects of factors such as poverty, illiteracy and unhealthy lifestyles, he emphasized the need for transparent and inclusive public health policy. Social determinants of health should be considered at all levels of the WHO reform process and should constitute a priority for the Organization as a whole and for each of its Member States.

Dr Guey-Ing DAY (Chinese Taipei), welcoming the progress in implementing resolution WHA62.14, strongly endorsed the "health in all policies" approach and the five key action areas identified in the Rio Political Declaration on Social Determinants of Health. Health inequities were monitored closely in Chinese Taipei. The difference in infant mortality between urban and rural populations had decreased by 40% in 12 years as a result of universal health care coverage and equitable prevention and community development activities. Integrated services – including outreach activities, specialist clinics and overnight emergency care – had been developed to strengthen further the delivery of health care to remote areas. Efforts were also being made to improve the quality of services. An approach that involved all government departments, not only the health sector, was needed in order to ensure success. Chinese Taipei looked forward to participating further in technical meetings and activities concerning social determinants of health.

Mr SWING (International Organization for Migration) stressed that migration was crucial to social and economic development in a globalized world. Migrants, however, were often exposed to conditions detrimental to their health, including marginalization, lack of access to health services and unsafe travelling, living or working conditions. Moreover, increasing anti-migrant sentiment frequently resulted in discriminatory policies and practices. To address those challenges, his organization advocated for the recognition of migration as a social determinant of the health of migrants. Little progress had been made since the adoption of resolution WHA61.17 on the health of migrants, and he urged WHO to follow up on that resolution within the context of the draft resolution contained in resolution EB130.R11. The 8th Global Conference on Health Promotion in Helsinki would offer an opportunity for governments to reflect on the progress made and to express their support for the right to health of the more than one billion migrants around the world.

Mr KADASIA (International AIDS Society) drew the Committee's attention to the central role of health promotion in improving everyday living conditions, which should be recognized in future action on social determinants of health. Given the crucial importance of the participation of all stakeholders, Member States and the Secretariat must strive to ensure that civil society played a meaningful role in policy-making and decision-making. When programmes were well conceived and implemented, stakeholders became not only beneficiaries but also actors, playing a key role in problem solving, monitoring and impact assessment.

Mrs EARDLEY (World Vision International) recalled that youths from seven countries in the Region of the Americas had presented a declaration to the World Conference on Social Determinants of Health, which had stressed the importance of ensuring the participation of adolescents and young people in decision-making and monitoring of national, regional and global health and development goals; greater involvement of civil society organizations, particularly those working at the local level, in national health plans and policies; attention by the health sector to the specific needs of children and young people; and health care coverage for children and young people that was high quality, universal, affordable and sensitive to gender and cultural issues.

Ms SCHLEIFF (CMC – Churches' Action for Health), stressing the need for action on social determinants of health in order to achieve health for all, urged Member States to ensure the necessary funding. She pointed out that social determinants of health were more than a collection of fragmented risk factors and lifestyles; they were symptomatic of an ideology whose ultimate goal was the commercialization of life itself. In keeping with the "health in all policies" approach, action to address health determinants would have to cover a wide variety of areas and issues, including trade, taxation, finance and privatization.

Mr LEFEBVRE (International Federation of Medical Students' Associations), welcoming the draft resolution, drew attention to the need for innovative funding schemes to support action to tackle the social determinants of health and to reduce the inequities stemming from the unfair distribution of power and wealth at the global level. Youth and civil society needed to be included in the process and made aware of the issues. Young people, with their energy and fresh vision, had vast, untapped, potential to make a meaningful contribution to the promotion of health and equity for all. As future health professionals, the members of his organization were committed to engaging with all sectors involved in that work and to mobilizing other young people in their respective countries and communities.

Dr KIENY (Assistant Director-General) thanked the many delegates that had taken the floor for their comments and their support of the social determinants of health agenda. As requested in the Rio Political Declaration on Social Determinants of Health, the Secretariat had worked with ILO, UNAIDS, UNDP, UNFPA and UNICEF in order to agree on the alignment and coordination of the relevant work. They had established an informal United Nations platform and agreed a concrete, two-year workplan. In response to the request of Member States for strengthened capacity in the area of social determinants of health, the Secretariat had prepared a WHO global plan of action describing how best to support Member States and partners in their implementation of the Rio Political Declaration. As called for by the WHO reform agenda, the plan focused on the Organization's strategic priorities in the global context. The Secretariat thanked Member States for having drawn attention to the significance of the "health in all policies" approach, to which it would accord heightened importance. It further thanked the Government of Brazil for having efficiently and graciously hosted the World Conference on Social Determinants of Health. Now was the time for action.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB130.R11.

The draft resolution was approved.¹

The meeting rose at 21:40.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.8.

ELEVENTH MEETING

Saturday, 26 May 2012, at 09:35

Chairman: Dr L.Z. DUKPA (Bhutan)

1. THIRD REPORT OF COMMITTEE A (Document A65/55)

Dr JIDDAWI (United Republic of Tanzania), Rapporteur, read out the draft third report of Committee A, noting that it contained a draft decision on WHO reform, under agenda item 12. Paragraph (19) of that decision, as contained in the report, was incomplete. The paragraph should read:

“to request the Director-General to report, through the Executive Board at its 132nd session, to the Sixty-sixth World Health Assembly, on progress in the implementation of WHO reform on the basis of a monitoring and implementation framework.”

The CHAIRMAN said that, subject to that correction, the Committee wished to adopt the report.

The report was adopted.¹

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

Consultative Expert Working Group on Research and Development: Financing and Coordination: Item 13.14 of the Agenda (Documents A65/24 and A65/24 Corr.1) (continued from the fourth meeting, section 2)

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, said that the recommendations of the Consultative Expert Working Group on mechanisms to stimulate research and development should be supported. In order for those mechanisms to be successful, an overarching framework was needed, in the form of a binding convention, to ensure that priorities were set, funding was secured and innovation led to access. Unmet needs included: new treatments for drug-resistant tuberculosis and life-threatening drug-resistant infections; new treatments and diagnostic tools for kala azar, Chagas, and sleeping sickness; and vaccines that did not need to be refrigerated and could be administered without an injection. The fragile progress of the past had depended on donor philanthropy and corporate social responsibility. What was now needed was a sustainable solution, based on multilateral action, to ensure that innovation was able to deliver products which were immediately affordable and accessible. MSF International's involvement with the Drugs for Neglected Diseases initiative had shown that research and development of medicines could be made more efficient through the use of open knowledge innovation models or by delinking research and development costs from the price of products. She urged the Secretariat and Member States to initiate without delay the process of designing a new and sustainable global framework for medical research and development priorities.

¹ See page 275.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the emphasis placed in the report on the need to stimulate research and development on Type II and Type III diseases, where funding was inadequate. Members of his organization had undertaken 93 research and development projects in 2011, three quarters of them through collaborative ventures. As current projects progressed into clinical trials, greater attention should be paid to the regulatory infrastructure in developing countries where the trials might take place. Member States should carefully evaluate all the available options highlighted in the report, while taking into account the complexity and ongoing evolution of pharmaceutical innovation. Any successful model should recognize the need for prioritization, effectiveness and sustainability, with the aim of increasing innovation, and improving access to high quality, safe and effective medicines.

Mr MAHAMA (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, said that the patent system had failed to deliver medications for many of the conditions affecting people in developing countries. The system aimed to recover investment costs by charging high prices for medicines, which meant that the poor were denied access to those medicines and pharmaceutical companies did not invest in innovation for diseases of the poor. It was therefore essential to delink prices from research costs. The proposed convention on research and development would help to mobilize resources, manage the allocation of funds, coordinate public and private efforts, and ensure continuing policy development; it would also give concrete expression to the global community's moral obligation. He called on Member States to adopt the recommendations of the Consultative Expert Working Group with all urgency.

Dr KIENY (Assistant Director-General) thanked Member States and nongovernmental organizations for their useful comments.

The CHAIRMAN said that the drafting group established at the fourth meeting had produced a revised draft resolution, which read:

The Sixty-fifth World Health Assembly,

PP1 Having considered the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (CEWG);¹

PP2 Recalling resolution WHA63.28 which requested the Director-General, inter alia, to establish the CEWG in order to take forward the work of the Expert Working Group earlier established under resolution WHA61.21, and to submit the final report to the Sixty-fifth World Health Assembly;

PP3 Further recalling resolutions WHA59.24, WHA61.21 and WHA62.16,

1. WELCOMES the analysis of the CEWG report and expresses its appreciation to the Chair, Vice-Chair and all the members of the Working Group for their work;
2. URGES Member States:²
 - (1) to hold national level consultations among all relevant stakeholders in order to discuss the CEWG report and other relevant analyses resulting in concrete proposals and actions;
 - (2) to participate actively in the meetings at regional and global level referred to in this resolution;

¹ Documents A65/24, Annex and A65/24 Corr.1.

² And, where applicable, regional economic integration organizations.

(3) to implement, where feasible, in their respective countries, proposals and actions identified by national consultations;

(4) to establish and/or strengthen mechanisms for improved coordination of research and development (R&D)¹ in collaboration with WHO and other relevant partners, as appropriate;

3. CALLS UPON Member States,² the private sector, academic institutions and nongovernmental organizations to increase investments in health research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases;

4. REQUESTS regional committees to discuss at their 2012 meetings the report of the CEWG in the context of the implementation of the global strategy and plan of action on public health, innovation and intellectual property³ in order to contribute to concrete proposals and actions;

5. REQUESTS the Director-General to hold an open-ended Member States² meeting in order to analyse thoroughly the report and the feasibility of the recommendations proposed by the CEWG, taking into account, as appropriate, related studies. The meeting will also take into account the results from national consultations and regional committee discussions and develop proposals or options relating to (1) research coordination, (2) financing and (3) monitoring of R&D expenditures,⁴ to be presented under a substantive item dedicated to the follow up of the CEWG report at the Sixty-sixth World Health Assembly, through the Executive Board at its 132nd session.

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

1. Resolution: Consultative Expert Working Group on Research and Development: Financing and Coordination

2. Linkage to the Programme budget 2012–2013 (see document A64/7 http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_7-en.pdf)

Strategic objective(s): 11

Organization-wide expected result(s): 11.1

How would this resolution contribute to the achievement of the Organization-wide expected result(s)?

Access to essential medicines and medical technologies is a fundamental pillar of national medicine policies. Research and development of new medicines and technologies for effectively tackling the diseases that disproportionately affect developing countries is critical to improving access. It is also very important that new technologies, when developed, are affordable. Currently, spending on research and development is insufficient, and even when new medicines are developed they are not affordable. This resolution will support discussions and consultations among Member States on the feasibility of the recommendations of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, in particular those concerning a binding global instrument, aimed at enhancing sustainable funding for research and development and ensuring that the resulting products and

¹ In the context of this resolution R&D shall refer to health research and development related to Type II and Type III diseases and the specific research and development needs of developing countries in relation to Type I diseases.

² And, where applicable, regional economic integration organizations.

³ Resolutions WHA61.21 and WHA62.16.

⁴ As defined in the Global strategy and plan of action on public health, innovation and intellectual property.

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| <p>technologies are affordable.</p> <p>Does the programme budget already include the products or services requested in this resolution? (Yes/no) No.</p> |
| <p>3. Estimated cost and staffing implications in relation to the Programme budget</p> <p>(a) Total cost Indicate (i) the lifespan of the resolution during which the Secretariat's activities would be required for implementation and (ii) the cost of those activities (estimated to the nearest US\$ 10 000).</p> <p>(i) 1 year (covering the period 2012–2013) (ii) Total: US\$ 1 370 000 (staff: US\$ 370 000; activities: US\$ 1 000 000)</p> <p>(b) Cost for the biennium 2012–2013 Indicate how much of the cost indicated in 3 (a) is for the biennium 2012–2013 (estimated to the nearest US\$ 10 000). Total: US\$ 1 370 000 (staff: US\$ 370 000; activities: US\$ 1 000 000) Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant. Headquarters and regional offices. Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no) No. If “no”, indicate how much is not included. US\$ 1 370 000</p> <p>(c) Staffing implications Could the resolution be implemented by existing staff? (Yes/no) No. If “no” indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant. For the secretariat of the open-ended Member States meeting: one staff member at grade P.3 and one staff member at grade G.4 for one year.</p> |
| <p>4. Funding Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no) No. If “no”, indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds). US\$ 1 370 000; source(s) of funds: funding proposals will be sent to selected Member States and donor agencies.</p> |

Dr KIENY (Assistant Director-General) drew attention to an error in the text of the report on financial and administrative implications of the draft resolution. The correct text of paragraph 2 would read as follows: “This resolution will support discussion and consultations among Member States on the feasibility of the recommendations of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination, aimed at enhancing sustainable funding for research and development and ensuring that the resulting products and technologies are affordable.”

Dr VIROJ TANGCHAROENSATHIEN (Thailand), introducing the revised draft resolution, compared the work of the drafting group, which he had chaired, to the process of birthing a baby, with the Committee as natural parents, the drafting group as midwives, and the Director-General and her staff as foster parents and babysitters of a new draft resolution. Agreement on the text had been reached by consensus.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution.

The draft resolution was approved.¹

Dr DAULAIRE (United States of America) thanked the chairman of the drafting group for serving as its chief obstetrician. The degree of consensus reached on the resolution in such a short time had set a new standard for future drafting groups. There had been a commendably focused commitment among drafting group members to ensuring that new, appropriate and affordable products could be made available to people in need around the world. Noting the Assistant Director-General's explanation of the error in the report on the financial and administrative implications, he requested that the document be reissued with the necessary correction.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, commended the leadership displayed by the chairman of the drafting group. The lack of research and development in the area of health products of benefit to developing countries was a serious problem that needed to be addressed. The process of reinforcing and expanding the initiatives already in place should go hand in hand with the preparation of decisions to be taken at the Sixty-sixth World Health Assembly. The Secretariat should provide advice and support to help identify the most appropriate and cost-effective sequencing of decisions, options and actions in a budget-constrained environment. The European Union was also prepared to consider the possibility of early deliverables.

Dr GAMARRA (Paraguay), speaking on behalf of the members of the Union of South American Nations, thanked the chairman of the drafting group for his wisdom, patience and leadership in the difficult hours leading up to the birth of the draft resolution. All the members of the group had made substantive contributions to the discussions, and the Secretariat had provided valuable support by preparing documentation in a timely manner. The spirit of Geneva had prevailed, making it possible to reconcile diverging positions and achieve a consensus.

Ms MATSOSO (South Africa) congratulated the chairman of the drafting group on his skilful guidance of the work on the draft resolution, and recalled that he had previously also made an invaluable contribution to the drafting of the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property.

Dr EL OAKLEY (Libya), speaking on behalf of the Member States of the Eastern Mediterranean Region, thanked the chairman of the drafting group for making the impossible possible.

Dr MALECELA (United Republic of Tanzania) thanked the chairman for his skilful leadership and good humour in guiding the work of the drafting group in difficult circumstances. She commended the spirit of compromise that had prevailed in the group.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA65.22.

The DIRECTOR-GENERAL thanked the Member States, who were the natural parents of the resolution, and the members of the Consultative Expert Working Group, who were its surrogate parents. As a foster parent of the text, she was mindful of the need for efficiency and effectiveness and considered that time and resources should not be wasted. She would strive to ensure that the resolution served to facilitate the building of a fairer world, which was the goal of WHO in the 21st century.

Pandemic influenza preparedness: sharing of influenza viruses and access to vaccines and other benefits: report on the work of the Advisory Group: Item 13.9 of the Agenda (Document A65/19)

Dr AL-TAAE (Iraq), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed the report of the Advisory Group and the establishment of a framework for sharing influenza viruses, which would assist in the preparation of pandemic guidelines. It was important to promote research in relation to virus sharing and access to vaccines and to establish partnerships in different countries. The decision to use 70% of resources for preparedness and 30% for response was well founded, as it would make it possible to strengthen global partnerships, build necessary institutional partnerships, and improve capacity building in countries and regions. The Pandemic Influenza Preparedness Framework was a major step forward.

Dr CHAND (Nepal), speaking on behalf of the Member States of the South-East Asia Region, welcomed the support given by WHO to the Pandemic Influenza Preparedness Framework, which was an important initiative for countries in his Region. Implementation of the Framework would benefit national, regional and global public health, and promote equity in the sharing of influenza viruses and the associated benefits. Sharing of benefits should be based on levels of development. There were great variations in States' preparedness and response capacity, as well as in the degree to which each State was affected by avian influenza (A/H5N1). In his Region, six cases of avian influenza had been reported in Bangladesh, 129 in Indonesia, one in Myanmar and 25 in Thailand. The risk of the disease spreading to other countries, within and outside the Region, had led several south-east Asian countries to develop capacity to produce influenza vaccine. Those States might therefore benefit from the transfer of appropriate technology.

Although the Pandemic Influenza Preparedness Framework had been adopted one year earlier, standard material transfer agreements (SMTAs) between the Global Influenza Surveillance and Response System and other entities did not appear to have come into effect, and he requested the Director-General to indicate a time frame for operationalization. SMTA 2 negotiations should be accelerated, starting with at least one type of virus or manufacturer by the end of 2012. Noting that the interim mechanism for virus transfer to third parties was in place, he asked the Director-General to report back to the Sixty-sixth, Sixty-seventh and Sixty-eighth World Health Assemblies on the progress of SMTA 2 negotiations. He asked whether any manufacturers had made contributions to WHO in relation to pandemic influenza preparedness. Consideration should be given to establishing a mechanism to enable the needs of Member States to be communicated directly to the Advisory Group, so that informed decisions could be taken on the allocation of benefits and technology transfer. He asked the Secretariat to update Member States on a more regular basis regarding the status of Advisory Group recommendations and the status of virus sharing.

Dr KUDO (Japan) said that, when an influenza pandemic occurred, it was essential to respond by sharing pandemic virus specimens quickly. The Pandemic Influenza Preparedness Framework would play a crucial role, but its effectiveness would depend on the feasibility of its detailed application. The amount of companies' partnership contributions should be set on the basis of the views of industries, as key stakeholders in the Framework. Their nature and capacities should be reflected appropriately, as described in the Framework document.

Although the Advisory Group had held closed meetings, he requested the Group to consider making its materials available publicly once meetings were over, in order to ensure transparency. The total amount of partnership contributions for 2012 was some US\$ 28 million, estimated as 50% of the

operating costs of the Global Influenza Surveillance and Response System; however, no specific plan had yet been laid out to indicate how the total requirement of US\$ 57.4 million would be obtained. It would be difficult to obtain contributions from industry without providing sufficient explanation. Allocating 70% of partnership contributions to preparedness and the remainder to pandemic response seemed reasonable.

Miss ORATHAI WALEEWONG (Thailand), welcoming the consensus reached on the Framework, commended the Advisory Group and other partners for their commitment to finalizing negotiations and requested the Secretariat to implement the Framework to achieve a fair, transparent, equitable, efficient and effective system. Although the process of finalizing the standard material transfer agreement 2 (SMTA 2) was complicated, time consuming and difficult, it was a stepping stone to implementation of the Framework. She therefore encouraged the Director-General to accelerate work in that regard and urged recipients of pandemic influenza preparedness biological materials outside the Global Influenza Surveillance and Response System to contribute to finalizing the SMTA 2 negotiations.

While it was clear that research must continue, it was also clear that certain research, which could generate more dangerous forms of the influenza virus, had the potential to pose a serious threat to the public. In the absence of a global or national regulatory mechanism, such high-risk research should be carried out only after all significant public health risks and benefits had been identified and thoroughly reviewed. Research facilities, biological material repositories and data management should operate to internationally acceptable standards in order to maximize benefits and guard against risks to public health. She urged WHO to work with research sponsors, Member States and other key parties towards developing a research regulation mechanism.

Pandemic influenza preparedness would continue to be a work in progress, as the Framework remained under development. Thailand was fully committed, and would contribute, to global preparedness. She stressed that mistrust and legal difficulties should not be allowed to hamper the global public health movement.

Mrs SMIRNOVA (Russian Federation), expressing appreciation to the Advisory Group for its work, welcomed the Organization's flexibility in its efforts to finalize the SMTA 2 negotiations, particularly with respect to the interim process for transferring pandemic influenza preparedness biological materials. Parties would be required to adhere to the spirit of a mechanism for sharing viruses and benefits on the basis of mutual trust and equity, so as to safeguard global public health. SMTA 2 negotiations should be finalized promptly through legal and other consultations, and preventive measures should be a priority to ensure that countries were prepared for pandemics. The Secretariat should also be flexible with regard to allocating resources on the basis of the prevailing epidemiological situation.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, said that the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia, aligned themselves with her statement.

She commended the Advisory Group and the Secretariat for the progress made in implementing the Framework, which marked an important step towards an efficient Global Influenza Surveillance and Response System and would enhance international public health and laboratory collaboration. She supported the proposal that, over the coming five years, 70% of partnership contributions should be used for pandemic preparedness and 30% for response. Capacity building and technology transfer for vaccine production were essential elements of preparedness, but the decision on how to allocate resources for preparedness in order to develop sufficient capacity in all regions should be left to the Director-General, based on advice from the Advisory Group.

Building on integrated surveillance and response capacities in developing countries would be essential for strengthening pandemic influenza preparedness globally, and she welcomed work on a classification system to determine, on the basis of public health system capacities and epidemiological and economic criteria, which countries would benefit from contributions. She particularly welcomed the proposal that core capacities under the International Health Regulations (2005) should be one of the classification criteria.

Endorsing the view of the Advisory Group on SMTA 2 negotiations, she underscored the need for a practical, balanced and uniform interim process so that materials could continue to be transferred outside the Global Influenza Surveillance and Response System, but without losing the incentive to conclude final agreements with industry swiftly. She urged the Secretariat to speed up work to that end and to report frequently to Member States on progress achieved, and affirmed the European Union's willingness to cooperate in further work, including the Framework review scheduled for 2016.

Ms WISEMAN (Canada) said that a robust and dynamic Advisory Group was key to implementing the Framework. Finalizing SMTA 2 negotiations was essential in order to ensure full virus sample sharing under the Framework. Her Government would be pleased to play its part, recognizing that the Secretariat needed human and financial resources to achieve that goal, including legal support.

Dr WU Liangyou (China), expressing appreciation to WHO for its efforts to establish a transparent, fair and reasonable Framework, said that the rapid response of Member States and the Secretariat to the outbreak of pandemic (H1N1) 2009, including the prompt sharing of viruses, had enabled his country to produce vaccine quickly and to vaccinate key groups. With WHO support, his Government had made remarkable progress in surveillance and preparedness. The Chinese Center for Disease Control and Prevention had served as the WHO Collaborating Centre since 2010, and China would continue to support and actively participate in global surveillance and share viruses and benefits. Where possible, it would also make donations to the international vaccine reserve. He suggested that partnership contributions should be determined, taking into account each individual company's capacity.

Mrs ESCOREL DE MORÃES (Brazil) said that the Advisory Group was right to prioritize partnership contributions and SMTA 2 negotiations, both of which were of fundamental importance for the functioning of the Framework. The Advisory Group had a key role to play in determining the contributions to be made by individual companies and others and in establishing rules for resource allocation, which could serve as a good example for discussions on WHO reform.

SMTA 2 negotiations should be finalized and the agreements implemented rapidly, as such agreements would provide the essential basis for producing vaccines and sharing benefits. A reasonable level of benefits should be provided, including the sharing of knowledge, technology and know-how with developing countries, with a view to increasing and diversifying vaccine production capacity. She congratulated the Advisory Group on the transparent manner in which it was maintaining a dialogue with industry.

The Framework was intended to strengthen cooperation between Member States and should be implemented fairly, efficiently and transparently, favouring those that had less, including those that would not have the capacity to respond with their own means in the event of a pandemic. Brazil attached great importance to the pandemic influenza preparedness process because it highlighted the critical importance of making the dynamics of decision-making within WHO more democratic and set an example for current and future negotiations.

Dr DOUA (Côte d'Ivoire), welcoming the equitable approach to benefit sharing encouraged in the report of the Advisory Group, said that sentinel surveillance for influenza at 19 sites across his country allowed monitoring of changes in the virus and enabled Côte d'Ivoire to participate in collaborative activities with WHO. He reaffirmed the principle of equitable access to vaccines and

universal access to medicines at affordable prices and expressed support for both the transfer of appropriate technologies and the necessary technical support to ensure a sustainable supply of vaccines.

Given the multifaceted nature of the fight against pandemic influenza, his Government was committed to doing its part by sharing clinical and virus samples from its laboratories. WHO should establish a framework to improve access to vaccines for people in Africa, and should also work on tracing systems for samples and viruses. He expressed appreciation to the Secretariat and to other Member States for their support in strengthening epidemiological and microbiological surveillance, and requested further technical, material and financial support to improve pandemic preparedness.

Dr DÍAZ (Chile) said that his country had complied with the resolutions of the Executive Board and the Health Assembly on the subject of pandemic influenza preparedness. It had formulated both a national influenza prevention and control policy and a national preparedness and response plan and had always supported virus sharing, which was a field in which WHO coordination and leadership had achieved positive results. He urged the Advisory Group to focus in particular on availability of vaccines and sharing of viruses and benefits, including identification of exactly which benefits were to be shared, and requested the Secretariat to maintain and strengthen mechanisms for disseminating viral epidemiology information, specifically with regard to the swine-origin triple reassortant influenza A(H3N2) and avian influenza A(H5N1) viruses, so as to improve preparedness and mitigate their pandemic potential.

Dr DAULAIRE (United States of America), expressing support for the Organization's efforts to strengthen global pandemic influenza surveillance and response, said that his Government remained strongly committed to the Pandemic Influenza Preparedness Framework and looked forward to its implementation, in accordance with the consensus already achieved. The Framework had broken new ground on a number of levels, requiring adaptation to new procedures for the operation of the Global Influenza Surveillance and Response System and challenging the Secretariat to engage with Member States and civil society, including manufacturers, in new ways. The progress made thus far was encouraging.

It was important to keep the Global Influenza Surveillance and Response System in operation during the transition period in implementing the Framework. The Secretariat had provided guidance for the interim period and had interacted well with the Advisory Group, industry and other elements of civil society. It was particularly satisfying that stakeholders had been involved in Advisory Group meetings, a practice that should continue. Active consultation with civil society, including industry, was an integral part of Framework implementation. He welcomed the initiation of SMTA 2 negotiations with industry, noting that questions had already been raised by stakeholders concerning the implementation of the Framework during the interim period preceding the conclusion of those negotiations.

The budgetary challenges faced by WHO should not be ignored: it was the joint responsibility of Member States to ensure that the Secretariat could meet its responsibilities with respect to the Framework and he encouraged Member States to provide necessary human and financial resources. His Government stood ready to do its part.

Dr Ho-Sheng WU (Chinese Taipei) said that experience had shown the importance of virus sharing and access to vaccines for pandemic influenza preparedness. As the vaccine manufacturer in Chinese Taipei was capable of producing vaccine for internal use, it hoped to be included in preparedness efforts. A Global Influenza Surveillance and Response System self-assessment would be welcome, as would WHO support to build influenza surveillance and laboratory capacity in developing countries. Some countries might require further technical or financial support from WHO to implement the Framework. Chinese Taipei would be pleased to share its experience. Highlighting the importance of stockpiles of pre-pandemic vaccines, he expressed support for Advisory Group efforts to establish an international stockpile of vaccines for avian influenza A(H5N1) and other

viruses with pandemic potential. Chinese Taipei would contribute more in that respect, provided that its vaccine manufacturer was approved by WHO.

Mr DURISCH (Stichting Health Action International), speaking at the invitation of the CHAIRMAN, and on behalf of the Berne Declaration, the Third World Network and the People's Health Movement, expressed disappointment that, in the year since the adoption of the Framework, not a single SMTA 2 had been signed, even though biological materials had been exchanged with recipients outside the Global Influenza Surveillance and Response System. That situation had also affected full implementation of existing SMTAs within the Global Influenza Surveillance and Response System. It would be interesting to know whether the contributions due from manufacturers under the Framework had already been made and how much each manufacturer would contribute; additional information on the activities envisaged with respect to preparedness under the proposed 70%–30% division of partnership contributions would also be welcome. Pandemic preparedness should encompass building influenza surveillance and laboratory capacity and vaccine manufacturing capacity in developing countries. In the interests of equity and transparency, he suggested that the Secretariat should make available to the public the annual reports of the Advisory Group and information on partnership contributions made by manufacturers, including the use thereof.

Dr FUKUDA (Assistant Director-General), welcoming the support provided by Member States for the process of negotiating and implementing the Framework, said that it had indeed broken new ground and helped to democratize discussions within the Health Assembly and among Member States. The Secretariat was working towards full implementation as quickly as possible, but the process was complex and full of challenges. Significant progress had been made over the last year: the Advisory Group had held three meetings, with substantive discussions on SMTAs, including the finalization of SMTA 2, and partnership contributions, and efforts had been made to disseminate information and raise awareness, including the publication of a handbook on the Framework in all six official languages and the creation of a dedicated section on the WHO web site. He welcomed calls for the reports of the Advisory Group to be made more widely available and committed to doing so.

Formal discussions with three of the largest vaccine manufacturing companies on SMTA 2 arrangements had started well. The companies recognized the importance of the Framework and had expressed full support for its implementation. Discussions would be extended to other companies, including manufacturers in developing countries and manufacturers of diagnostic equipment and antiviral medicines. Realistically, however, the pace of negotiations was limited by the size of the Secretariat and the availability of legal support. The problem was being discussed with Member States.

The first US\$ 28 million of partnership contributions was due in 2012, and the Secretariat was engaged in discussions with industry on how individuals contributions should be apportioned. Based on the principle of fairness, the amount each company was asked to provide should reflect what materials they received through the Framework and their market share. The Executive Board, at its 131st session, would consider whether the Director-General's proposal that 70% of the partnership contribution should be allocated to preparedness and 30% to response, was reasonable.

Responding to points raised by the delegates of Thailand and the United States of America, he said that a matter of concern to WHO and Member States was ensuring that research using viruses with pandemic potential was done under the safest possible conditions. The Secretariat hoped to convene a meeting on the subject later in 2012 or early 2013.

With regard to the allocation of partnership contributions, he said that the Advisory Group had recognized the need to build capacity in countries where it was needed most, and the Secretariat would work closely with the Group to that end. On the issue of the interim process for transferring pandemic influenza preparedness materials before the finalization of SMTA 2, he welcomed calls for flexibility. Companies receiving materials had been asked to agree to enter into discussions on concluding an SMTA 2. The aim was to ensure that viruses and other materials could continue to be shared for public health purposes during the interim period.

The DIRECTOR-GENERAL said that the speed with which the Framework could be implemented depended on several factors. Member States had expressed the desire for a transparent, fair process driven by a representative group of countries. Three meetings of the Advisory Group established for that purpose had already been organized, and the Group had provided beneficial advice, particularly for SMTA 2 discussions. She hoped that industry would likewise make its contribution to the process. The issue of partnership contributions placed WHO in a difficult situation, given the potential for conflicts of interest to arise, and the advice of the Advisory Group was particularly valuable in that respect. While acknowledging civil society calls for more progress to be made, she emphasized that the Secretariat could not compromise on fairness and transparency for the sake of speed. Progress depended partly on how many staff were available, and legal expertise was vital. She welcomed the financial and legal support provided by the Governments of Canada and the United States of America, but said that more was still needed. She reaffirmed the Secretariat's commitment to implementing the Framework.

The Committee noted the report.

Implementation of the International Health Regulations (2005): Item 13.7 of the Agenda (Documents A65/17, A65/17 Corr.1, A65/17 Add.1, A65/17 Add.2 and A65/17 Add.3)

The CHAIRMAN, introducing the item, said that informal consultations had already begun on the draft resolution contained in document A65/17 Add.2, the financial and administrative implications of which were set out in document A65/17 Add.3. Pending the results of those consultations, he invited general comments on the implementation of the International Health Regulations (2005).

Mr SKOTHEIM (Norway) said that, in order to save time, he would submit the full text of his statement to the Secretariat in writing.

Dr AL-TAAE (Iraq) said that Iraq considered the International Health Regulations (2005) to be a key part of global health partnership and had taken several measures to implement them nationally, including establishing within the Ministry of Health a steering committee and focal points. Legislation and workplans had been developed or strengthened for the implementation of the Regulations across all sectors; particular issues of concern had been addressed and monitoring and evaluation strategies had been developed. His Government's priorities included halting the transmission of communicable diseases, developing procedures to ensure food safety, scaling up joint management, planning, monitoring and evaluation measures across all ministries. It would continue to incorporate the requirements of the Regulations into key areas of health, including control of communicable diseases, health of travellers, and food and medicines.

Dr HEMMATI (Islamic Republic of Iran) said that the threat posed by pandemic (H1N1) 2009 had provided countries with the opportunity to evaluate their preparedness for public health emergencies of international concern. All Member States should use the International Health Regulations (2005) core capacity monitoring framework to develop and strengthen their core capacities in order to ensure that they would be able to deal successfully with future public health emergencies. To address the challenges that remained in implementing the Regulations, additional interregional collaboration mechanisms were needed, as was further technical support from WHO to strengthen capacity in areas such as human resources, surveillance and cross-border health activities.

Ms POLL (Costa Rica) said that the Regulations were fundamental to monitoring health at all land, air and sea borders. Her country's Ministry of Health had been responsible for implementation, supported by other sectors and PAHO, and significant progress had been made. Core capacities had been assessed, and improvement and contingency plans had been established. Subnational monitoring

plans had also been developed at points of entry. The country was thus well prepared to respond to any public health event of international concern. Efforts had also included the production of guidelines for dealing with specific situations, including coordinating the notification and management of emergencies relating to contaminated food and to bioterrorism, and for communication of risk when transferring a patient from one country to another. Her delegation called on the international community and on the Secretariat to continue supporting countries in implementing the Regulations and sustaining the progress already made.

Ms SCHJØNNING (Denmark), speaking on behalf of the European Union and its Member States, said that the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement. The International Health Regulations were the core instrument for improving global health security, and she strongly encouraged all States Parties to collaborate actively in ensuring full implementation of the Regulations, particularly strengthening and maintaining the required core capacities. The Health Assembly should continue to monitor progress.

As the June 2012 deadline approached, a review was needed to determine the extent to which the core capacities had been implemented and what action was needed in order to overcome remaining challenges to full and effective implementation. There was a clear need to keep implementation of the Regulations high on the international health agenda, and the European Union therefore urged the Secretariat to formulate a post-2012 workplan for guidance, training and assessment of States Parties' implementation of the core capacities, so as to ensure that the Regulations remained the common leading instrument for global health security.

Dr DÍAZ (Chile) reaffirmed his Government's commitment to enhancing its human, physical and financial resources in the health sector in order to implement the Regulations. By June 2012, Chile would have fulfilled 93% of the core capacity requirements under the Regulations and would continue to work towards full compliance by improving point-of-entry surveillance and response capabilities and developing intersectoral contingency plans. The Government did not intend to request an extension of the deadline. It was willing to share its experience with other Member States in order to further global implementation of the Regulations.

Ms ALI (Maldives), speaking on behalf of the Member States of the South-East Asia Region, said that, while significant progress had been made in strengthening core capacities in the Region, the level of implementation was uneven among countries and across capacities. Fulfilling the requirements of the Regulations demanded policy and action in non-health sectors and greater commitment and partnership at the national, regional and global levels. WHO should have an increased role in advocacy and facilitating dialogue.

Meeting the core capacity requirements by the June 2012 deadline would be a challenge, and most Member States in the Region would be applying for a two-year extension. Achieving full compliance within that extension period would require realistic implementation plans, with political commitment at the country level and continued technical and financial support from WHO and other partners. WHO support would be particularly welcome in regard to conducting full assessments of core country capacities and developing guidelines and ensuring the availability of contingency funding for public health emergencies. The current financial constraints faced by WHO and the low level of donor and partner support were matters of concern, especially as the full implementation of the Regulations required financial investment beyond the capacity of developing countries. Urgent action was needed to resolve the issue of funding if the deadlines for implementation were to be met.

Mr ROLLIANSYAH SOEMIRAT (Indonesia) said that it was vitally important to strengthen core capacities and develop national plans for the implementation of the International Health Regulations as a means of achieving global health security. Her Government had established a national committee on implementation of the Regulations but recognized that there were many areas where capacity still needed strengthening. It had therefore applied for an extension of the deadline to mid-2014.

Dr RAMSARAN (Guyana), speaking on behalf of the member countries of the Caribbean Community, said that an analysis of core capacity levels had shown clear regional differences in current strengths and weaknesses; intensified efforts were required from countries, the Secretariat and the regional offices to eliminate those regional variations. The capacity of the countries of the Caribbean Community to respond to chemical and radionuclear events was currently weak but, through support from PAHO and the Caribbean Epidemiology Centre, subregional plans had been formulated for strengthening systems of regulation, detection and response to such events. Individual country action plans would allow for national responses involving not just the health sector but all stakeholders. Other subregional activities included the development of a training curriculum on inspection of ships and aircraft; courses on port health, which could be offered online; and workshops on strengthening legislation and collaboration with ICAO and IAEA in order to build core capacities.

Dr SA'A (Cameroon) said that, despite facing a number of challenges, his Government had made significant progress in strengthening the core capacities required under the International Health Regulations. He commended the Secretariat's development of indicators and tools to be used in the annual monitoring of implementation of the Regulations. It was to be hoped that continued Secretariat support would be provided to help countries attain their core capacities by the extended deadline of mid-2014.

Mr NEVES SILVA (Brazil) emphasized that all countries must remain committed to assessing and developing their core capacities for surveillance and response to public health emergencies and to implementing the Regulations. The Secretariat should ensure that the necessary support was provided to countries. His Government had complied with the requirements set out in Annex 1 of the Regulations and had carried out an assessment of capacities at the subnational level and developed a plan to strengthen them further. It remained committed to supporting other countries in the implementation process in a spirit of South-South cooperation.

Dr HAO Yang (China) said that the implementation of the Regulations had greatly contributed to the development of capacities for assessment, surveillance and response to public health emergencies. His Government was continuing to strengthen core capacities and, to that end, had held training workshops and ensured real-time communication with WHO. He underscored the need for all States Parties to improve their core capacities for assessment, notification and response to public health emergencies. WHO had provided valuable support and tools to countries in recent years for monitoring capacity building at subnational level. States Parties should respond to the relevant WHO questionnaires with a view to determining whether they could meet the June 2012 deadline for fulfilling the core capacity requirements.

Mrs SMIRNOVA (Russian Federation) observed that although many Member States had made progress towards achieving the core capacities required under the Regulations, others had more to do and would need to take action within a relatively short space of time. It was very important for countries requesting an extension to identify gaps, formulate clear national plans to eliminate them and mobilize all necessary resources to that end. Some countries, particularly those with limited resources, would doubtless need support from WHO and other partners, but there must be a clear understanding of what support was required.

The Russian Federation had developed a methodology for implementing the Regulations and applied it at national level. Steps were being taken to modernize the national laboratory network, enhance intersectoral cooperation, and formulate and implement training programmes for experts. National standards and methodologies had been aligned with the Regulations. By the deadline set, all core capacities would be in place. Her Government stood ready to provide scientific and human resources to assist other States Parties in building and strengthening their core capacities. She welcomed the guidelines produced by the Secretariat thus far and requested that guidance also be prepared on port certification procedures.

Ms MATSOSO (South Africa) said that States Parties to the International Health Regulations needed to ensure a common interpretation of public health requirements, with uniform procedures for vaccine-preventable and epidemic-prone diseases in particular. Drawing attention to the section in the Secretariat's report (document A65/17) on yellow fever and the list of countries where it still occurred, she requested clarification on the proper interpretation of Annex 7, when read in conjunction with Article 31, paragraph 2, and Article 36 of the Regulations. All States Parties should adhere to their commitments under the Regulations, given their importance for controlling the spread of disease and protecting health.

Dr CHIN Zing Hing (Malaysia) expressed appreciation for the Secretariat's continued efforts to support countries in developing their core capacities under the International Health Regulations. While Malaysia had already attained its core capacities, it would continue to strengthen them in the areas of importance identified in the Asia Pacific Strategy for Emerging Diseases 2010, which also served as a strategy for compliance with the International Health Regulations (2005).

Dr DAULAIRE (United States of America) said that the International Health Regulations had proved their value in protecting the international community from the spread of public health threats across borders and it was therefore critically important, in the next two years, to intensify international efforts to build core capacities for the benefit of all Member States. His Government had taken several measures to ensure compliance with the Regulations, including through a trilateral, cross-sectoral plan with Canada and Mexico on preparing for and responding to pandemic influenza threats. He urged all countries to formulate similar plans to improve information-sharing and preparedness. The Secretariat should continue to work with Member States to ensure full compliance with the Regulations by mid-2014 and should also facilitate connections between countries and potential providers of support in the strengthening of national core capacities.

Ms BALAS (Germany) expressed appreciation for the Secretariat's support to Member States for the implementation of the Regulations, which had been an enormous task, but one that had contributed considerably to better global public health preparedness. Her Government had produced legislation fulfilling the legal requirements of the Regulations and had worked hard to translate the requirements relating to airports, ports and ground crossings into national recommendations. It would be pleased to share those recommendations with other interested States Parties in order to support their own implementation efforts. The Secretariat should continue to support Member States in further developing their preparedness and response capacities in the post-2012 period.

Dr GORI MOMOLU (Equatorial Guinea) said that his Government had provided training to staff in various areas to help implement the Regulations throughout the country, including at points of entry, ports and airports. National surveillance and response capacity had been assessed and a plan of action developed. A national focal point had also been appointed for the management of health emergencies, and border personnel had received training on the notification of and response to such emergencies.

Mr LASKAR (Bangladesh) noted that although progress had been made on implementing the International Health Regulations (2005), many countries would not be able to meet the June 2012 deadline owing to technical and financial constraints. Bangladesh had made considerable progress in building capacity, particularly in relation to surveillance, management of public health emergencies of international concern, laboratory strengthening and the drafting of a new law to enforce the Regulations. However, additional financial, human and material resources were needed in order to ensure full compliance, particularly in the areas of infection control and prevention and the implementation of measures at border entry points. He urged the Secretariat to mobilize additional resources to support Member States in meeting the proposed extended deadline for implementation. Advocacy efforts should be strengthened with all stakeholders in order to raise awareness of the importance of the Regulations, and support should be provided to enable Member States to improve their border entry point capacities.

Dr JIMA (Ethiopia), speaking on behalf of the Member States of the African Region, said that, although significant progress had been made in the assessment of national core capacities in relation to surveillance and response, laboratory services and zoonotic events, many countries in the African Region had reported relatively low capacity in relation to human resources and the detection of chemical and radionuclear events. To date, 40 of the 46 African Member States had assessed their national core capacities for surveillance and response and had developed plans of action. Thirty had identified competent authorities to oversee the implementation of public health measures in line with the Regulations and 19 countries had assessed capacity at designated points of entry. However, in spite of the progress made, many African countries would not be able to meet the June 2012 deadline, mainly owing to lack of financial resources. The Secretariat had an important role to play in mobilizing resources and supporting Member States in accelerating the attainment of the core capacities, including assessment and enhancement of laboratory capacity; development of new tools to strengthen capacity at points of entry; and training of public health professionals. It was of particular importance to enable African Member States to attain the core capacities, given that many of the diseases with the potential to cause international health emergencies originated in the Region.

Dr IWATA (Japan) said that many Member States would not be able to fulfil the core capacity requirements by the agreed initial deadline and asked the Secretariat what support they could be given in that regard. Additional technical support should be provided to Member States to enable them to improve the detection of and response to chemical and radionuclear events and emergencies. The development of an enforcement mechanism would increase the operational effectiveness of the International Health Regulations (2005). Japan was continuing to strengthen its domestic system for implementation of the Regulations and stood ready to promote international cooperation, in collaboration with WHO, for the building of core capacities.

Dr SALALH (Egypt) said that his country was implementing the International Health Regulations and strengthening its human resources in that area. The Ministry of Health had developed a web site providing information on the country's core capacities, which might be useful to other Member States. Referring to the outbreak of *Escherichia coli* (E. coli) O104:H4 in Germany in 2011, he thanked WHO for the support provided to establish the source of the outbreak. Egypt had been wrongly alleged by some to be the source, which had led to significant economic losses as a result of reduction in trade. Countries and organizations should not implement restrictions or bans on the import of products without consulting and cooperating with the countries concerned, given the potential social and economic impact. WHO should maintain a leading advisory role in such matters.

Mr URQUIDO VELÁSQUEZ (Colombia) said that full compliance with the International Health Regulations and the strengthening of national core capacities were essential to national and international public health security. His Government had developed a programme to implement the Regulations, which included assessment of national core capacities; institution-building and allocation

of resources at the local level to enhance monitoring and response capacities; strengthening of international and cross-border cooperation; support and technical support for port health; and strengthening of national communication links and networks for purposes of monitoring, risk assessment and reporting to WHO of events posing a potential risk to global public health. Member States must continue their efforts to apply the Regulations, which were an important instrument for the monitoring and management of public health and gave new meaning to the concept of national and global public health security.

Ms WISEMAN (Canada) said that her Government remained committed to collaborating with WHO and PAHO to support the implementation of the International Health Regulations, which continued to pose significant challenges for some Member States, a number of which would not meet the core capacity requirements by the June 2012 deadline. Considerable effort would be needed to ensure that national core capacity requirements were met by the new 2014 deadline. Partnerships would be important for stimulating progress, as would strong national focal point networks and the promotion of knowledge-sharing activities, which would encourage the exchange of public health information as well as resources and best practices.

Dr BENJAPORN PANYAYONG (Thailand) welcomed the progress made in strengthening implementation of the Regulations, but expressed concern at the slow progress made by some States Parties in building human resource capacity, especially in relation to chemical and radionuclear events. Multisectoral action and international collaboration were essential for the effective implementation of the Regulations; States Parties and the Secretariat should work together to promote the engagement of stakeholders at all levels. Multiple channels of communication should be promoted, including between national focal points and the Organization, as well as with formal and informal national, regional and transregional networks, in order to ensure a timely and effective response to public health emergencies of international concern. Regional and global networks should be supported and fostered; they had already proved to be effective in providing an immediate cross-border response to avian influenza A(H5N1). Field epidemiology training programmes, such as the ASEAN+3 Field Epidemiology Training Network, had contributed to the strengthening of human resources.

Dr LARIK (Pakistan) said that the International Health Regulations were essential to protect communities from cross-border infections. His country had completed the self-assessment questionnaire on the implementation of the Regulations and had taken a range of measures to improve port health, including the establishment of health clearance certificates, ship sanitation control certificates and ship sanitation exemption certificates that were periodically reviewed to ensure their effectiveness and alignment with international norms. National monitoring and surveillance systems had been established at all entry points in order to prevent cross-border transmission of yellow fever. As a result, Pakistan was yellow fever-free. The provision of additional technical support would enable his country to be fully compliant with the Regulations, in particular with regard to laboratory strengthening, the implementation of early warning systems and the preparedness of public health professionals, especially in the context of radionuclear and chemical events. His country would be requesting an extension of the compliance deadline.

Dr ALLENDE (Paraguay), speaking on behalf of the member and associate member countries of the Common Market of the Southern Cone (MERCOSUR), said that MERCOSUR had designed an instrument to assess national core surveillance and response capacities, and PAHO had assisted in the migration of the data collected. However, the assessment did not include core capacities at points of entry. Noting that a number of guidelines and other important documents existed only in English, he urged the Secretariat to provide them in all of the six official languages of WHO.

Although States Parties to the Regulations were required to provide a rapid response to radionuclear and chemical events, that would not always be possible given the time required to analyse the necessary data and consult the relevant experts at all levels of government. Requests for

information in relation to such events should be made directly to the highest ministerial authority, allowing it sufficient time to provide a comprehensive response. MERCOSUR countries had faced a number of challenges in implementing the Regulations, including lack of procedures for monitoring overall compliance and difficulties in defining the measures needed to address key aspects of implementation. The operational framework of the Regulations should be reviewed, including the definition of the functions of national communication networks and the feasibility of ensuring full compliance, including the financial implications. Full implementation of the Regulations would require a concerted effort on the part of all States Parties.

Dr BANGA-MINGO (Central African Republic) said that the International Health Regulations were an important instrument for preventing and controlling communicable diseases, which remained the most serious public health issue in many countries, including his own. With the support of WHO, his country had made some progress in applying the Regulations, for example by establishing an institutional and regulatory framework to facilitate implementation, by raising awareness, and by strengthening national core capacities and epidemiological surveillance activities. However, full implementation of the Regulations was hindered by a number of major challenges, including insufficient qualified human resources, lack of resources, and an inadequate technical platform to support the health system and laboratories in monitoring and surveillance activities. His Government was working to strengthen those areas and reinforce multisectoral partnerships in order to achieve compliance with the Regulations. Full implementation was also hindered by the apparent unwillingness of neighbouring countries to declare outbreaks of disease promptly and candidly, owing to the possible implications for trade and tourism. He encouraged all States Parties to adhere to the Regulations in order to facilitate the management of global public health risks and emergencies.

Dr Ho-Sheng WU (Chinese Taipei) encouraged the Secretariat to continue providing support to those countries that would not meet the national core capacity requirements by the mid-2012 deadline. Chinese Taipei had attained the minimum core capacity requirements and would willingly share its experience. It would also continue to work with the Secretariat and States Parties in detecting the emergence of infectious diseases and potential public health emergencies of international concern. He expressed support of the Secretariat's activities with global partners to monitor, assess and respond to important food safety-related events and looked forward to further international collaboration on health issues of global concern.

Dr FUKUDA (Assistant Director-General), thanking Member States for their comments, said the Secretariat had understood the interventions and that appropriate responses would be provided to the concerns raised.

The CHAIRMAN asked the Secretary to read out the amendments to the draft resolution contained in document A65/17 Add.2, as proposed by an informal drafting group.

Dr DAYRIT (Secretary) said that the amendments focused on four key areas: the difficulties in implementing the Regulations with regard to points of entry; the need for constructive engagement of stakeholders; the importance of regional and transregional networks; and the provision of an interim progress report to the 132nd session of the Executive Board. In preambular paragraph 4, "Member States" should be changed to "States Parties". Preambular paragraph 4bis should read: "Recognizing that there still exist difficulties to the implementation of International Health Regulations, especially regarding points of entry, including with respect to the operational understanding of International Health Regulations, which make it necessary to strengthen the capacities related to Annex 1.B". Preambular 4ter should read: "Recognizing the importance of having available tools and procedures for continuous monitoring of core capacities related to Annex 1.A and 1.B".

Preambular paragraph 5bis should read: "Recognizing the need to strengthen the role and capacity of States Parties and international organizations in effective implementation of IHR that

requires constructive engagement of stakeholders in health and non-health sectors as well as regional and transregional networks of States Parties". Preambular paragraph 6 should read: "Recognizing that States Parties may, as provided for in the International Health Regulations (2005), report to WHO and obtain, on the basis of a justified need and an implementation plan, an extension of two years in which to fulfil their obligations, and acknowledging in particular the decision of the majority of the Member States of the African Region of WHO to seek such an extension". In paragraph 2 of the draft resolution, "Member States" should be changed to "States Parties" and a footnote should be inserted thereafter to read: "And, where applicable, regional economic integration organizations". Subparagraph 2(1) should read: "to ensure identification of remaining gaps including institutional, human and financial resources in the development, strengthening and maintenance of the core public health capacities required under the International Health Regulations (2005), including Articles 5 and 13 and Annex 1, in accordance with their national implementation plans".

Mrs ESCOREL DE MORÃES (Brazil), rising to a point of order, said that in view of the large number of amendments, a document containing the full text of the amended draft resolution should be prepared. Although the drafting group had reached consensus on the amendments, it was important for all Member States to see them and fully understand their implications.

The DIRECTOR-GENERAL said that the proposed amendments had already been translated into two official languages and the existing language versions could be made available to participants immediately. If Member States wished to have the text in all six official languages, she would recommend that the meeting be suspended and reconvened once all language versions were available.

The CHAIRMAN took it that the meeting should be suspended pending preparation of all six language versions of the amendments.

It was so agreed.

The meeting was suspended at 12:50 and resumed at 14:40.

The CHAIRMAN drew attention to a revised version of the draft resolution contained in document A65/17 Add.2, incorporating all the proposed amendments proposed by the draft group, and which read:

Further to the submission of the two reports on implementation of the International Health Regulations (2005) (documents A65/17 and A65/17 Add.1), the Health Assembly is invited to consider the following draft resolution.

The Sixty-fifth World Health Assembly,

PP1 Having considered the reports on implementation of the International Health Regulations (2005);¹

PP2 Recalling resolution WHA58.3 on revision of the International Health Regulations, which underscored the continued importance of the International Health Regulations as the key global instrument for the protection against the international spread of disease, and which urged Member States inter alia to build, strengthen and maintain the capacities required under the International Health Regulations (2005) and to mobilize the resources necessary for that purpose;

¹ Documents A65/17 and A65/17 Add.1.

PP3 Recalling that Articles 5.1 and 13.1 of the International Health Regulations (2005) provide that each State Party shall, as soon as possible but no later than five years from entry into force of the Regulations for that State Party, develop, strengthen and maintain the capacity to detect, assess, notify and report events, in accordance with the Regulations, as specified in Annex 1 therein, and to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in that Annex, and that the date for having these core public health capacities falls in June 2012 for all but a small number of States Parties which have later dates;¹

PP4 Also recalling resolution WHA61.2 on implementation of the International Health Regulations (2005), which urged ~~Member States~~ **States Parties [secretariat]** to take steps to ensure that the national core capacity requirements specified in Annex 1 to the Regulations are developed, strengthened and maintained, in accordance with Articles 5 and 13 of the International Health Regulations (2005);

PP4bis Recognizing that there still exist difficulties to the implementation of International Health Regulations, especially regarding points of entry, including with respect to the operational understanding of International Health Regulations, which makes it necessary to strengthen the capacities related to Annex 1B [Argentina, Finland, Switzerland]

PP4ter Recognizing the importance of having available tools and procedures for continuous monitoring of core capacities related to Annex 1A and 1B.

PP5 Further recalling resolution WHA64.1 on implementation of the International Health Regulations (2005), which urged Member States to support the implementation of the recommendations contained in the final report of the Review Committee on the Functioning of the International Health Regulations (2005) in relation to Pandemic (H1N1) 2009,² which in its first recommendation noted the need to accelerate implementation of the core capacities required by the Regulations;

PP5bis Recognizing the need to strengthen the role and capacity of States parties and International Organizations, in effective implementation of IHR, that requires constructive engagement of stakeholders, in health and non-health sectors as well as regional and trans-regional networks of States Parties [Thailand]-

PP6 Recognizing that ~~Member States~~ **Parties** may, as provided for in the International Health Regulations (2005), report to WHO and obtain, on the basis of a justified need and an implementation plan, an extension of two years in which to fulfil their obligations, **and acknowledging in particular the decision of the majority of the Member States of the Africa Region of WHO to seek such an extension [Ethiopia]**

1. AFFIRMS its renewed commitment to full implementation of the International Health Regulations (2005);

¹ The time frames for the States Parties which made reservations to the International Health Regulations (2005) (United States of America and India) are slightly later (entry into force for United States of America on 18 July 2007, and for India on 8 August 2007). The time frame was also later for Montenegro (entry into force 5 February 2008), which became a State Party after entry into force of the Regulations on 15 June 2007; and for Liechtenstein (which became a State Party in 28 March 2012). See States Parties to the International Health Regulations (2005) at http://www.who.int/ihr/legal_issues/states_parties/en/ (accessed 21 May 2012).

² Document A64/10.

2. URGES States Parties¹:

- (1) to ensure identification of remaining **including institutional, human and financial resources [Thailand]** gaps in the development, strengthening and maintenance of the core public health capacities required under the International Health Regulations (2005), including Articles 5 and 13 and Annex 1, in accordance with their national implementation plans;
- (2) to take the necessary steps to prepare and carry out appropriate national implementation plans in order to ensure the required strengthening, development and maintenance of the core public health capacities as provided for in the International Health Regulations (2005);
- (3) to respect time frames stipulated in the International Health Regulations (2005) in Articles 5 and 13 and Annex 1 for undertaking and completing activities and communications relating to implementation of core capacity requirements and procedures concerning related extensions;
- (4) to strengthen coordination and collaboration among **and within [EU] States Parties** intersectorally and multisectorally to develop, ~~and~~ establish **and maintain [Japan]** the core public health capacities and operational functions required under the International Health Regulations (2005);
- (5) to further strengthen active collaboration among ~~Member~~ States Parties, WHO and other relevant organizations and partners as appropriate, by measures including the mobilization of technical ~~and~~ financial **and logistical [Japan]** support for building core public health capacities, so as to ensure full implementation of the International Health Regulations (2005);
- (6) to reconfirm their support to developing countries and countries with economies in transition upon their request in the building, strengthening and maintenance of the core public health capacities required under the International Health Regulations (2005);

3. REQUESTS the Director-General:

- (1) to build and strengthen the capacities of WHO to perform fully and effectively the functions entrusted to it under the International Health Regulations (2005), in particular through strategic health operations that provide support to countries, **regional and trans-regional networks of States Parties [Thailand]** in detection, reporting and assessment of, ~~and~~ response to, **and capacity strengthening in [Thailand]** public health emergencies;
- (2) to collaborate ~~with~~ **and assist [Canada, Egypt]** States Parties through ministries of health as well as all other relevant ministries and sectors in the mobilization of technical support and financial resources to support building, strengthening and maintaining the core capacities required under the International Health Regulations (2005), **in particular those related to Annex 1B in relation to ports of entry core capacities [Argentina]** including technical support to help interested countries to assess their own needs and to make the business case for investment in implementing the Regulations, in accordance with national plans;
2bis to promote the engagement with relevant international organizations and stakeholders to strengthen their contribution towards effective IHR implementation [Thailand]

¹ And, where applicable, regional economic integration organizations.

(3) to ensure the transparent sharing of information on progress of States Parties in the full implementation of the national core capacities required under the International Health Regulations (2005), so as to facilitate provision of appropriate support **including guidance and training [EU]** as needed, by posting the list of States Parties that have requested and received extensions to the initial deadline on the restricted WHO web site for National IHR Focal Points;

(4) to facilitate the provision of appropriate support between and among States Parties for the establishment of the national core capacities required under the International Health Regulations (2005) by posting a relevant summary of the country information collected through the IHR core capacity monitoring framework on the restricted WHO web site for National IHR Focal Points;

(5) to monitor the progress of each State Party that has received an extension to the initial deadline using the implementation plans submitted with the request for extension and the annual reports required under Articles 5.2 and 13.2 of the International Health Regulations (2005) from all States Parties receiving extensions;

(6) to monitor the maintenance of the national core capacities required under the International Health Regulations (2005) in all States Parties not requesting extensions to the deadline through the development of appropriate ~~indicators~~ **methods of assessing [EU]** of effective functioning of the established core capacities;

(7) to develop and publish the criteria to be used in 2014 by the Director-General, in conjunction with the advice of the Review Committee of the International Health Regulations (2005), when making decisions about the granting of any further extensions to the timeline for establishment of the national core capacities as provided for in Articles 5.2 and 13.2;

7bis to submit an interim progress report to the Sixty-sixth World Health Assembly through the Executive Board at its 132nd session [Canada];

(8) to report to the Sixty-seventh World Health Assembly, through the Executive Board at its 134th session, on progress made by States Parties and the Secretariat in implementing this resolution.

Dr DAYRIT (Secretary) said that there were a number of typographical errors in the document, including the following in particular: in subparagraph 2(1), the word “gaps” should be moved from the second line so that it appeared after the word “remaining” in the first line. In subparagraph 3(2), the words “ports of entry” should be changed to “points of entry”.

Mr ADMASU (Ethiopia) proposed that in the sixth preambular paragraph, the words “the majority of the” should be changed to “many” and the words “of the African Region of WHO” should be deleted.

Mr THOMSON (Switzerland) said that, in preambular paragraph 4, the words “Member States Parties” should be changed to “States Parties”, in line with the language used in resolution WHA61.2. He also suggested that in subparagraph 3(1) in the French language version, “*des urgences de santé publique*” should be moved to the end of the paragraph.

Ms WISEMAN (Canada) suggested that in subparagraph 3(2) the word “with” should be inserted after the word “collaborate”, in line with the original wording contained in document A65/17 Add.2.

Dr BANGA-MINGO (Central African Republic) suggested changing the words “*établir et appliquer*” to “*élaborer et mettre en oeuvre*” in subparagraph 2(2) of the French language version.

The CHAIRMAN said that he took it that the Committee wished to approve the draft resolution, with the proposed amendments.

The draft resolution, as amended, was approved.¹

3. FOURTH REPORT OF COMMITTEE A (Document A65/58)

Dr MALECELA (United Republic of Tanzania), Rapporteur, read out the draft fourth report of Committee A.

The CHAIRMAN said that, in the absence of any objections, he took it that the Committee wished to adopt the report.

The report was adopted.²

4. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee A completed.

The meeting rose at 14:55.

¹ Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA65.23.

² See page 276.

COMMITTEE B

FIRST MEETING

Wednesday, 23 May 2012, at 11:40

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

later: Professor C.K. AGBA (Togo)

1. OPENING OF THE COMMITTEE: Item 14 of the Agenda

The CHAIRMAN welcomed participants and Dr Mouzinho Saíde, who, as Chairman of the Programme, Budget and Administration Committee of the Executive Board, would report on several issues on the agenda dealt with on behalf of the Executive Board by that Committee at its sixteenth meeting (Geneva, 16 to 18 May 2012).

Election of Vice-Chairmen and Rapporteur

The CHAIRMAN informed the Committee that Professor Charles Kondi Agba (Togo) and Dr Enrique Tayag (Philippines) had been nominated for the offices of Vice-Chairmen of Committee B, and Dr Paul Gully (Canada) for the office of Rapporteur.

Decision: Committee B elected Professor C. K. Agba (Togo) and Dr E. Tayag (Philippines) as Vice-Chairmen, and Dr P. Gully (Canada) as Rapporteur.¹

2. ORGANIZATION OF WORK

The CHAIRMAN appealed to speakers to limit their statements to three minutes. As agreed in plenary, agenda item 15 would be dealt with after consideration of item 16.1. The agenda items allocated to the Committee would then be dealt with in the order in which they appeared in the agenda, document A65/1 Rev.1.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, noted that the European Union worked closely with WHO on a wide range of matters, both within the European Region and at the global level. In view of the exchange of letters in 2000 between WHO and the European Commission concerning the consolidation and intensification of cooperation, and without prejudice to any future conclusion of a general agreement between WHO and the European Union, she requested that, in accordance with Rule 46 of the Rules of Procedure of the World Health Assembly and as on previous occasions, the European Union should be invited to participate as an observer, without vote, in the meetings of the Health Assembly, its committees and subcommittees or other subdivisions dealing with matters within the competence of the European Union.

It was so agreed.

¹ Decision WHA65(4).

3. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 16 of the Agenda

Programme budget 2010–2011: performance assessment: Item 16.1 of the Agenda (Documents A65/28 and A65/44)

Dr SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, reported on the work of its sixteenth meeting as reflected in document A65/44. The Committee recommended, on behalf of the Executive Board, that the Health Assembly note the performance assessment of the Programme budget 2010–2011.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, recognized that the majority of the expected results for the biennium 2010–2011 had been fully achieved and that most of the partly achieved results had only narrowly missed the targets. At the same time, some of the strategic objectives with a high number of fully achieved results had clearly received less funding than was provided for in the approved Programme budget. The European Union would welcome further explanation as to whether the targets had been set too low or the necessary funding estimates too high. Furthermore, the analysis of Organization-wide expected results varied substantially. In many cases the assessment of WHO's output and contribution to the results achieved was unclear. The performance assessment was hampered by a structural defect as a result of the way in which the Programme budget was set up. Performance could only be measured against realistic targets, meaning targets that the Organization could theoretically achieve, depending on its mandate, efficiency and effectiveness. Moreover, budgeting must be based on proper estimates of costs through standardized costing of activities, which implied that the resources needed should actually be available. Introducing a resource-based management framework meant focusing on results, setting realistic targets with measurable indicators and ensuring that the budget was funded. The draft budget must include information on available and aspirational resources in order to give an indication of the funding gap. Performance assessment was a learning tool; the European Union therefore asked the Secretariat what major lessons could be learnt from the report. It further requested the Secretariat to be more specific about the three assessment levels, namely "fully met", "partially met" and "not met", in the next performance assessment. The European Union believed that annual reporting would provide better transparency and more timely lessons.

Ms HALÉN (Sweden), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, and endorsing the statement made by the delegate of Denmark on behalf of the European Union, said that three things were necessary for a results-based system: a budget based on expected results; measurable goals, targets and indicators to measure performance; and a results analysis that fed into strategic planning. While WHO's results-based management was better than many other international organizations, a stronger focus on results and clearer links between the budget and expected results were needed. The report indicated a weak relationship between budget levels and results. Moreover, as most of the indicators did not adequately reflect the performance of the Secretariat, it was difficult to draw conclusions about the Organization's contribution to achieved results. Two types of indicators were problematic: those that measured country performance but not WHO's contribution to it, and those that measured production of tools that could vary from a pamphlet to a technical manual that had taken months to produce. Improved analysis of results and performance was also required in order to feed into strategic planning, enhance WHO's credibility and stimulate donor investment. The Nordic countries would like to see results reported on three levels: WHO outputs; WHO's contribution to country effects in the short to medium term; and WHO's contribution to country and global health in the medium to long term. In addition, denominators should be developed that more accurately reflected levels of achievement between "fully achieved" and "not achieved": it was misleading for an achievement rate of 10% to be ranked in the same way as one of 95%.

Ms BLACKWOOD (United States of America) welcomed the report's detailed assessment of WHO's performance in the 2010–2011 biennium. The presentation of programme implementation information was an essential part of results-based management and provided a good basis on which to assess how effectively the Organization was aligning resources with strategic objectives. She supported WHO's efforts to deal with the funding gap that had resulted from contributions being lower, and costs higher, than projected. The initiatives taken to reduce costs and improve efficiency were particularly welcome. Aligning herself with the observation by the delegate of Sweden that the Secretariat should provide more detailed information on how results were reported, she emphasized that details concerning challenges identified and lessons learnt should inform future budgets.

Dr OUMAROUDOU (Niger), speaking on behalf of the Member States of the African Region, welcomed the progress that had been made in capacity building and compliance with WHO's standards and criteria, but pointed out that the relatively poor results achieved in relation to strategic objective 2, to combat HIV/AIDS, tuberculosis and malaria, represented a serious threat to the continent of Africa. He noted that Base programmes were the segment of the budget that had received the least contributions, which explained the unsatisfactory results achieved in that area. He inferred that donors were more likely to fund specific programmes than the fight against epidemics, but pointed out that the Base programmes represented a sustainable strategy for improving the health of communities. The resource mobilization rate had reached 93% overall and 82% for the regions, but that was still inadequate in terms of global needs and targets.

Dr LI Mingzhu (China) noted that a great many positive results had been achieved in the biennium 2010–2011. Referring to the specific opinion expressed by China at the meeting of the Programme, Budget and Administration Committee the previous week, he drew attention to the fact that the performance assessment for 2008–2009 had contained a paragraph for each strategic objective, setting out the lessons learnt; that was a practice which China considered to be extremely useful and which it hoped to see continued.

Mr BLAIS (Canada) observed that performance assessment provided important information to Member States in support of their governing role. Recent improvements in the performance reporting process were commendable, but significant weaknesses remained, particularly with regard to the achievement of Organization-wide expected results. Canada encouraged the Secretariat to continue strengthening the entire assessment framework in order to ensure that performance reporting was accurate, reliable and, most importantly, consistent with the other means of evaluation and reporting being carried out, especially in the light of the new evaluation policy that was to be introduced.

Dr DAHL-REGIS (Bahamas) said that, while some progress had been made on performance indicators, which constituted a relatively new exercise, more work was required, especially in the area of reporting on the different levels of the Organization. Referring to paragraph 9 of document A65/44 on the allocation of resources to priority areas, she said that, if the matter were not given full attention, it would be difficult to interpret what the Organization was doing and how it was meeting its strategic planning requirements; that would hamper the ongoing reform process. Work on aligning the programme and the budget must continue. She requested details from the Secretariat on how it planned to address those issues.

Miss AUNGSUMALEE PHOLPARK (Thailand) expressed two concerns. First, the overall approved Programme budget 2010–2011 had been greater than the funds available and Base programmes had been underfunded, while special programmes and collaborative arrangements, and outbreak and crisis response had been overfunded. That might affect WHO's overall performance. The matter should be addressed by WHO reform through appropriate prioritization processes. Secondly, notwithstanding the higher proportion of fully achieved results compared to partly achieved results, there was still room for improvement on every objective except WHO leadership, governance, and

partnerships. The fact that developing countries' performance in relation to HIV/AIDS, tuberculosis and malaria was poorer than on other strategic objectives was also a matter of concern. More work was therefore needed on under-performing objectives so that planned targets could be met.

Dr EL ISMAIL LALAOUI (Morocco) said that the main concerns expressed by previous speakers had related to methods, targets and indicators, particularly with regard to the reliability of the results presented in the performance assessment. It was important to ensure that the reform process took account of all the methodology-related issues that had been raised during the current discussion. He therefore urged that an external evaluation should be made of the working methods used; it was possible that the evaluation would find that no changes were needed, but it might also show that new mechanisms were required to ensure that WHO was on the right track to achieve its objectives.

Dr JAMA (Assistant Director-General) said that the report contained in document A65/28, the second of its kind, was a self-assessment exercise across all three levels of the Organization and was an important tool for describing lessons learnt. There was consistency in the reporting, but he noted the deficiencies highlighted by Member States. The results chain, which was a major component of the reform process, would clarify the output, outcome and impact of the work of the Secretariat. Although significant progress had been made in reporting at all levels, the main programme budget issue was the selection of indicators, which was defined as an outcome, not as an output that could directly be attributed to the Secretariat. The difference between outcomes and outputs was that outcomes were results achieved by the Secretariat in conjunction with Member States, while outputs were results that the Secretariat could show that it had achieved and for which it was accountable.

He reminded the Committee that the Programme budget 2010–2011 had been aspirational and acknowledged the concerns raised by Member States regarding the uneven implementation rate and the uneven distribution between strategic objectives and major offices. Referring to Table 2 in the report, which showed that Base programmes had been funded at 73% of requirements whereas the implementation rate in the same segment had been 90%, he said that the Secretariat recognized the challenges posed by structural discrepancies, which would be addressed in the 2014–2015 budget. Funding of Organizational priorities still required improvement, and it was hoped that the reform process would address the concerns expressed by Member States in that regard. The discrepancies between funding of the strategic objectives and the results achieved could be explained by cost increases in the case of some strategic objectives and the use of earmarking.

Steps should be taken to improve the method used to formulate objectives, results, indicators and targets. There was currently some confusion between what the Member States were achieving in partnership with the Secretariat, and what the Secretariat was expected to achieve independently. It was hoped that that issue would be addressed through the reform process. As requested by Member States, the lessons learnt would be highlighted more prominently in the next report. The Secretariat would also work on a better definition of achievements and how they were calculated. Lastly, he observed that the Executive Board would shortly be discussing a new evaluation policy, including a provision for an independent evaluation that it hoped to implement in the next biennium.

The Committee noted the report.

Professor Agba took the Chair.

4. HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:
Item 15 of the Agenda (Documents A65/27 Rev.1, A65/INF.DOC./2, A65/INF.DOC./3, A65/INF.DOC./4 and A65/INF.DOC./5)

The CHAIRMAN drew attention to a draft resolution proposed by Algeria, Bahrain, Bangladesh, Egypt, Jordan, Kuwait, Lebanon, Libya, Morocco, Palestine, Qatar, Saudi Arabia, Tunisia and the United Arab Emirates. The text read:

The Sixty-fifth World Health Assembly,

PP1 Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

PP2 Recalling all its previous resolutions on health conditions in the occupied Palestinian territory and other occupied Arab territories;

PP3 Taking note of the report of the Secretariat on the health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan;¹

PP4 Stressing the essential role of UNRWA in providing crucial health and education services in the occupied Palestinian territory, particularly in addressing the emergency needs in the Gaza Strip;

PP5 Expressing its concern at the deterioration of economic and health conditions as well as the humanitarian crisis resulting from the continued occupation and the severe restrictions imposed by Israel, the occupying power;

PP6 Affirming the need to guarantee universal coverage of health services and to preserve the functions of the public health services in the occupied Palestinian territory;

PP7 Recognizing that the acute shortage of financial and medical resources in the Palestinian Ministry of Health, which is responsible for running and financing public health services, jeopardizes the access of the Palestinian population to curative and preventive services;

PP8 Affirming the right of Palestinian patients, medical staff and ambulances to have access to the Palestinian health institutions in occupied east Jerusalem;

PP9 Affirming that the blockade is continuing and that the crossing points are not entirely and definitely opened, meaning that the crisis and suffering that started before the Israeli attack on the Strip are continuing, hindering the efforts of the Ministry of Health of the Palestinian Authority to reconstruct the establishments destroyed by the Israeli military operations by the end of 2008 and in 2009;

PP10 Expressing deep concern at the grave implications of the wall on the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem,

1. DEMANDS that Israel, the occupying power:

(1) immediately put an end to the closure of the occupied Palestinian territory, particularly the closure of the crossing points of the occupied Gaza Strip that is causing the serious shortage of medicines and medical supplies therein;

(2) abandon its policies and measures that have led to the prevailing dire health conditions and severe food and fuel shortages in the Gaza Strip;

(3) comply with the Advisory Opinion rendered on 9 July 2004 by the International Court of Justice on the wall which, inter alia, has grave implications for the accessibility and quality of medical services received by the Palestinian population in the occupied Palestinian territory, including east Jerusalem;

¹ Document A65/27 Rev.1.

- (4) facilitate the access of Palestinian patients, medical staff and ambulances to the Palestinian health institutions in occupied east Jerusalem and abroad;
 - (5) improve the living and medical conditions of Palestinian detainees, particularly children, women and patients, and provide the detainees who are suffering from serious medical conditions worsening every day with the necessary medical treatment, and facilitate the transit and entry of medicine and medical equipment to the occupied Palestinian territory;
 - (6) respect and facilitate the mandate and work of UNRWA and other international organizations, and ensure the free movement of their staff and aid supplies;
2. URGES Member States and intergovernmental and nongovernmental organizations:
- (1) to help overcome the health crisis in the occupied Palestinian territory by providing assistance to the Palestinian people;
 - (2) to help meet urgent health and humanitarian needs, as well as the important health-related needs for the medium and long term, identified in the report of the Director-General on the specialized health mission to the Gaza Strip;
 - (3) to call upon the international community to exert pressure on the Government of Israel to lift the siege imposed on the occupied Gaza Strip in order to avoid a serious exacerbation of the humanitarian crisis therein and to help lift the restrictions and obstacles imposed on the Palestinian people, including the free movement of people and medical staff in the occupied Palestinian territory, and to bring Israel to respect its legal and moral responsibilities and ensure the full enjoyment of basic human rights for civilian populations in the occupied Palestinian territory, particularly in east Jerusalem;
 - (4) to remind Israel, the occupying power, to abide by the Fourth Geneva Convention relative to the Protection of Civilian Persons in Time of War of 1949, that is applicable to the occupied Palestinian territory including east Jerusalem;
 - (5) to call upon all international human rights organizations, particularly the International Committee of the Red Cross, to intervene on an urgent and immediate basis vis-à-vis the occupying power, Israel, and compel it to provide adequate medical treatment to Palestinian prisoners and detainees who are suffering from serious medical conditions worsening every day, and urge civil society organizations to exercise pressure on the occupying power, Israel, to save the lives of detainees and ensure the immediate release of critical cases and to provide them with external treatment, and to allow Palestinian women prisoners to receive maternity care services and medical follow up during pregnancy, delivery and postpartum care, and to allow them to give birth in healthy and humanitarian conditions in the presence of their relatives and family members and immediately to release all children detained in Israeli prisons;
 - (6) to support and assist the Palestinian Ministry of Health in carrying out its duties, including running and financing public health services;
 - (7) to provide financial and technical support to the Palestinian public health and veterinary services;
3. EXPRESSES deep appreciation to the international donor community for their support of the Palestinian people in different fields, and urges donor countries and international health organizations to continue their efforts to ensure the provision of necessary political and financial support to enable the implementation of the 2008–2010 health plan of the Palestinian Authority and to create a suitable political environment to implement the plan with a view to putting an end to the occupation and establishing the state of Palestine as proposed by the Government of Palestine, which is working seriously to create the proper conditions for its implementation;

Indicate at which levels of the Organization the costs would be incurred, identifying specific regions where relevant

The activities will be primarily implemented through the WHO Office in Jerusalem, which is responsible for WHO's cooperation programme with the Palestinian Authority. WHO's country-level efforts will be supplemented by support from the Regional Office for the Eastern Mediterranean, and by the headquarters clusters working on operations against poliomyelitis and on emergency response and country cooperation as well as on health security and the environment.

Is the estimated cost fully included within the approved Programme budget 2012–2013? (Yes/no)

Yes

If "no", indicate how much is not included.

(c) Staffing implications

Could the resolution be implemented by existing staff? (Yes/no)

No

If "no" indicate how many additional staff – full-time equivalents – would be required, identifying specific regions and noting the necessary skills profile(s), where relevant.

Implementation of the humanitarian health activities and interventions requested in the resolution will require the Secretariat to sustain beyond May 2012 the necessary national and international staff presence at country level, particularly in respect of the Health Cluster Coordinator.

4. Funding

Is the estimated cost for the biennium 2012–2013 indicated in 3 (b) fully funded? (Yes/no)

No

If "no", indicate the funding gap and how the funds would be mobilized (provide details of expected source(s) of funds).

US\$ 1 185 000; source(s) of funds: it is envisaged that these resources will be raised as humanitarian voluntary contributions through the Consolidated Appeal Process. US\$ 15 000 have already been raised through the Process this year.

Dr ELSAYED (Egypt), introducing the draft resolution, said that it dealt with the deteriorating health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, caused by the continuing Israeli occupation policies and practices, particularly in the wake of the most recent Israeli incursion into the Gaza Strip, in December 2008, in contravention of international customary law and instruments. The draft resolution was consistent with the purposes and principles of the WHO Constitution, which affirmed that the health of all peoples was fundamental to the attainment of peace and security, and with previous United Nations General Assembly resolutions on health conditions in the occupied Arab territories. It was thus vital that WHO assume its responsibilities with respect to the delivery of essential health services to the Palestinian people with a view to preventing any further worsening of the health situation.

He drew particular attention to the demands made of Israel in subparagraphs 1(3) and 1(5) of the draft resolution, the appeals directed to Member States in subparagraphs 2(1) and 2(4), and the requests addressed to the Director-General in paragraph 5 in the interest of relieving the suffering of the Palestinian people. Efforts had been made to build agreement on the draft resolution, the submission of which to the Health Assembly, as in the past, was closely linked to the continuation and escalation of Israel's practices on the ground and its violation of previous resolutions demanding its compliance with well-established international principles and the fulfilment of its humanitarian and

legal responsibilities towards the Palestinian people in accordance with international humanitarian conventions and instruments.

Mr CHU Guang (China) welcoming the Secretariat's report (document A65/27 Rev.1), highlighted the important role that had been played by WHO in the creation of health systems, formulation of relevant standards, development of capacity-building activities and provision of technologies and medical assistance. He expressed concern at the dire humanitarian situation in the occupied territories, particularly with regard to the long-term detention of Palestinians by the Israeli security forces. He expressed hope that Israel would take steps to improve the conditions in which detainees were held and work to create conditions for the political resolution of the relevant issues. He urged both parties to do their utmost to remove any impediments to peace talks, with the support of the international community. China, having consistently promoted the Middle East peace process, was ready to work with the international community in support of a comprehensive, just and lasting peace, and therefore supported the draft resolution.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) welcomed the continued efforts of the Secretariat to fill some of the gaps in areas such as supply of medicines and to provide urgently needed technical support, health services, medical equipment and spare parts. The report had highlighted the restriction of access to health services and the limits placed on the movement of patients and health-care professionals and on the importation of medical supplies and equipment. It had thus provided a clear picture of the reasons for the deaths of so many people in the occupied Palestinian territory, including women and children. The report had also noted the delays experienced by patients from the Gaza Strip in receiving permits for access to medical services and the interrogation of those patients by security forces as part of the application process. Such occurrences were alarming to the international community.

Other humanitarian concerns in the occupied territories included food insecurity, inadequate supply of electricity, water quality, water supply to households and access to water network connections. Chronic malnutrition and associated cases of anaemia and micronutrient deficiencies were of particular concern. Moreover, extremely high levels of unemployment and poverty, two social determinants of health, were found in the occupied territories.

His country was concerned that WHO had been denied access to the occupied Syrian Golan. The international community had a responsibility to monitor health conditions in the occupied territories; accordingly, WHO should be guaranteed access to all those territories. He urged the international community to work together to resolve the situation.

Dr KHABBAZ HAMOUI (Syrian Arab Republic) drew attention to the constant suffering of the inhabitants of occupied Palestine and of the occupied Syrian Golan, where medical treatment was denied to anyone without Israeli identity papers. Syrians imprisoned in Israeli jails were susceptible to illness owing to the lack of health-care and first-aid facilities and the inhumane conditions of detention, and three of them had died. Buried in the occupied Syrian Golan, moreover, were radioactive nuclear waste and landmines, affecting the soil and water in the first case and killing and maiming people in the second. The lack of international pressure on Israel, the occupying power, led it to carry such practices to extremes, contravening even the most fundamental rights of access to health care and flouting the principles of international humanitarian law and the relevant Geneva Conventions.

He reaffirmed a previous request for a WHO fact-finding mission to visit the occupied Syrian Golan as soon as possible in order to assess the health needs of the Syrian population living under Israeli occupation. Efforts should also be made to conduct a study of the illnesses prevalent among that population and among Syrians detained in Israeli jails. All States were urged to send a message of support to the inhabitants of the occupied Arab territories by endorsing the draft resolution currently before the Committee, particularly insofar as the report by the Secretariat (document A65/27 Rev.1)

confirmed that health conditions in those territories had deteriorated as a result of Israel's entrenched practices of racism against the inhabitants ever since the occupation had started in 1967.

Ms BLACKWOOD (United States of America) expressed disappointment that the draft resolution was being discussed by the Health Assembly. Although the United States was deeply committed to Israeli/Palestinian peace and, ultimately, to a two-State solution, the adoption of such a politicized draft resolution would not improve the health conditions of the Palestinian population in the West Bank and Gaza Strip.

Her country was the largest donor to UNRWA. In 2011 it had pledged substantial contributions, including US\$ 40 million for the General Fund to support core health, education and social services for the millions of refugees in the West Bank, the Gaza Strip, Jordan, the Syrian Arab Republic and Lebanon, and US\$ 35 million for emergency operations in the West Bank and the Gaza Strip.

Through its contributions, the United States was helping to provide primary health-care services in the Gaza Strip and the West Bank, including access to clean water and sanitation systems and mental health counselling. It also provided direct bilateral assistance to Palestinians in the occupied territory through the United States Agency for International Development (USAID) which, among other things, provided support for infrastructure development, economic growth projects and health sector development. In 2011, USAID's budget for assistance to the West Bank and the Gaza Strip had totalled approximately US\$ 545 million, US\$ 17 million of which had been spent on promoting high-quality health care, transparency and good governance in the Palestinian health system.

Although the humanitarian situation in the Gaza Strip had improved over the past year, with increases in the range and scope of goods and materials being imported, an increase in international reconstruction activity and a gradual expansion of exports, her Government remained concerned about the overall situation and committed to its improvement. She encouraged other countries to join in that effort. Regrettably, the draft resolution was overtly political and one-sided and failed to recognize the cooperation that could and did take place between Israelis and Palestinians. It represented a missed opportunity, as the health sector could provide potential for peace building. Her Government's opposition to the draft resolution did not indicate a lack of commitment to the welfare of the Palestinian people. She therefore requested a roll-call vote on the draft resolution.

Dr KHRAISI (Palestine) drew attention to the report of the Israeli Ministry of Health to the current session of the Health Assembly, annexed to document A65/INF.DOC./3, in particular paragraph 1 thereof, which stated that a politically motivated debate and resolution on the current item had no place on the Health Assembly's agenda and that the Health Assembly should not discuss the health situation of a "population" in a specific conflict. That statement clearly indicated Israel's attitude towards the Palestinian people living under the yoke of its immoral and illegal occupation, a people whose presence in Palestine dated back thousands of years, preceding even the advent of Judaism, Christianity and Islam in Palestine. WHO's Members broadly recognized the situation of that "population in a specific conflict" and would surely welcome Palestine among its ranks. For a variety of reasons, however, Palestine had not embarked on the road to full membership in the Organization.

The same report likewise asserted that the Health Assembly was not the place to decide on political matters. The draft resolution entailed no political decision; it simply sought to ensure that a WHO Member respected the Organization's Constitution and recognized the fact that health was for all. Only a few days earlier, for instance, the leader of the Israeli Shas party had been reported as calling for a ban on access to medical facilities and treatment on the Jewish Sabbath to anyone other than Jewish persons, thereby excluding 1.6 million Palestinian Christians and Muslims. WHO, which had done much to promote health worldwide, including in Palestine, should exert pressure on Israel, the occupying power, to open the hundreds of crossings into Palestine for the delivery of humanitarian aid, food and medicines. Hindering electricity and fuel supplies, Israel's six-year blockade against the Gaza Strip had adversely affected health conditions. The health system was unable to cope, and patients, including pregnant women, had to travel outside Palestine in order to get the necessary care.

It was also because of the practices of the occupying power that resources for provision of the most basic health care to Palestinian refugees remained scarce.

The draft resolution called neither for an end to the occupation nor for the elimination of, or measures against, Israel. It did not seek an outcome whereby Israel would cease its participation in the Organization, as it had done in the case of the Human Rights Council. Rather, the moral intent of the draft resolution was to assist Israel, as a Member of the Organization, to comply with the WHO Constitution by facilitating the delivery of health services to the Palestinian people, who, unbelievably in the twenty-first century, were enclosed within the walls of an apartheid ghetto. In short, the draft resolution was designed to ensure fulfilment of the international obligations of the occupying power and its extremist leadership.

Ms EKEMAN (Turkey) said that the report contained in document A65/27 Rev.1 once again demonstrated that people in the occupied territories were deprived of their basic needs and lived in very poor conditions. She noted with great regret that health conditions in the region continued to deteriorate and that the gap between the West Bank and the Gaza Strip was widening owing to the unjustifiable blockade and the measures applied by the Israeli Government. Mortality rates among infants and children under five years of age remained high. More worrying was the fact that most deaths in that age group were caused by avoidable and preventable diseases closely associated with obstacles to access to health-care services, as well as insufficient food and medical products.

She expressed appreciation for the endeavours of WHO and other stakeholders to improve the health situation of the Palestinian people who lived in such unacceptable conditions, but pointed out that the Organization's work was mainly directed towards improving health-care services. Under normal circumstances, that approach would achieve meaningful results; however, the people of the West Bank and Gaza Strip were clearly living in extraordinary and unsustainable conditions, and the Organization's response should take that into account. The first steps must be the lifting of the blockade on the Gaza Strip and the removal of restrictions and obstacles imposed on the Palestinian people. Both were essential to improve health conditions and overcome the humanitarian crisis in the occupied Palestinian territory.

Turkey therefore called for immediate and concrete action to remove the obstacles that prevented the Palestinian people from gaining access to food, essential medicines and medical supplies and reiterated its support for any measure that would serve that end. It also called upon WHO to create a dedicated section on its web site to provide updates of the situation on the ground. She asked for her country's name to be added to the list of sponsors of the draft resolution and called on all Member States to support it.

Mr LASKAR (Bangladesh) said that his country remained concerned by the fragile health and economic situation in the occupied Palestinian territories, but appreciated the sustained efforts of the Palestinian Ministry of Health to overcome emerging challenges under difficult circumstances. Taking note of the useful work being undertaken by WHO to strengthen health systems in the territories through a range of policy and institutional support measures, including support for improving the health information system, he urged concerned development partners to consider enhancing their support for the Palestinian authorities, particularly in the health and nutrition sectors.

Welcoming the reduction in infant and under-five mortality in the occupied territories, he urged WHO to continue to scale up its work on perinatal health care, anaemia and micronutrient deficiencies. Given that noncommunicable diseases were the leading cause of death in the occupied territories, he recommended tackling the dual burden of communicable and noncommunicable diseases through a sustainable, integrated approach. Improving surveillance capacity for noncommunicable diseases was also critical.

The health infrastructure in the occupied territories was relatively well developed, but its optimum use was undermined and hindered by the persistent challenges of occupation. The continued Israeli blockade had further exacerbated the situation in the Gaza Strip. Of particular concern were restrictions on the movement of patients, denial of referrals to neighbouring countries and territories,

and interruptions in access to medicine and certain basic amenities. The international community must prevail upon Israel, as the occupying power, to take urgent measures to address such unwarranted humanitarian problems which grossly violated the basic human rights of the Palestinian people.

The Government and people of Bangladesh would maintain their principled support for the inalienable rights of the Palestinian people to independent statehood and to development, including the right to health.

Mr CASPI (Israel) said that discussion of the agenda item under consideration, which was blatantly politicized, cast a blemish on the otherwise well-earned reputation of WHO as a professional organization, strictly focused on its vital task of advancing public health in every corner of the world. Discussing the item, which singled out a political issue and a specific region, took up the Health Assembly's valuable time and detracted from other pressing matters, as if there were no global challenges that the world community urgently needed to meet, or as if the health conditions of the Palestinians were so extremely poor that they deserved immediate and full attention.

The Palestinians and Syrians consistently abused international forums to advance their political interests. The current debate came at the expense of a serious discussion on health and humanitarian crises around the world, including in the Middle East and in the Syrian Arab Republic itself, where 10 000 civilians had been killed in the last year and thousands of others prevented from receiving medical treatment. The absurdity of referring to the Golan Heights in resolutions of the kind under discussion had always been evident, but the current state of affairs in the Syrian Arab Republic transformed that absurdity into farce. Debating a draft resolution initiated by a country where people were being killed on a daily basis was a badge of shame for the Committee. Residents of the Golan Heights enjoyed much better health conditions than those in Damascus, Homs or Aleppo.

The singling out of the Palestinian territories for discussion and funding by the Health Assembly because of supposedly poor health conditions was at odds with reality, as the figures showed: the UNDP Human Development Index ranked the Palestinian Authority 114th in the world, life expectancy was higher than the world and Middle East averages, and the under-five mortality rate was lower than average. There was steady economic growth in the territories, poverty was declining, and, as the report contained in document A65/27 Rev.1 said, the health system was relatively well developed.

Israel cooperated fully with WHO and facilitated the entry of WHO experts into the Palestinian Authority territories when needed. In addition, it assisted the Palestinian population directly by providing medical care in Israel for Palestinian patients, medical training for Palestinian health professionals, and more. Israel always extended its hand to its neighbours in cooperating on health issues. While there was always room for improvement, it seemed that other places in the world were more deserving of the immediate attention and limited budget of WHO than the Palestinian territories.

The draft resolution, which was negative, one-sided and polemic, was counterproductive both for the Palestinian people and for cooperation between Israel and the Palestinian Authority, and should not have been submitted to the Health Assembly, which must resolve no longer to let its agenda be hijacked by politically motivated factors. The need to improve the health situation of the Palestinian people was proper and valid, but the Health Assembly should be sensitive to the needs of many others, whose voice was not being heard because they did not serve a certain political cause. It was time to end the hypocrisy, which had nothing to do with either public health or the reality on the ground. It was time for WHO to cease being a tool of the Palestinians and Syrians. He urged Member States to oppose the draft resolution and to decide that the issue should not be raised at future Health Assemblies.

Mr RAO (India) commended the Organization's efforts to provide high-quality health care to the people of Palestine. While expressing concern about the health situation there, he said that any humanitarian assistance, including provision of health facilities by UNRWA or other international bodies, should be carried out in accordance with United Nations General Assembly resolution 46/182,

which required the State concerned to be involved in humanitarian efforts, in order to ensure conformity with established practice and operational efficiency.

Mrs RIACHI ASSAKER (Lebanon) said that the ongoing Israeli occupation of Palestinian territories, including east Jerusalem, had a direct adverse impact on the overall health system in those territories and on the social determinants of health, including poverty, unemployment, housing and nutrition. Measures taken by the occupying power, such as the construction of the separation wall, the continuing blockade and the closure of crossings to and from the Gaza Strip, impeded access to treatment facilities and hampered the delivery of drugs and medical supplies, severely affecting their availability. The operation of health facilities was also affected by the interruptions of electricity and fuel supplies. The data reflected the extent of the decline in health conditions in the occupied Palestinian territories. That situation could not continue.

As to the occupied Syrian Golan, she condemned the blackmail of its citizens by Israel, the occupying power, which had made health coverage conditional on the possession of Israeli identity documents. Israel thus bargained with the health of those citizens in order to coerce them into relinquishing their legitimate right to their national identity. Such restrictions on health care violated the most basic human rights principles and constituted a blatant denial of health rights. The acute shortage of doctors in health facilities was also extremely disturbing. International pressure must be exerted on Israel to improve health conditions, in line with global standards, throughout the territories under its occupation. She therefore urged full support for the draft resolution.

Dr SEITA (Director of Health, UNRWA) said that almost half the 4.3 million people living in the occupied Palestinian territory were refugees, but that both the refugee and non-refugee populations faced the same threats to their health. The matter was one of human rights and human security. UNRWA provided primary health care and contributed to improving the health status of Palestinian refugees under extremely difficult circumstances, and he expressed appreciation to host governments, donors and the international community for their continued support.

UNRWA, fully committed to improving its health services, had recently introduced family health teams at health centres, providing a holistic, family-centred approach so as to ensure comprehensive and continuous care. From two centres in October 2011, the initiative had been extended to ten health centres in the Gaza Strip and the West Bank, and initial community responses had been positive. UNRWA hoped to have family health teams in place in all health centres by 2015.

Family health teams were important for refugees because of the burden of noncommunicable diseases, which were by far the biggest threat to refugees' health. Of the 2.1 million Palestinian refugees UNRWA served in the occupied Palestinian territory, around 100 000 were receiving care for diabetes and hypertension, and the number had doubled over the previous decade.

The role of family health teams would be expanded to address noncommunicable diseases and behavioural risk factors, but the challenges were immense and often extended beyond the domain of health services. A particularly serious example was access to life-saving care, which was constantly compromised by the long-standing occupation and blockade. In the West Bank, mobility restrictions and complicated procedures for granting permission for hospital referrals made it difficult to obtain life-saving care in east Jerusalem.

Stress-related disorders and mental health conditions were another emerging problem. Available indicators showed that the socioeconomic situation in the occupied Palestinian territory had been worsening, with unemployment remaining high. In such circumstances, the weakest members of society – women and children – suffered the most. Violence against women and children had reached alarming levels. UNRWA provided community-based psychosocial and mental health care in the West Bank and Gaza Strip. In the West Bank, the number of people receiving care had doubled between 2009 and 2010. There was some evidence that unemployment among men was a major contributory factor to gender-based violence.

He emphasized the frustration and futility of development work in the absence of political solutions, which inevitably affected refugees, in particular the weakest among them. UNRWA would

continue its efforts to improve its health services with the help of host governments, donors, and the international community, and to call for support for the Palestinian refugees who suffered the most.

Dr AYLWARD (Assistant Director-General), expressing appreciation to Member States for their guidance and recognition of the Organization's work to improve health conditions for Palestinians, took note of the concerns expressed and suggestions made for further work. He thanked donors and partners for supporting the Organization's activities in that area.

The CHAIRMAN suggested that, in view of time constraints and the lack of a quorum, the Committee should vote on the draft resolution at a subsequent meeting.

It was so agreed.

The meeting rose at 13:30.

SECOND MEETING

Wednesday, 23 May 2012, at 11:40

Chairman: Professor C.K. AGBA (Togo)

later: Dr E. TAYAG (Philippines)

later: Professor M.H. NICKNAM (Islamic Republic of Iran)

1. **HEALTH CONDITIONS IN THE OCCUPIED PALESTINIAN TERRITORY, INCLUDING EAST JERUSALEM, AND IN THE OCCUPIED SYRIAN GOLAN:** Item 15 of the Agenda (Documents A65/27 Rev.1, A65/INF.DOC./2, A65/INF.DOC./3, A65/INF.DOC./4, A65/INF.DOC./5) (continued)

The CHAIRMAN invited the Committee members to resume their debate on the draft resolution that had been introduced at the previous meeting.

Dr ELSAYED (Egypt) said that the phrase “, particularly the International Committee of the Red Cross,” should be deleted from subparagraph 2(5).

The CHAIRMAN recalled the proposal to proceed to a roll-call vote.

At the invitation of the CHAIRMAN, Mr SOLOMON (Office of the Legal Counsel) explained the procedure for the roll-call vote. The Member States whose right to vote had been suspended by virtue of Article 7 of the Constitution, or which were not represented at the Health Assembly, and would therefore be unable to participate in the vote were: Antigua and Barbuda, Belize, Central African Republic, Comoros, Grenada, Guinea-Bissau, Niue, Saint Lucia, Saint Vincent and the Grenadines, Somalia, Suriname and Tajikistan.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Vanuatu, the letter V having been determined by lot.

The result of the vote was:

In favour: Algeria, Argentina, Azerbaijan, Bahrain, Bangladesh, Belarus, Bolivia (Plurinational State of), Botswana, Brazil, Brunei Darussalam, Burundi, Chile, China, Congo, Costa Rica, Cuba, Ecuador, Egypt, Georgia, Guatemala, Indonesia, Iran (Islamic Republic of), Iraq, Jamaica, Jordan, Kazakhstan, Kuwait, Lebanon, Libya, Malaysia, Maldives, Mexico, Monaco, Morocco, Mozambique, Namibia, Nicaragua, Oman, Pakistan, Paraguay, Peru, Philippines, Qatar, Russian Federation, Saudi Arabia, Senegal, Serbia, South Africa, Syrian Arab Republic, Tunisia, Turkey, United Arab Emirates, Venezuela (Bolivarian Republic of), Viet Nam, Yemen, Zambia.

Against: Australia, Canada, Israel, Micronesia (Federated States of), New Zealand, United States of America.

Abstaining: Armenia, Austria, Belgium, Bhutan, Bosnia and Herzegovina, Bulgaria, Cape Verde, Colombia, Côte d'Ivoire, Cyprus, Czech Republic, Denmark, Estonia, Finland, France,

Germany, Ghana, Greece, Honduras, Hungary, Iceland, India, Ireland, Italy, Japan, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Panama, Poland, Portugal, Republic of Korea, Romania, San Marino, Sao Tome and Principe, Singapore, Slovakia, Slovenia, Spain, Sweden, Switzerland, Thailand, The former Yugoslav Republic of Macedonia, Ukraine, United Kingdom of Great Britain and Northern Ireland.

Absent: Afghanistan, Albania, Andorra, Angola, Bahamas, Barbados, Benin, Burkina Faso, Cambodia, Cameroon, Chad, Cook Islands, Croatia, Democratic People's Republic of Korea, Democratic Republic of the Congo, Djibouti, Dominica, Dominican Republic, El Salvador, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Guinea, Guyana, Haiti, Kenya, Kiribati, Kyrgyzstan, Lao People's Democratic Republic, Lesotho, Liberia, Madagascar, Malawi, Mali, Marshall Islands, Mauritania, Mauritius, Mongolia, Montenegro, Myanmar, Nauru, Nepal, Niger, Nigeria, Palau, Papua New Guinea, Republic of Moldova, Rwanda, Saint Kitts and Nevis, Samoa, Seychelles, Sierra Leone, Solomon Islands, South Sudan, Sudan, Sri Lanka, Swaziland, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Turkmenistan, Tuvalu, Uganda, United Republic of Tanzania, Uruguay, Uzbekistan, Vanuatu, Zimbabwe.

The draft resolution, as amended, was therefore approved by 56 votes to 6, with 48 abstentions.¹

Mr AGHAZADEH KHOEI (Islamic Republic of Iran), speaking in explanation of vote, said that his country's support for the resolution should not in any way be construed as recognition of Israel.

Ms LEE (Singapore), speaking in explanation of vote, said that her delegation's abstention was not a pronouncement on the merits or demerits of the issue. Singapore had always supported all efforts to bring about a just and lasting peace in the region and had consistently taken a principled stand on the right of the Palestinian people to a homeland and on the need for a two-State solution. While recognizing the difficult health situation faced by the Palestinian people, she considered that it was inappropriate to introduce political elements into a Health Assembly resolution and had therefore abstained.

Mrs FERNÁNDEZ PALACIOS (Cuba), speaking in explanation of vote, said that Israel had continued its aggressive policies against Palestine and the occupied Syrian Golan. The building and extension of illegal settlements and the blockade of the Gaza Strip had to cease completely or the health situation would worsen further. Israel's actions were preventing access to health-care services and had led to stagnation of efforts to achieve the Millennium Development Goals. Under the blockade of the Gaza Strip, hospitals and other care services continued to operate, but experienced many obstacles. She reiterated her country's unequivocal support for the Palestinian people in its legitimate desire for a free, independent, sovereign State based on the frontiers established in 1967 and with east Jerusalem as its capital.

Mr SMIDT (Denmark), speaking in explanation of vote and on behalf of the European Union and its Member States, said that Norway aligned itself with his statement. The European Union remained concerned about the deteriorating health situation in the occupied Palestinian territory and east Jerusalem but considered that the resolution contained elements relating to political issues that were outside the remit of the Health Assembly. The European Union advocated a more balanced text that focused more closely on health issues and took greater account of the findings presented in the

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.9.

report by the Secretariat (document A65/27 Rev.1). The European Union had therefore abstained from the vote.

Since 1971, the European Union had been the largest provider of development aid to the occupied Palestinian territory, and that support would continue. Between 2000 and 2011, it had provided almost €4000 million of assistance through various instruments. In the period 2010–2011, the European Union and its Member States had provided almost 40% of UNRWA's budget. The European Union had also provided funding directly to the Ministry of Health of the Palestinian Authority – an average of €2.6 million per month between 2008 and 2011 to pay the salaries of civil servants and pensioners. Exceptionally, the European Union had earmarked €10 million for hospitals in east Jerusalem to respond to the financial crisis faced by the Palestinian Authority in 2012. Those and other aspects of the European Union's support would continue, despite its abstention from the vote on the draft resolution.

The European Union remained committed to assisting Palestinians in realizing their right to appropriate health care, including adequate emergency services. It would continue to play an active role in efforts to improve health conditions in the occupied Palestinian territory and to address the humanitarian needs of the Palestinian people. It was important to find an approach that adequately took into consideration the impact of the conflict on all sides.

Ms ABBAS (Syrian Arab Republic) said that the text of the draft resolution in Arabic should be brought into line with the English text. The phrase "Israel, the occupying power", used in preambular paragraph 4 and paragraph 1 of the draft resolution, was not properly reflected in the Arabic text.

Mr WILSON (New Zealand), speaking in explanation of vote, said that his country shared the concerns expressed in the resolution about poor health and economic conditions in the occupied Palestinian territory, particularly in the Gaza Strip. New Zealand urged the relevant governments to ease access restrictions for individuals and humanitarian-purpose goods, and to work together to improve the health conditions for the Palestinian people. His Government would have supported a resolution that restricted itself to addressing humanitarian needs but could not support one that raised political issues outside the mandate of the Health Assembly and sought to apportion blame in an unbalanced fashion. The delegation of New Zealand had therefore voted against the draft resolution.

Ms STONE (Australia), speaking in explanation of vote, said that her country continued to be deeply concerned about the poor health conditions in the West Bank and Gaza and called on the two parties to work together and in cooperation with partner countries and agencies to improve the situation. Her Government's decision to oppose the resolution did not arise from a lack of concern but from its objection to the introduction of political issues into the Organization's work. Australia strongly supported efforts aimed at a negotiated and enduring peace based on a two-State solution but considered that the resolution would contribute neither towards that goal nor to improving the situation on the ground.

In support of the peace process, her Government was making a substantial contribution to strengthening Palestinian institutions and improving basic services, including in the health sector. In 2012–2013, Australia would provide 56.7 million Australian dollars in official development assistance to the Palestinian territories, following the provision of 48.5 million Australian dollars in 2011–2012 and as part of a commitment of 300 million Australian dollars over the next five years. Australia supported the crucial work of UNRWA, to which it had been a significant donor since 2000. In late 2011, in response to a funding shortfall, it had brought forward its 2012 payment to UNRWA, and it was also working to structure its core contributions over a five-year period through a partnership agreement, with funding expected to rise during the span of the agreement. Australian support had already, in the period 2010–2011, helped health-care workers to care for Palestinian refugees in 134 centres across the Palestinian territories, Jordan, Lebanon and the Syrian Arab Republic, and had contributed to providing health care for 15 000 refugee children in schools. In partnership with WHO,

Australia had also helped to provide care for 35 000 mothers and 40 000 newborn infants in the Gaza Strip.

Mr WINTER (Uruguay) regretted his delegation's absence during the roll-call vote and said that his country would have voted in favour of the resolution.

Dr KHRAISI (Palestine) thanked those delegations that had voted in favour of the resolution and also those that had abstained. He did not understand the reasons behind the abstentions; he hoped that Israel would not interpret them as encouragement to continue with its current policies but rather as a signal to Israel to respect its own constitution and commitments and provide suitable health care. He also did not want the issue to be politicized; he wanted the Palestinian people to have the right to the medical care enjoyed by other peoples, but doubted that that could happen while the occupation continued. It was his hope that Palestine would become a full Member of WHO in 2013.

Dr Tayag took the Chair.

2. PROGRAMME BUDGET AND FINANCIAL MATTERS: Item 16 of the Agenda (continued)

Financial report and audited financial statements for the period 1 January 2010–31 December 2011: Item 16.2 of the Agenda (Documents A65/29, A65/29 Add.1 and A65/45)

Dr SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that WHO had received a clean audit opinion, that the financial statements for 2010–2011 had been partially compliant with the International Public Sector Accounting Standards and that the Organization was currently considered to be fully compliant.

According to the Secretariat's report (document A65/29), the total income of the Organization for the biennium 2010–2011 had been US\$ 4847 million, while the total operating expenses had amounted to US\$ 4593 million. Included in both income and expenditure were in-kind contributions worth US\$ 485 million. Income for the Programme budget 2010–2011 had been US\$ 3844 million, with a budget utilization of US\$ 3866 million, resulting in a small deficit. The sources of voluntary contributions remained stable, with 54% coming from Member States.

The Committee recommended, on behalf of the Executive Board, that the Health Assembly adopt the draft resolution contained in document A65/45.

Ms EDGAR (New Zealand) congratulated the Secretariat on its efforts to achieve sustainable financing for the Organization. The measures taken in relation to staff liabilities, the health insurance fund and administration costs were particularly noteworthy. While Member States were to be commended for their significant support in the form of voluntary contributions, the high degree of specifically earmarked contributions continued to diminish the Organization's flexibility and to cause imbalances in funding.

She requested clarification from the Secretariat as to the options it had in mind for tackling the structural currency imbalance, whether Member States would be consulted on the issue and how much notice they would receive of any changes that might be made.

Mrs SAOWAPA JONGKITIPONG (Thailand) said that seemingly flawless financial reports did not necessarily reflect good performance or effective use of resources and should always be examined in conjunction with performance assessments in order to get a balanced view. The fact that voluntary contributions accounted for up to 75% of the Organization's total budget and were often earmarked for purposes that did not match WHO's priorities was a cause for concern. Thailand endorsed the

Committee's recommendation that travel costs should be reduced. Replacing face-to-face meetings by information technology communication channels would minimize those costs and reduce carbon dioxide emissions from air traffic as well.

Salaries represented the largest item on the budget, particularly at headquarters. Her country was therefore in favour of outsourcing services to the private sector or moving them to less expensive locations. The closing or merging of regional offices would allow major cost savings without having a negative effect on performance, since, in the Internet era, country offices and Member States could work directly with headquarters, although such measures would require a constitutional amendment.

Mr BLAIS (Canada), drawing attention to the high expenditure on travel at WHO, urged the Secretariat to continue applying its efficiency measures and to implement the relevant recommendations contained in the report of the Internal Auditor (document A65/33), in particular those concerning travel authorization procedures.

Mr GBENYO (Togo), speaking on behalf of the Member States of the African Region, welcomed the global management of the Organization's funds. He noted with satisfaction that voluntary contributions had increased by 17% with respect to the period 2008–2009 and that Member States continued to be the largest source of such contributions, despite the grave financial crisis. Welcoming the increase in expenditure for medical supplies purchased and distributed by WHO, he thanked the companies that had provided in-kind contributions worth some US\$ 450 million, which would result in much wider vaccination coverage. Earmarking of voluntary contributions was a concern since that made it more difficult for WHO to allocate funds in accordance with its priorities. He therefore urged donors to cooperate more closely with their partners and demonstrate greater flexibility.

Dr LI Mingzhu (China) noted with satisfaction the transparent manner in which the Secretariat had reported its financial condition to Member States. He underscored the importance of applying the 13% administrative charge to voluntary contributions; using assessed contributions for that purpose would have a detrimental effect on the Programme budget. He endorsed the draft resolution contained in document A65/45.

Mrs GARCÍA ARREOLA (Mexico) appreciated the inclusion in document A65/29 of tables presenting Programme budget implementation as that information made it possible to identify funding for each strategic objective. However, analysis of the document would have been easier if it had been distributed earlier. Aware that the financial report for 2012 would be produced in accordance with International Public Sector Accounting Standards, she suggested that interim financial reports should be prepared to help Member States to understand the differences in the reporting formats. Other areas of concern included the Organization's financial position for the biennium 2010–2011 in comparison with the previous biennium, staff and personnel costs and the unequal allocation of funds in the light of budgetary needs by programme. As part of the reform process, efforts should be made to ensure that resource allocation was consistent with WHO priorities and to develop mechanisms to mitigate currency exchange risk.

Mr JEFFREYS (Comptroller) said that the structural currency imbalance had been discussed by the Programme, Budget and Administration Committee and would be taken up by the Executive Board at its 131st session. In the report that it would be submitting to the Board, the Committee had included its views on proposals to address the currency imbalance, notably changing the currency of assessment to the Swiss franc. Any proposal of that kind would be brought to the Health Assembly, the following year at the earliest, and any change would be subject to considerable discussion. Other issues such as the earmarking of funds and cost recovery, in particular of programme support costs, were likely to be given further consideration during the debate on WHO reform. When issued, the financial statements for 2012 would be accompanied for the sake of clarity by a breakdown of all the changes made under

the International Public Sector Accounting Standards and information regarding their impact on financial statements. WHO was already complying with the recognition policies under the International Public Sector Accounting Standards as far as revenue and expenditures were concerned.

The draft resolution was approved.¹

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 16.3 of the Agenda (Documents A65/30 and A65/46)

The CHAIRMAN drew attention to the third report of the Programme, Budget and Administration Committee (document A65/46), which included two draft resolutions. He had been advised by the Secretariat that, since the Committee's third meeting, Guinea had paid its contribution, so that Article 7 no longer needed to be invoked.

Dr SILVA DO RASARIO (Sao Tome and Principe), speaking on behalf of the Member States of the African Region, said that, despite the serious global financial crisis, all Member States must make every effort to pay their assessed contributions. Although the rate of collection had increased from 86% in 2008–2009 to 93% in 2010–2011, the total of outstanding contributions as at 31 December 2011 was still in the order of US\$ 109 million. Those Member States that had paid their contributions for 2012 in advance, including 11 African countries, should be commended. It was regrettable that the voting privileges of four countries of the African Region had been suspended because of non-payment of contributions.

She endorsed the two draft resolutions before the Committee.

The CHAIRMAN invited the Committee to consider draft resolution 1 contained in document A65/46, with deletion of the reference to Guinea.

The draft resolution, as amended, was approved.²

He further invited the Committee to consider draft resolution 2 contained in document A65/46.

The draft resolution was approved.³

Assessment of new Members and Associate Members: Item 16.5 of the Agenda (Document A65/41)

The CHAIRMAN drew attention to the report contained in document A65/41, assessment of new Members and Associate Members: South Sudan, which had already been considered and noted by the Programme, Budget and Administration Committee.

The Committee noted the report.

Professor Nicknam took the Chair.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.10.

² Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.11.

³ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.12.

3. AUDIT AND OVERSIGHT MATTERS: Item 17 of the Agenda

Report of the External Auditor: Item 17.1 of the Agenda (Documents A65/32 and A65/47)

Dr SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, introduced the Committee's fourth report (document A65/47).

Mr PATNAIK (representative of the External Auditor), speaking on behalf of the External Auditor, introduced the Report of the External Auditor. The External Auditor had placed an unqualified opinion on the financial statements for the financial period 2010–2011.

Audits had been performed in accordance with the International Standards on Auditing at all the regional offices and six selected country offices and had focused on the financial, compliance and performance aspects of their work. The audits had been facilitated by excellent cooperation from staff at both headquarters and regional and country offices and regular coordination with the Office of Internal Oversight Services. He was pleased to note that the Director-General had accepted the recommendations made in the External Auditor's report. Detailed reviews had also been conducted on the operations of the Office of Internal Oversight Services, the Income and Award Management unit at headquarters, the Global Management System and the Enterprise Resource Planning System and its related information technology systems.

WHO had been gradually adopting the International Public Accounting Standards (IPSAS) prior to their full implementation in 2012. IPSAS 2, 4, 6, 14 and 23 had been applied in the course of the 2010–2011 audit and, as a result, the financial statements had presented the Organization's financial position in a more transparent manner. Adoption of IPSAS 23 (revenue from non-exchange transactions) represented a significant departure from the way income had been recorded in previous bienniums and had led to increases in both assets and liabilities. Under that standard, voluntary contributions were recognized as revenue if the full amount agreed was payable upfront; however if conditions were attached to the receipt of funding at a future date, the revenue pertaining to the future was deferred. With respect to management reform, he welcomed the Secretariat's efforts to strengthen the internal control framework, including the eManual, which was readily available to staff on the WHO Intranet site, and he encouraged it to work towards the adoption of an enterprise risk management framework.

The report had highlighted issues related to budgetary control and the underutilization of funds, example of which had been noted in both regional and country offices, where fund utilization against budget allocations had been low. The field audits had indicated that, at the time they were conducted, the budget centres continued to have high encumbrances.

Examination of the bank reconciliation procedure at headquarters had shown that the balances in the bank reconciliation statements for certain accounts did not correspond to the balances in the general ledger, resulting in incomplete reconciliation. Furthermore, some bank accounts were still showing longstanding unreconciled items, some even going back to the previous financial period. Similar problems had been identified in the regional and country office audits. Imprest accounts continued to be a risk area: some were consistently holding amounts in excess of the stipulated ceiling, and others had incurred expenditures over the ceiling limits; surprise cash verifications were not always carried out; and delays in submission of monthly closure reports had been observed.

The report had underscored the need for the Organization to ensure compliance with its provisions on procurement of goods and services. It had also recommended strengthening of internal controls regarding the recording, valuation, physical verification and custody of assets and inventories. Concerning the issue of nonrecovery of advances to staff, which had been highlighted in earlier reports to the Health Assembly, the External Auditor was pleased to note that the Secretariat had established a project team under the supervision of the Comptroller to conduct a full analysis of balances arising from prior salary advances and to ensure that, where necessary, recovery was made.

WHO had made a laudable attempt to implement the Global Management System, which had the advantage of promoting greater transparency. However, it had emerged from a detailed review of the System's five modules that some of the business rules had not been validated. In addition, WHO's internal control framework had been weakened by changes associated with the operations of the System, in particular with regard to staff receivables. Given that WHO was currently enhancing the System and planning to reduce customization, the External Auditor had recommended implementation of compensating controls where needed.

WHO's rationale for continuing to use "White Pages" and other legacy systems should be reviewed in the light of the capacities of the Global Management System. With regard to future plans for the System, the External Auditor had recommended that WHO proceed with de-customization, provided that the business processes were aligned with Oracle best practices. When de-customization was not possible, alternative controls were needed, in the form of pre- and post-audits, reporting of warning signs and detailed analysis of transactions by experts.

Monitoring the implementation of the External Auditor's recommendations was an important part of accountability. Most of the recommendations were at various stages of implementation, a few had been fully implemented and he urged WHO to ensure full implementation of the rest.

He expressed his sincere appreciation to the Director-General and her staff for the courtesy and cooperation extended to the Comptroller and Auditor-General of India throughout his eight-year tenure as External Auditor of WHO. During that time, the External Auditor had endeavoured to provide independent, balanced, professional advice, with a view to promoting accountability, transparency and governance at WHO. He thanked the governing bodies and Member States for giving the Comptroller and Auditor-General of India the opportunity to serve as WHO's External Auditor and for their support. He wished the Chairperson of the Commission on Audit of the Philippines every success as WHO's new External Auditor and assured Member States that the handover would be smooth.

Miss SITANUN POONPOLSUB (Thailand) commended the Director-General's commitment to improving the Organization's governance and financial operations in a transparent manner and welcomed the External Auditor's constructive recommendations, which should be implemented effectively. The introduction of International Public Sector Accounting Standards, the Global Management System, the enterprise risk management system and the financial control framework required not only sustained attention from management but also support for WHO officials at headquarters and at regional and country level.

Financial operations could not be improved without human capital; honest, qualified, responsible officers were the key to success. Awareness-raising about the need for integrity and ethics among responsible officers was needed, as was strong support for the Ethics Office.

Ms BLACKWOOD (United States of America) said that the External Auditor had set a standard of excellence and commended his work. Noting with concern the issues of noncompliance, in particular with regard to procurement, she urged WHO to implement all the recommendations in a timely manner and welcomed the personal commitment of the Director-General to that end.

Mr JEFFREYS (Comptroller) assured Member States that the Director-General had, at the meeting of the Programme, Budget and Administration Committee, emphasized the importance she attached to timely implementation of all the audit recommendations. A full accountability framework encompassing accounting and control as well as systems and processes was indeed required, and the Ethics Office could play an important role in that respect.

He expressed his gratitude to the Comptroller and Auditor-General of India for his valuable work as External Auditor. Every effort would be made to ensure a smooth handover of responsibility to his successor.

Mr ADOMAKO (Ghana) said that prudent financial management was essential and urged WHO to implement in full all the recommendations of the External Auditor.

The CHAIRMAN invited the Committee to approve the draft resolution recommended by the Programme, Budget and Administration Committee, on behalf of the Executive Board, and contained in document A65/47.

The draft resolution was approved.¹

The meeting rose at 19:00.

¹ Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA65.13.

THIRD MEETING

Friday, 25 May 2012, at 09:50

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

1. FIRST REPORT OF COMMITTEE B (Document A65/53)

Dr GULLY (Canada), Rapporteur, read out the draft first report of Committee B.

Mr CHIRINCIUC (Republic of Moldova) said that had he been present during the vote on the draft resolution on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan, he would have abstained.

Ms ABBAS (Syrian Arab Republic) said that all language versions of the resolution should be aligned with the English text, in particular the words “Israel, the occupying power” in the fifth preambular paragraph and in paragraph 1.

The report was adopted.¹

2. AUDIT AND OVERSIGHT MATTERS: Item 17 of the Agenda (continued)

Report of the Internal Auditor: Item 17.2 of the Agenda (Documents A65/33 and A65/48)

Dr SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee’s fifth report (document A65/48).

Dr SEAKGOSING (Botswana), speaking on behalf of the Member States of the African Region, said that the Member States remained committed to strengthening the Office of Internal Oversight Services. In view of the global recession, he welcomed the introduction of efficiency measures such as reducing travel costs, but emphasized the need to enforce compliance with the relevant control procedures of the Global Management System. Moreover, a team leader should be appointed to coordinate preparation of the General Management Cluster’s Standard Operating Procedures.

Operational audits conducted in three country offices had revealed risks including reliability and integrity of financial and operational information; safeguarding of assets; and compliance with WHO’s regulations and rules. He urged the Director-General to work with the Member States concerned to develop or strengthen controls and to monitor progress. Integrated audits had confirmed the important role played by country offices in providing technical advice and boosting compliance in high risk areas. Country offices should however spend more time on supporting governments in meeting their national and international targets and less time on routine programme matters. Integrated audits

¹ See page 276.

should, where applicable, include the causes of the anomalies identified and the recommendations made in that regard. He appreciated the performance audits that had been conducted but noted that some risks still needed to be mitigated.

Reports on investigations of alleged cases of misconduct at headquarters should in future provide information on the method by which the incident was handled and the justification for it, as that might be helpful to Member States dealing with parallel cases.

He urged the Director-General to ensure that pending operational audit recommendations were closed as rapidly as possible, and to meet with representatives of country offices to identify strategies to put an end to recurring operational risks. Increased clarity, appropriate resourcing, enforcement of responsibilities for key positions and, above all, appropriate sanctions for non-compliance were needed. The database for tracking recommendations and the classification of audit recommendations launched in 2011, which should be supplemented by an implementation-per-risk category, were valuable contributions.

As set out in Annex 1 to document A65/33, audits had implementation rates ranging from 0% to 98%. That was a matter of concern. In the case of low implementation, individuals must be made accountable and appropriate sanctions applied. The comments column in Annex 1 should be filled in and, where appropriate, an explanation for the low implementation rate should be provided. An explanation of the two columns preceding the comments column would also be welcome. Open audits for which no progress update had been received in 2011 (Annex 3 to the report) were also a matter of concern. Explanations should be sought and sanctions applied for audits in that category.

Dr THITIKORN TOPOTHAI (Thailand) recalled that more than three quarters of the Organization's budget was derived from earmarked voluntary contributions, which were not subject to the same audit controls as other funds. In any event, in view of the overall scarcity of funds, all resources should be more carefully allocated. Endorsing the views of the delegate of Botswana regarding cases of misconduct, he pointed out that such cases could affect WHO's credibility and should be resolved immediately. The number of open audit recommendations was a matter of concern and those cases should be closed as soon as possible. Was there a mechanism that could facilitate the Secretariat's work in that regard? Performance audit coverage should be broadened to include technical areas.

Mr IFLAND (Germany) welcomed the frank and transparent way in which the Office of Internal Oversight Services had dealt with potential risks to the Organization, ensuring efficient use of its resources, compliance with agreed policies and safeguarding of its assets. He also appreciated the steps that had been taken to strengthen the Office, despite the limited resources available. While the Internal Auditor had stressed that compliance with approved rules and procedures was a critical issue in most investigations, little had been done to enforce compliance even though all three levels of the Organization should be taking steps to do so. The Office of Internal Oversight Services was mandated to assess potential risks to the Organization and to make recommendations to protect it from harm. Its recommendations were based on comprehensive consultations with the parties involved and should be implemented in a timely manner.

Mr COTTERELL (Australia) voiced concern at the number of country offices that had not implemented or reported on their audit recommendations. He asked the Director-General and regional directors to work with country offices to improve compliance and reporting as a matter of urgency.

Mr BLAIS (Canada), endorsing the views of the delegate of Australia, said that efforts should be made to strengthen country offices' control procedures, capacity and accountability, with particular emphasis on human resources, procurement policies and use of the Global Management System. He reiterated his earlier request that audit reports should be made more readily available to Member States.

Dr LI Mingzhu (China) said that the Office of Internal Oversight Services needed more resources to enable it to contribute more effectively to the reform process. The Secretariat should tackle new issues, such as non-compliance, and continue to facilitate the implementation of recommendations made in previous reports.

Mr WEBB (Office of Internal Oversight Services) said that measures had been taken to strengthen controls at headquarters and in regional and country offices, the most notable of which was the adoption of the internal control framework. His Office was responsible for conducting investigations and filing reports, but was not involved in follow-up decisions or sanctions, and consequently could not provide such information to Member States. Two of the investigations involving wrongdoing or harassment had been closed; information about ongoing investigations was confidential.

In reply to the query about Annex 1, he said that the column entitled “Number of recommendations not implemented (b) high significance (d)” presented the degree of implementation considered by the Office to be the most significant. The column entitled “Quick wins not implemented (b) high priority (c)(d)” listed important recommendations that could be implemented in a short period of time.

Responding to the suggestion that performance audit coverage should be broadened to include technical areas, he recalled that the Programme, Budget and Administration Committee had requested that the focus for 2012 should be on compliance within country offices. However, it would certainly be possible to increase the number of performance audits in technical areas the following year.

The Director-General, senior managers and regional directors received a quarterly status report on the implementation rates of open audit recommendations. Fourteen responses had been received since the last status report had been published, reducing the percentage of open items from 38% to less than 16%. Nonetheless, management at all levels needed to do more to improve implementation and close audit recommendations.

With the aim of providing easier access to audit reports, WHO was considering options used by other United Nations bodies, such as the UNICEF remote access system.

Dr JAMA (Assistant Director-General) said that WHO took the recommendations of internal and external auditors very seriously. Strengthening country offices and ensuring compliance and accountability were key reform measures that were already being implemented. The new internal control framework would identify control points, and the individuals responsible for management and administration.

Some audit recommendations had been outstanding for over two years, and more detailed explanations in that regard would be provided to the Programme, Budget and Administration Committee at its meeting in January 2013. Delays were often caused by the time needed to institute policy changes and find adequate funding. The Secretariat was in the process of finalizing the internal control framework and the Standard Operating Procedures as part of the reform process. Compliance units had been set up in some regional offices, and a unit would also be set up at headquarters. The Comptroller would have greater authority under the new reform and that would help to improve communication and coordination between headquarters and regional and country offices. The Secretariat intended to do even more to streamline travel costs, procurement and personal accounts.

Ms JAKAB (Regional Director for Europe), speaking on behalf of the Global Policy Group, said that the Organization’s senior management remained fully committed to establishing a culture of compliance with WHO’s regulations and rules, strengthening the internal control environment and implementing the recommendations of the Internal and External Auditors, all of which required staff training at all levels and locations. The purpose of the planned compliance units was to ensure implementation of audit recommendations, and feedback on whether staff had implemented recommendations for which they were responsible would be reflected in the staff’s performance assessment.

The Committee noted the report.

3. STAFFING MATTERS: Item 18 of the Agenda

Human resources: annual report: Item 18.1 of the Agenda (Documents A65/32 and A65/49)

Dr SAÍDE (Mozambique), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introduced the Committee's seventh report (document A65/49).

Ms RUPPEN (Switzerland) said that the staff members were an essential resource at WHO, which was a knowledge-based organization, and would continue to represent a significant expenditure. The Organization should endeavour to keep its staff motivated and take steps to ensure that it remained an attractive employer, so that it could meet the needs of its Member States. She thanked the Department of Human Resources Management for its valuable work, which deserved support and encouragement. She also thanked all the Organization's staff members for their hard work and commitment in a difficult environment.

Ms RIMBY (Sweden) welcomed efforts to improve gender parity across the Organization, but noted a continuing imbalance at the P4 level and above, in all regions. Professional staff were not able to move easily from one region to another even though mobility was vital to making effective use of staff experience and knowledge. One aim of the reform process was to bolster the Organization's convening authority and leadership role in global health, which meant that highly-qualified staff were needed at the country level. Current human resources policies strengthened WHO's role in project implementation, rather than in policy advice, and that had led to a significant increase in professional and general services staff. But country offices did not need more staff - they needed more qualified staff. The large number of staff members soon to retire would provide the Organization with an opportunity to recruit new staff who met the reform agenda criteria.

Mr STUPPEL (United Kingdom of Great Britain and Northern Ireland) said that the human resources report was dominated by figures and failed to reflect staff performance or output. Better analysis of the available data and more details on performance management should be provided in future reports. Like the delegate of Sweden, he was also concerned about the lack of gender parity within the Organization.

Ms BLACKWOOD (United States of America) said that she favoured a strategic approach to human resources planning as part of the reform process. Mobility of staff across all regions should be increased and gender parity ensured, especially in regions where the gender gap was considerable. Future reports should include disaggregated staff data specifying the number of continuing and fixed-term contracts and should define the criteria on the basis of which fixed-term contracts were converted to continuing contracts.

Ms GARCÍA ARREOLA (Mexico) asked what long-term human resources strategies were being considered in order to ensure more systematic succession planning, gender equality and geographical diversity within the Organization. Also what strategies or recommendations were being implemented in the Region of the Americas in the light of its difficulties in compiling regional data? According to the report, overall staffing costs still accounted for 50% of expenditure, despite a reduction in the number of staff. Were any steps being taken to tackle that problem?

Ms ALTMAIER (Human Resources Management) said that human resources were WHO's most valuable asset precisely because it was a knowledge-based organization. Everything possible was being done to improve outreach activities even further and to ensure diversity and adequate representation of all Member States, at headquarters and in the regional offices.

Strategic planning to ensure the best match between skills and posts could still be improved. To that end, the Secretariat was developing a skills inventory framework, under which it would map existing skills, identify gaps and make use of global learning and training programmes to give staff the skills needed to fill those gaps. A management development programme focusing on leadership and advisory skills would be held in 2013 and 2014, and training at the regional level in negotiation, diplomacy and policy-making would be strengthened. A global learning management platform and a personal development tracking mechanism were also being developed. That approach based on a blend of learning opportunities would enable the Organization to invest in the skills of its staff, maintain staff motivation and enhance career development. A centralized mobility system modelled on successful regional mobility programmes would also be established.

The Secretariat would seek to provide improved statistical analysis in future reports. Two reports would be produced for the meeting of the Programme, Budget and Administration Committee in January 2013: one would focus on performance management, and the other on the issue of superior performance and under-performance by staff members and ways to reward the former and sanction the latter. The Department of Human Resources Management would also be holding consultations with the staff associations to discuss contract types, eligibility criteria, a quota for continuing appointments, and an overall policy on appointments and separations.

The Committee took note of the report.

Report of the International Civil Service Commission: Item 18.2 of the Agenda (Document A65/35)

The Committee took note of the report.

Amendments to the Staff Regulations and Staff Rules: Item 18.3 of the Agenda (Documents A65/36 and EB130/2012/REC/1, resolution EB130.R16)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB130.R16. The revised figures for the gross base salaries approved by the United Nations General Assembly, which the Health Assembly was invited to approve, were shown in square brackets.

Dr GHEBREHIWET (Eritrea), speaking on behalf of the Member States of the African Region, said that the Member States were in favour of revising the gross base salaries of staff in ungraded posts and of the Director-General. The gross base salaries approved by the United Nations General Assembly in resolution 66/235, which had come into effect on 1 January 2012, were lower than those presented to the Executive Board for consideration at its 130th session, but the changes would not affect the net salaries of the staff members concerned. He endorsed the draft resolution before the Committee.

Ms ALTMAIER (Human Resources Management) said that the original figures provided by the United Nations Secretariat had been updated. An amended version of the resolution had been prepared and was now before the Committee.

The CHAIRMAN said that, if he heard no objection, he would take it that the Committee wished to approve the draft resolution, including the revised figures shown in brackets.

The draft resolution, as revised, was approved.¹

Appointment of representatives to the WHO Staff Pension Committee: Item 18.4 of the Agenda (Document A65/37)

The CHAIRMAN proposed the nomination of Dr A.J. Mohamad (Oman) as a member and Dr M. Tailhades (Switzerland) as an alternate member to the WHO Staff Pension Committee for a three-year term until 2015.

It was so decided.²

4. MANAGEMENT AND LEGAL MATTERS: Item 19 of the Agenda

Agreements with intergovernmental organizations: Item 19.2 of the Agenda (Document A65/42)

Ms SY (Senegal), speaking on behalf of the Member States of the African Region, welcomed the imminent signing of an agreement between the Commission of the African Union and WHO, which would improve upon and replace previous agreements and strengthen cooperation between the two parties. The agreement reflected the African Union's new policy orientation, under which the promotion of access to health care, disease prevention and the strengthening of health systems were accorded the highest priority. The renewed momentum in relations between the African Union and WHO would undoubtedly contribute to improving the health and welfare of the African people.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to approve the draft resolution contained in document A65/42.

The draft resolution was approved.³

Legal matters

Mr PELLET (France) said that he wished to draw attention to the implications, in particular for WHO, of Internet-based health information and of creating a ".health" domain name. What initiatives were envisaged by the Organization in that regard?

Mr BURCI (Legal Counsel) said that the Organization was aware of the potential risks and benefits of Internet use, such as using the domain name "health" to market poor-quality goods and services, and its possible impact on public health. WHO was currently reviewing the financial, administrative and policy implications of registering the domain name "health". If, following the review, the Secretariat considered it appropriate to proceed with the application to register the domain name, a proposal to that effect would be transmitted to the governing bodies for approval.

WHO was also, in consultation with other international organizations and the Internet Corporation for Assigned Names and Numbers (ICANN), exploring ways of protecting the ".WHO"

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65.14.

² Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65(10).

³ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65.16.

domain. He hoped to report on progress made in that regard to the Executive Board at its next session or to the Health Assembly.

Election of the Director-General of the World Health Organization: report of the Working Group: Item 19.1 of the Agenda (Document A65/38)

Ms TAN YEE WOAN (Singapore), speaking in her capacity as Chair of the Working Group on the Process and Methods of the Election of the Director-General, said that, over the course of its three formal meetings, in addition to a series of informal regional and interregional consultations, the Working Group had reached consensus on a package of recommendations for revision of the process of nominating and appointing the Director-General. Those recommendations were set out in document A65/38.

Dr GWINJI (Zimbabwe), speaking on behalf of the Member States of the African Region, thanked Ms Tan for her excellent leadership of the Working Group. He welcomed the Group's conclusion that equitable geographical representation should be an overarching aim of the election process. That conclusion corresponded to the Region's strong political resolve to give priority to the three regions, including his own, that had not yet had a chance to lead the Organization. The package of recommendations would benefit the Organization in several ways: the recommendation that the Executive Board should nominate three candidates for consideration by the Health Assembly would strengthen the latter's constitutional role; the establishment of a candidates' forum would reinforce the Organization's core values of democracy and the sovereign equality of states; and the application to the selection process of a revised list of criteria would facilitate the nomination of qualified candidates capable of leading the Organization. The Working Group's recommendations reflected the inherent weaknesses of the current system. He therefore hoped that the Director-General would facilitate the process of amending the Rules of Procedure of the World Health Assembly so that the new system could enter into force.

Mr OSEI (Ghana) said that the flexible, constructive and cooperative spirit demonstrated by the members of the Working Group constituted a good model for future consultations.

Dr DAHL-REGIS (Bahamas) expressed appreciation for the package of recommendations produced by the Working Group and encouraged Member States to approve the draft resolution contained in the report.

Mr PELLET (France), speaking on behalf of the Member States of the European Region, acknowledged Ms Tan's effective leadership of the Working Group, which had enabled the participants to reach consensus on a complex and sensitive issue. He endorsed the draft resolution.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) welcomed the recommendations of the Working Group, which would foster fairness, transparency and equity among the Organization's six regions. Equitable geographical representation must be an overarching consideration in the election process. The Health Assembly's role would be strengthened by the opportunity to consider three candidates for the post of Director-General rather than one. He endorsed the proposal to draw up a code of conduct that would apply to both candidates and Member States and would be based on the key principles set out in the Working Group's report. The package of recommendations, to which his country had contributed, reflected a convergence of views and thus constituted a solid basis for future consultations and review.

Miss NANOOT MATHURAPOTE (Thailand) fully supported the draft resolution and the package of recommendations proposed by the Working Group, which should ensure the nomination of candidates with a high degree of professional integrity, on the basis of a transparent, fair and equitable

process. Equitable geographical representation was an important principle but the appointment of the Director-General should be based, first and foremost, on professional qualifications and leadership ability.

The Committee took note of the report.

The CHAIRMAN said that, if he heard no objections, he would take it that the Committee wished to approve the draft resolution contained in document A65/38.

The draft resolution was approved.¹

The CHAIRMAN invited the Health Assembly to join him in applauding Ms Tan Yee Woan for her work as Chair of the Working Group.

5. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 20 of the Agenda (Document A65/39)

Dr LI Mingzhu (China) endorsed the strategic priorities listed in paragraph 8 of the Secretariat's report (document A65/39). In the context of the post-2015 development agenda, WHO should continue to participate in, among other mechanisms, the H4+ and IHP+ health initiatives to ensure that public health remained a priority at the global level.

Dr SHOHANI (Iraq) said that thanks to the efforts of the United Nations Development Assistance Framework (UNDAF), whose role was to ensure that resources were channelled to areas where they were most needed, primary, secondary and tertiary health services had been improved, and assistance to countries had been strengthened. That in turn had helped to bolster national efforts to focus on social determinants of health and noncommunicable disease prevention. WHO, which would be signing an agreement with the Commission of the African Union on strengthening cooperation, should conclude similar agreements with other organizations in order to sustain efforts to achieve the Millennium Development Goals.

Dr CHOSITA PAVASUTHIPAISIT (Thailand) commended WHO's efforts to place health issues on the global agenda. While appreciating the Organization's work under the United Nations Development Assistance Framework, she believed that it should focus on increasing the involvement of organizations in the United Nations system in promoting universal health coverage at the country level. She welcomed WHO's increased access to the Multi-Donor Trust Funds since that would help to meet the need for predictable and non-earmarked funding and to make up for budget shortfalls.

Ms HAMILTON (Canada) said that achieving improved health outcomes on a global scale required direct interventions on the ground and "upstream" investment in policy coherence and coordination of efforts across a broad spectrum of partners. The 2012 Quadrennial Comprehensive Policy Review would provide a valuable opportunity for promoting health issues within the United Nations system. She welcomed the Organization's commitment to the United Nations country team framework and its participation in the Harmonization for Health in Africa initiative as ways of promoting health at the country level. Recognizing the demands that such partnerships placed on the Organization, she suggested that consideration should be given to conducting regular reviews of partnerships to assess their relevance to WHO's strategic priorities.

¹ Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA65.15.

Dr **WORNING** (Executive Director, Office of the Director-General) said that the request by the Sixty-fourth World Health Assembly for more details concerning WHO's collaboration within the United Nations system had been taken into consideration in the preparation of document A65/39. The report suggested ways in which the Organization could increase the effectiveness of its partnerships, in particular by focusing on strategic priorities and alignments. WHO must ensure that public health issues remained high on the global agenda in the post-2015 period.

Mr **LÚCIO** (World Meteorological Organization) highlighted the impact of weather and climate on health. Global climate changes would increase the risk of vector-borne diseases such as malaria, West Nile virus encephalitis and dengue fever as well as water-borne diseases such as cholera and leptospirosis. WMO was spearheading efforts to develop a global framework for climate services, the aim of which was to bridge the gap between supply and demand with regard to climate services in climate-sensitive sectors, including through the provision of accurate and long-range weather forecasts. The framework would also provide the health sector with an opportunity to learn more about the impact of climate on health and to improve its response to climate-related health risks. WHO was contributing to the preparation of the framework implementation plan by providing information on health needs and priorities. In addition, WHO and WMO were working jointly on the preparation of an atlas showing the distribution and scale of health challenges and climate variability and change and explaining how climate information could be used to inform health decisions. The draft implementation plan and the governance structure of the global framework would be available for review until mid-July; comments by Member States were welcome and would be reflected in the framework document.

The Committee took note of the report.

6. TECHNICAL AND HEALTH MATTERS: Item 13 of the Agenda (continued) (transferred from Committee A)

Draft global vaccine action plan: Item 13.12 of the Agenda (Documents A65/22, A65/22 Add.1 and EB130/2012/REC/1, resolution EB130.R12)

Mr **LASKAR** (Bangladesh) welcomed the draft global vaccine action plan, in particular its focus on active interventions and its recognition of vaccination as a part of comprehensive disease control and prevention. The plan's accountability framework, operationalization plan and post-2020 follow up were particularly worthy of mention. Bangladesh, like the other Member States of the South-East Asia Region, had shown keen interest in improving routine immunization coverage and introducing new vaccines. It had even been recognized by the United Nations as having made tremendous strides in immunization during the past decade, with the introduction of two major vaccines, and it was currently in the process of introducing vaccination programmes against rubella and pneumococcal infection.

Dr **HASAN** (Bahrain) said that with its enhanced vaccination programme her country had made considerable progress against vaccine-preventable diseases, raising the vaccination coverage rate to 95%. Diphtheria and poliomyelitis had been eradicated. Other immunization activities were being carried out, and it was hoped that measles could also be eradicated in the near future. He endorsed the activities set out in the global vaccine action plan and was confident that the challenges mentioned therein could be met.

Dr **FISCHER** (Denmark), speaking on behalf of the Member States of the European Union, said that the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Ukraine, the Republic of Moldova, Armenia and Georgia aligned themselves with her statement.

Equitable access to vaccines and immunization was of great importance for global health and for that reason, the European Union welcomed the draft global vaccine action plan, which would give governments the guidance they needed in order to define stronger immunization goals, develop country-specific action plans and integrate immunization programmes into national public health systems. The use of established vaccines and the introduction of new ones could bring many benefits, especially to low-income countries. Nevertheless, people's reluctance to participate in immunization campaigns could undermine progress. Transparency, evidence-based policies and new communication tools were needed to tackle that problem.

Coordination with other WHO activities, such as the global action plan for pandemic influenza vaccines, had to be ensured. The establishment of a forum for ongoing dialogue between vaccine suppliers and buyers might help to predict demand and to guarantee a supply of effective, safe, stable and cheaper vaccines.

It was a matter of concern that the draft action plan already faced a funding gap of several billion United States dollars and that funding for the poliomyelitis eradication plan was also uncertain. To be realistic and sustainable, plans had to take account of the global financial crisis. More information on the proposed governance structure and its relationship to other initiatives would be welcome, as would information on when the accountability framework would be ready for review by Member States.

Dr SHOHANI (Iraq) said that disease eradication efforts faced many challenges, especially that of achieving total immunization coverage. His country had made significant progress in that regard; for example, it had introduced new vaccines the previous year as part of an enhanced vaccination programme launched in the 1980s. Attention should be drawn to such programmes in order to raise public awareness and encourage vaccination acceptance. Cooperation at all levels and the pooling of experiences were essential to extending vaccination coverage.

Dr ABANIDA (Nigeria) said that the success of the draft action plan hinged on several crucial factors, including country ownership, improving equity, strengthening health systems and ensuring access to sustainable funding and a supply of high quality vaccines, all of which would need to be enhanced if immunization programmes were to improve over the coming decade. As custodians of their citizens' health, governments should think critically about the challenges for immunization and how they could be overcome. Nigeria, a country with one of the largest unimmunized populations, had made significant progress under its Expanded Programme on Immunization, but still needed to take drastic steps to improve coverage. Immunization and poliomyelitis eradication were top governmental priorities.

Turning to the draft resolution in document A65/22, he said that in subparagraph 2(1), the words, “, paying particular attention to improving EPI performance, and” should be inserted after the words “components of their national health strategy and plans”. A new subparagraph 3(2) should be inserted to read: “to ensure that support to the Global Vaccine Action Plan's implementation at regional and country levels includes a strong focus on strengthening routine immunization;”.

Mr LAHLOU (Morocco) said that vaccination was a vital aspect of the human right to health, a shared responsibility and a long-term investment in preventing disease and providing a better future for humanity. It was time for the international community and United Nations bodies, particularly WHO and UNICEF, and the GAVI Alliance, to review their roles and obligations with respect to immunizing the world's population against vaccine-preventable diseases. Renewed commitments by governments and development partners were needed in order to assess the cost effectiveness of immunization programmes. With the introduction of new technologies and vaccines, child and neonatal mortality and morbidity could be reduced, bringing the achievement of the Millennium Development Goals one step closer. However, use of the newer, more expensive vaccines would significantly increase the cost of immunization programmes, making it difficult for some countries to sustain them in the long term. The international community should seek new mechanisms, and adapt

existing ones, within the context of the actual financial capacities of the developing countries, and should make special purchase arrangements available to middle-income countries. He encouraged organizations such as WHO, UNICEF, the GAVI Alliance and the Bill & Melinda Gates Foundation to work together to ensure fair and sustainable access for all to essential vaccines.

Dr RONQUILLO (Philippines) reiterated his country's commitment to the goals and milestones of vaccine research and development described in the draft action plan, which should be guided by demand-driven, country-led approaches. The strategies chosen to deal with the gap between supply and demand should be based on the principles of equity, responsibility and shared accountability. His country was seeking viable mechanisms that would be participatory, inclusive and sustainable, with a view to fostering vaccine self-reliance and self-sufficiency.

Mr PRASAD (India) endorsed the main thrusts of the draft action plan. Adequate financing of immunization programmes depended primarily on the commitment made to them by governments, rather than on legislative frameworks that guaranteed funding, and efforts should focus on convincing countries that immunization was a high priority. Vaccines should be introduced as a matter of necessity rather than in response to pressure from special interest groups. The decision to use vaccines should take into account the factors of disease burden, cost-effectiveness and delivery mechanism capacity.

Strategic objective 1 under the global action plan was to achieve universal commitment to immunization as a priority. According to the plan, a key indicator for monitoring progress towards that goal was the presence of an independent technical advisory group. While endorsing the idea of an advisory group, he was strongly in favour of integrating it into government where it would have a more holistic perspective.

Raising public awareness and developing community ownership of immunization programmes would help to decrease resistance to vaccination and increase community demand for it, and should be an integral part of any comprehensive strategy. Vaccine safety, the timely availability of affordable vaccines, and vaccine research and development were areas to which greater priority should be given.

Mrs SMIRNOVA (Russian Federation) said that it was important to develop common guiding principles in the field of immunization for all countries, regardless of their income level or capacities, and in that respect the draft action plan was particularly welcome. Among the most noteworthy elements of the plan were: measures to draw attention to the importance of immunization; development and implementation of comprehensive, country-wide policies that included populations living in remote areas; and dialogue between vaccine suppliers and buyers.

Scientific research at national, regional and international levels, backed by governments, civil society and private sector donors, should make it possible to accelerate the development and introduction of new vaccines and improve access to them. The global action plan provided a framework that would enable countries to draw up their own national plans tailored to their particular conditions and capacities, and to mobilize resources for strengthening and ensuring the sustainability of national immunization programmes.

Dr DECOCK (United States of America) said that, as a major supporter of the Decade of Vaccines, his Government welcomed the efforts to develop the global vaccine action plan. There was broad international commitment to improved immunization coverage as a key to reducing mortality rates for children under five years of age and to ensuring that progress in that regard continued, or even accelerated, in the post-2015 phase.

Annex 2 to document A65/22, which set out the roles and responsibilities of vaccine development stakeholders, was a welcome addition to the action plan. He also appreciated the plan's emphasis on vaccine safety, strengthening of national regulatory systems, and aggressive pursuit of a global regulatory science agenda, which were essential factors in providing access to safe, effective high-quality vaccines worldwide. Providing high-quality immunization services was, however, a

major challenge. Many countries were giving immediate priority to improving routine immunization as part of building a functioning health system, which was a prerequisite for more ambitious undertakings. Recent outbreaks of vaccine-preventable diseases in high-income countries had highlighted the need for those countries to re-establish and increase demand for vaccines. He welcomed the idea of setting up a forum for discussing future vaccine needs but warned that in doing so there was a risk of violating anti-trust laws on price collusion.

He wished to propose two amendments to the draft resolution contained within resolution EB130.R12. In preambular paragraph six, the words “is scheduled to be” should be replaced by the word “was” to reflect the fact that World Immunization Week had already taken place, in April 2012. In subparagraph 2(1), the word “assure” should be replaced by “ensure”.

Dr ISMAIL (Brunei Darussalam) welcomed the significant strides made by the international community in the area of immunization over the past decade. Efforts to ensure broad and low-cost vaccination coverage for children should be supported. Maintaining a high level of immunity among very young children, ensuring effective monitoring of immunization programmes, carrying out case-based surveillance and increasing community awareness had been recognized as primary strategies for the control and elimination of vaccine-preventable diseases.

His country had made considerable progress towards the elimination of measles and viral hepatitis. It had updated its national immunization programme through the use of combination vaccines and booster doses to ensure better compliance with immunization schedules and extend the immunization period. Beginning in 2013, a school-entry immunization record would be required for all pupils.

Professor BAGGOLEY (Australia) welcomed the draft action plan and took note in particular of the fact that the plan had taken account of comments previously made by his country on the issue. The action plan should be updated to address the important gaps that remained, in particular unequal immunization coverage across countries and relatively low coverage in some Pacific island countries. The indicators proposed in Annex 1 to the action plan should be incorporated into a broader framework that covered vaccine delivery effectiveness, cost effectiveness and alignment with existing regional plans. As a strong supporter of the GAVI Alliance, Australia encouraged WHO to work closely with the Alliance to avoid duplication of effort and to coordinate programme monitoring.

Dr BRENNEN (Bahamas) said that immunization was a core component of the right to health. His Government was committed to financing five new antigens and introducing them to its national immunization schedule within the next three years. The full potential of immunization at the global level would only be realized when all countries had an equal opportunity to reach appropriate population coverage levels for previously introduced vaccines and to introduce new vaccines into their immunization programmes.

He applauded the efforts of PAHO’s Revolving Fund, a funding mechanism that had helped countries such as his own to achieve their immunization goals and sustain their gains. However, developing countries, and the region’s small island developing States in particular, continued to face challenges. WHO could help to meet one of those challenges by providing support to countries that were not eligible for support from the GAVI Alliance so that they might reach their goals as rapidly as those receiving assistance. He endorsed the proposed draft resolution.

Dr YU Jingjin (China), endorsing the overarching goals of the draft action plan, suggested that the plan should lay particular stress on health education and promotion; increasing government support for immunization activities; raising public awareness and facilitating access to vaccines. Before introducing new vaccines into their immunization programmes, governments should determine what human and financial resources would be needed and whether they were available. National immunization programmes should be assessed regularly and adjusted accordingly. Multi-country progress reviews should be held annually, and the Organization should support States in making policy decisions.

Dr AL BELOOSHI (United Arab Emirates), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region had made significant progress over the past decade in broadening immunization coverage and reducing morbidity and mortality by introducing new vaccines. Nevertheless, major challenges remained: more than one million children were without basic vaccine coverage; mumps had re-emerged in some low-income countries that could not afford to purchase the vaccine; and middle-income countries were having funding problems and needed greater support.

Greater efforts should be made to reduce the morbidity and mortality rates of vaccine-preventable diseases. It was up to governments to take ownership of their immunization programmes and, to that end, adopt the proposed action plan, which should provide them with greater resources and ensure a regular supply of vaccines. Joint purchasing of vaccines on a local basis should also be undertaken.

Turning to the draft resolution, he proposed that a paragraph should be added to it in which the Health Assembly would call on the Director-General to provide greater financial resources in order to ensure implementation of the action plan in middle-income countries.

Ms HAMILTON (Canada) said that despite significant progress in immunization worldwide, vaccine-preventable diseases remained a major cause of morbidity and mortality. Immunization had been and would continue to be an integral part of her Government's health programme budget and, in that spirit, she endorsed the draft action plan, in particular its focus on strengthening health systems and its recognition that vaccine delivery and surveillance systems could not be effective without properly-functioning health systems. Once adopted, the action plan should give rise to detailed operational plans focusing both on joint efforts and on individual country ownership, the latter of which was critical to achieving the goals of the Decade of Vaccines.

Further work was needed on the accountability framework which would benefit from being aligned with existing frameworks, such as the Commission on Information and Accountability for Women's and Children's Health. When would the accountability framework be ready and who would be in charge of its work?

Mr NEVES SILVA (Brazil) said that the countries of Latin America and the Caribbean had considerably strengthened the Expanded Programme on Immunization by launching Vaccination Week in the Americas, which promoted equal access to health care by targeting populations with limited access and at high risk of contracting vaccine-preventable diseases. World Immunization Week was a positive response to those regional success stories.

The immunization programme in Brazil was one of its most successful public health initiatives. His country was also developing campaigns to ensure access to vaccines, in conjunction with other countries and PAHO. Vaccines should be adapted to developing country needs and he encouraged WHO to support those countries in devising more effective strategies to combat the rising costs of vaccines and ensure their accessibility.

Many challenges remained. Nevertheless, with joint efforts and commitments from countries and institutional partners, the objectives of the draft action plan could be achieved.

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

The meeting rose at 12:35.

FOURTH MEETING

Friday, 25 May 2012, at 14:30

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

later: Dr E. TAYAG (Philippines)

1. ORGANIZATION OF WORK

The CHAIRMAN asked whether the Committee was willing to accept the transfer from Committee A to Committee B of agenda items 13.8 (Global mass gatherings: implications and opportunities for global health security) and 13.11 (Elimination of schistosomiasis).

It was so agreed.

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

Draft global vaccine action plan: Item 13.12 of the Agenda (Documents A65/22, A65/22 Add.1 and EB130/2012/REC/1, resolution EB130.R12) (continued from the third meeting, section 6)

Dr NORHAYATI RUSLI (Malaysia) said that, once adopted, the draft action plan would dictate rather than guide government policy-making. Malaysia did not support objectives 1 and 2 of the plan's six strategic objectives. Under objective 1, for example, requiring a legal framework that guaranteed financing for immunization would place a burden on governments should they need to borrow funds for that purpose. Also, while appreciating the need for an independent technical advisory group, she would not want the recommended list of actions to become mandatory. With regard to objective 2, despite her Government's sensitivity to the health needs of its citizens, she could not agree that immunization should be promoted as a "core component of the right to health", which the public could "demand". Careful study of issues such as vaccine efficiency, cost-effectiveness and suitability for inclusion in a national immunization plan, rather than emotional demands, should be the primary consideration. Similarly, the proposal to offer cash and other incentives to health-care workers and households in order to promote vaccination programmes required careful study. The suggested establishment of a system for pooled procurement and short-term credit based on models used elsewhere called for discussion both within and between countries, as it would involve an agreed contractual financing mechanism. Negotiations with vaccine producers should be conducted collectively at the regional level while procurement should remain the responsibility of individual countries.

Vaccination was an effective tool for disease prevention but sometimes created a false sense of security since children could still become infected with microorganisms against which the vaccine did not confer protection. Early identification and referral of suspected cases of infectious diseases should therefore be strengthened and integrated management of childhood illness taught, especially in remote areas. Rather than offering monetary and in-kind incentives to encourage vaccine use, which placed an additional burden on implementing agencies and governments, efforts should be made to raise socioeconomic status, educational level and health awareness, particularly among women.

WHO must maintain its leading role in setting standards for vaccine production and quality control. It should support middle- and lower-middle-income countries in the production of affordable vaccines that were as safe and effective as those produced in high-income countries, thereby ensuring the sustainability of immunization programmes.

Dr BORWORN SOM LEERAPAN (Thailand) said that a strong immunization programme was an integral part of a well-functioning health system. However, a major structural barrier to vaccine self-reliance in low- and middle-income countries was the high cost of new vaccines, whose production was often in the hands of a monopoly. As a result, access to new vaccines was blocked until a generic version became available, often years later. Vaccine production capacity should therefore be expanded in the developing countries in order to reduce the cost, and incentive mechanisms set up to separate research and development costs from vaccine prices. A voluntary patent pool, public-private partnerships in production, differential pricing for segmented markets, advance market commitments and regional-level pooled procurement were also needed and should be included under strategic objective 5 of the action plan. The celebration of World Immunization Week could be an effective advocacy tool, even though immunization should be promoted year-round. He was concerned, however, that the vaccine industry might take advantage of the Week to market unsuitable or irrelevant new products, giving rise to undue social pressure and unnecessary public demand. Activities during the Week should therefore focus on basic immunization, to the exclusion of commercial interests.

Mr ÁLVAREZ LUCAS (Mexico) welcomed the immunization activities in Member States and the harmonization of regional consultations by the Secretariat and host countries in the context of the Decade of Vaccines. Mexico had hosted the Regional Consultation of the Americas, at which participants had acknowledged the importance of multisectoral coordination in that strategic area of public health. The action plan offered a new vision for achieving universal coverage and access to immunization and countries would reap significant benefits from its adoption. His Government pledged to step up immunization efforts in accordance with the guidelines and priorities set out in the action plan.

Dr HEMMATI (Islamic Republic of Iran) said that sustainability and availability to all eligible groups were the most important criteria to consider when screening new vaccines for introduction into national immunization programmes. Were they to act as screening agents, WHO and UNICEF would be playing a key role, since implementation of short-term immunization programmes, without screening of new vaccines, might undermine national or even regional programmes. National programmes should be financed by the national budget and reliance on other sources limited to particularly important immunization campaigns for which domestic funding was unavailable or to international crises such as a pandemic. WHO and UNICEF should consider providing technical and financial support to modernize the cold-chain system in line with strategic objective 4 of the action plan. “Reaching every district” and “reaching every community” programmes could have been successful had greater investment been made in them, particularly in technical areas. Reactivating such programmes, especially in remote and marginal areas, could significantly boost immunization coverage. Periodic intensification of routine immunization would be successful only if it helped to expand coverage sustainably. The role of new vaccines in controlling outbreaks was not clear and should be clarified by WHO as soon as possible.

Ms POLL (Costa Rica) said that Costa Rica had good health indicators despite being a developing country. It had made significant progress in vaccination coverage, which had risen to at least 95%. Collaboration within the national health system between the health ministry, the social security administration and the private sector to implement the objectives of the draft action plan had been successful, although there was room for improvement. For example, the country’s information and registration system required strengthening, for which PAHO was offering support. The positive

results achieved under the Global Immunization Vision and Strategy offered a sound foundation on which to build the draft action plan and the Decade of Vaccines. Success depended, however, on the adherence of all interested parties and coordination with Member States to ensure commitment to the plan as a whole.

Ms MATSAU (South Africa), speaking on behalf of the Member States of the African Region, said that many countries in the Region had yet not reached the 90% coverage target set by the Global Immunization Vision and Strategy despite the significant gains made in recent years. The Region still faced challenges that had to be addressed if the goals of the action plan were to be reached.

First, the poorest, most vulnerable children were not being reached by immunization programmes, a problem that could only be solved with new innovative strategies and funding sources. Secondly, health systems in many countries had inadequate infrastructure, staff skills and delivery; overcoming those weaknesses must become an integral part of efforts to bolster immunization services. Thirdly, clinical and laboratory surveillance, which was vital for screening new vaccines, was inadequate and costly. Fourthly, many vaccination programmes remained vertical and continued to target children under two years of age. Lastly, the life-cycle approach to immunization would require a shift in thinking for policy-makers and managers and a commitment to finding new opportunities for integrating other services into immunization schemes.

Despite the GAVI Alliance's recent success in securing significant global funding, the countries in the Region would still have to draw on their own resources to purchase vaccines and run immunization programmes, even as they faced the global economic crisis and competing national priorities. That was a particular challenge for low- to middle-income countries that were not eligible for the Alliance's funding and had to negotiate vaccine prices with producers on their own. In many countries, funding for immunization programmes was under threat; innovative funding mechanisms, such a revolving fund, modelled on that of PAHO, or new tax initiatives must therefore be sought. Establishment and strengthening of national regulatory authorities and technical advisory groups was vital to the development of national vaccine strategies which, together with global strategies to support vaccine production capacity, should ensure effective implementation of the action plan. World Immunization Week was a worthy endeavour and, whenever possible, should be aligned with Child Health Week. The proposed ban on vaccines containing thiomersal, the amount of which was too low to have an environmental impact, would rule out the use of multi-dose vaccines, thus significantly increasing immunization programme costs, which in turn would affect child mortality.

Mr MESBAH (Algeria) said that vaccination was a right and a duty of all Algerians and was provided free of charge. Particular attention should be paid to ensuring that populations living in border regions were vaccinated, not only during epidemics but also through routine immunization programmes; WHO should provide assistance for developing and implementing effective strategies to that end. In a middle-income country such as Algeria, access to vaccines, in particular new vaccines, was limited by their high cost which threatened to undermine any progress made. In the spirit of the GAVI Alliance, WHO should guarantee vaccine affordability under the action plan. The solution was fourfold: ensure that global vaccine producers made vaccines affordable, set up pooled procurement mechanisms based on best practice, promote local production of high-quality vaccines, including through partnership mechanisms, and remove intellectual property restrictions.

Dr KWAK Jin (Republic of Korea) commented that the international community had made great strides in reducing vaccine-preventable diseases through immunization in the past decade. It was time for a new strategy to further reduce the burden of and, eventually, to eradicate those diseases. His Government had been working to raise vaccination coverage rates and reduce the disease burden by: increasing funding for the national immunization programme; expanding the school-entry immunization certificate programme; improving immunization management for vulnerable populations; developing a register-management system; and ensuring the regularity of the immunization recall and reminder system. It had also joined efforts to establish poliomyelitis- and

measles-eradication plans in the Western Pacific Region and had reorganized its national certification committee accordingly. His Government was committed to the process of finalizing and implementing the global vaccine action plan.

Dr MOHAMED (Oman), welcoming the draft action plan, said that there was nothing more effective and equitable, from an economic and social perspective, than vaccination; however, many countries in the Eastern Mediterranean Region were not eligible for support from the GAVI Alliance and thus could not afford to buy sufficient amounts of vaccine, leaving many women and children unvaccinated. It was unacceptable that, in the 21st century, millions of children were dying or suffering from vaccine-preventable diseases. WHO and its partners should put programmes in place to ensure that vaccines were accessible to all.

Dr ST JOHN (Barbados) recalled that her Government had sponsored the draft resolution on World Immunization Week, adopted by the Board at its 130th session in January 2012. The immunization programme in Barbados reflected the principles and objectives of the draft action plan. Her Government had committed itself to an expanded programme on immunization involving a public–private partnership. It had broadened the range of antigens delivered free of charge to citizens with the help of PAHO’s Revolving Fund. It had also expanded its life-cycle approach to immunization, paying particular attention to vulnerable groups and frontline public-sector workers. The national immunization programme was embedded in the primary health care system, both public and private, and had a dedicated line in the annual budget.

Annual meetings of immunization programme managers, convened by the Caribbean Epidemiology Centre, ensured common standards across the Caribbean region as well as continuing professional education. During Vaccination Week in the Americas, Barbados had focused on improving its programme to cover vaccination gaps, educate health providers and raise public awareness.

She urged WHO and its regional committees to support countries in implementing the action plan. Diseases such as poliomyelitis should not be allowed to re-emerge, as that could easily undermine the progress made in reducing the burden of vaccine-preventable diseases. The recent measles outbreak in the Americas was a reminder of how quickly such a situation could arise.

Dr ZAKARIAH (Ghana) said that the action plan represented a paradigm shift towards greater coordination among all stakeholders in the field of immunization, at all levels, and had led to significant gains to the African Region. In Ghana, progress had been made under the Expanded Programme on Immunization and all children under one year of age were vaccinated against 11 lethal diseases. Improved routine immunization and large-scale campaigns had helped to prevent transmission of vaccine-preventable diseases and had significantly reduced the related morbidity and mortality rates. Ghana had had no recorded case of infection with wild poliovirus since 2008 and no death due to measles since 2003. Maternal and neonatal tetanus had recently been eliminated leading to a remarkable decrease in the under-five mortality rate, which had freed up resources for reallocation to other pressing concerns. Healthier children also meant happier caregivers, which in turn gave rise to greater productivity and wealth. Many actors had helped to make the immunization programme a success: the Government and the Ministry of Health, health workers (particularly nurses), women, local partners and international stakeholders like the GAVI Alliance. Such cooperation was necessary to ensure immunization services for all.

Dr ORHII (Nigeria) proposed two amendments to the draft resolution contained in document A65/22. In subparagraph 2(1), the words “paying particular attention to improving EPI performance and” should be inserted following “national health strategy and plans,”. In paragraph 3, a new subparagraph 3(1)*bis* should be added to read: “to ensure that support to the Global Vaccine Action Plan’s implementation at regional and country level includes a strong focus on strengthening routine immunization”.

Dr SUNDARANEEDI (Trinidad and Tobago), endorsing the global action plan and the draft resolution contained therein, said that his Government was committed to the eradication of all vaccine-preventable diseases. Within the past two decades, his country had embarked on an expanded programme of immunization for all age groups, implemented through Government-funded health programmes with some private sector support. Despite the introduction of new antigens in the past 10 years, the high cost of the new vaccines had proved to be prohibitive and had limited the possibility of integrating them into the country's vaccination programme. He asked WHO and the international community to give priority to lowering the price of vaccines.

Ms PEREIRA MAGNO (Timor-Leste) highlighted the many challenges that her country faced in relation to vaccine-preventable communicable diseases, including access to vaccines, qualified health professionals and a sound infrastructure. Her Government had begun implementing the six strategic objectives of the draft plan and was fully committed to eradicating vaccine-preventable diseases. An increase in the general State budget, together with donor funding for the country's health services, would make it possible to prepare a sustainable development plan to reduce mortality and morbidity rates in the future.

Ms KINDE GAZARD (Benin), endorsing the draft resolution, said that with support from the GAVI Alliance, Benin had been introducing new vaccines regularly and also planned to recruit new health care personnel. The African Region had recently organized a second vaccination week, in which people had been identified who had not been vaccinated against measles and poliomyelitis. The next challenge was to strengthen the country's routine immunization programme, which should become a daily activity. Her Government considered the global action plan to be a priority and called on WHO and other partners to move ahead with its preparation.

Dr YAKUBU (United Nations Children's Fund) evoked the remarkable progress made in global immunization since the adoption of the Global Immunization Vision and Strategy. UNICEF would remain an active partner in international efforts to achieve the new goals set out in the draft action plan and to ensure that every eligible individual received the requisite vaccines, regardless of their circumstances. Adoption of the plan was an important, and necessary, step in meeting the demand for developing new vaccines and reaching new target populations, and a clear definition of each stakeholder's accountability in carrying out the plan was needed. Implementation should be accelerated and efforts to mobilize resources increased in order to support all countries in introducing new vaccines and reaching every child. World Immunization Week was an opportunity to advocate globally for immunization and to create a demand for it in all communities in order to ensure equal access to vaccines. He hoped that the draft resolutions on World Immunization Week and the global vaccine action plan would be adopted.

Dr Ho-Sheng WU (Chinese Taipei) said that Chinese Taipei had focused on community awareness as a means of increasing vaccination coverage rates. Its communicable disease control act had made funding for both standard and new vaccines completely independent. Collaboration among professionals and stakeholders regionally and internationally was vital to maximizing the benefits of immunization research and development. In an increasingly mobile world, regular information exchange and collaboration on vaccination policy should continue among Member States and regions in order to improve coverage and facilitate cross-border cooperation. WHO could help by facilitating international cooperation on immunization programmes and by supporting communities in meeting vaccine coverage targets. Chinese Taipei was willing to share its experience in implementing immunization programmes as a contribution to the draft action plan and World Immunization Week.

Dr BIGGER (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that in order to achieve the vision of the Decade of Vaccines, the draft global vaccine action plan, which she welcomed, should be refined, interactions

and partnerships clarified, objectives prioritized and opportunities for synergies identified. Resource requirements and funding sources should be identified and further discussion held on targeted indicators, a monitoring mechanism, and an accountability framework to define stakeholders' roles and responsibilities. Equitable, sustainable access to high-quality, safe, effective vaccines could be ensured by a well-functioning competitive market system in which innovation was rewarded and sustainable investment and collaboration sought. Recognition of current pricing and procurement mechanisms that had contributed significantly to improving access to affordable vaccines was one such example. Although the voluntary transfer of vaccine technology and know-how had potential value, an environment that supported future immunization research and development through the protection of intellectual property rights had to be preserved. The objectives of the Decade of Vaccines could not be achieved by countries alone. The Federation was ready to contribute to a country-led collaborative approach and to work with mutually accountable partners to achieve the goals of the plan.

Ms BERGER (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, welcomed the reference to the right to health and the emphasis on addressing the inequality in immunization coverage in the preamble to the draft resolution. By adopting it, Member States would be pledging to reducing that inequality. National immunization strategies should include disaggregated targets in order to reach the poorest, most vulnerable populations. The emphasis in the draft plan on strengthening health systems was welcome as health workers were central to achieving expanded coverage. The approach that had been used of holding broad consultations prior to drafting the global plan was commendable and should guide the process of translating the plan into country strategies and programmes. Steps must be taken to establish a transparent mutual accountability framework, to be coordinated by WHO, including a requirement for annual reports on progress towards disaggregated equity targets.

Ms ELDER (MSF International), speaking at the invitation of the CHAIRMAN, welcomed the renewed focus on immunization in the Decade of Vaccines and supported the draft action plan. Providing infants with the most basic package of vaccines was a significant challenge owing to weaknesses in routine immunization systems in some developing countries where children were disproportionately affected by vaccine-preventable diseases. She therefore urged Member States and other stakeholders to address the problem of unvaccinated children. To optimize vaccination coverage, the action plan should focus on boosting routine immunization and expanded programmes of immunization. Furthermore, since better data were needed for planning and setting priorities, donors in developing countries should invest in building their data collection and assessment capacities. Developing countries also needed immunization products that were easier to use and better designed. MSF International advocated an approach that acknowledged the problems faced by communities, and provided practical solutions.

Dr BELL (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that the Federation was working closely with its partners to ensure that every child had access to vaccination, which was the best way to achieve Millennium Development Goal 4. Member States were urged to take action in four main areas. First, resources for civil society organizations had not been included in the action plan's cost estimates even though the support of civil society was needed in any comprehensive immunization programme. Secondly, transparency and inclusiveness in discussions and decision-making nationally and internationally must be ensured. Thirdly, local capacity in vaccine development and production should be promoted, and vaccine purchasers should ensure that their procurement practices stimulated competition to bring vaccine prices down to affordable levels. Fourthly, vaccine coverage should be optimized, and the introduction of appropriate, easy-to-use vaccines for developing countries should be accelerated. Her organization supported the draft plan and was convinced that it could be implemented.

Dr EVANS (The GAVI Alliance), speaking at the invitation of the CHAIRMAN, said that funds invested in cost-effective, proven interventions could have a huge impact. Member States' collective efforts to accelerate the uptake of new vaccines was laudable. A country-driven approach was inherent to the vision and strategy of the action plan, as the success of a new vaccine depended on routine immunization and a strong health system. The GAVI Alliance had been instrumental in reducing the gap between the time a vaccine became available in high-income countries and the time it became available in low-income countries, in accordance with the principle set out in the action plan of ensuring equity in vaccine coverage. Equity could nevertheless be improved even further with the aid of firm country leadership. The action plan targets must be achieved to ensure the success of the Decade of Vaccines, and that would require careful monitoring. The GAVI Alliance fully supported the call in the draft resolution for a special session of each regional committee to track progress, and was ready to play an integral part in that process.

Dr BUSTREO (Assistant Director-General) commended the valuable input to the draft action plan provided at regional consultations during the past year by more than 1000 leading experts in the field of immunization, representing 142 countries, and the participation of the Permanent Missions of the United Nations offices in Geneva and New York. Countries had made remarkable efforts to increase vaccine coverage, thus providing life-saving interventions to many women and children.

Replying to Member States' comments, she said that WHO would set the norms and standards referred to in the draft plan and support the preparation of regional and national action plans. Governance of the process would be handled by existing partnerships and coordination mechanisms, so that no new structure would be required. Progress would be monitored and reported to the Health Assembly and the regional committees through an accountability framework. To build the framework, the roles and responsibilities of stakeholders and the recommended indicators and targets for monitoring were being refined. A draft framework was expected to be submitted to the Strategic Advisory Group of Experts on immunization in November 2012, and a report would be submitted, through the Executive Board, to the next Health Assembly.

She assured the delegates of India and Malaysia that the Secretariat had taken note of their concerns regarding some of the proposed indicators. Adjustments would be made to those indicators in individual country action plans, in accordance with national contexts. Resolution EB130.R12 on World Immunization Week did not seek to promote inappropriate marketing of products by vaccine manufacturers but to increase advocacy for existing vaccines and to strengthen immunization systems.

The significant contributions that had been made by United Nations bodies, nongovernmental organizations and other partners to the draft global vaccine action plan would provide a framework for successful implementation, should the Health Assembly adopt the draft resolution.

The CHAIRMAN invited the Secretary of the Committee to read out the proposed amendments to the draft resolution contained in resolution EB130.R12.

Dr ONDARI (Secretary) said that two amendments had been proposed to the draft resolution. In the second line of the seventh preambular paragraph, the word "is" should be replaced by "was", and in subparagraph 2(1), the word "ensure" should be replaced by "assure".

After a brief exchange of views, Dr PABLOS-MÉNDEZ (United States of America) reiterated that his proposed amendment was to replace "assured" by "ensured".

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee wished to approve the draft resolution contained in resolution EB130.R12.

The draft resolution, as amended, was approved.¹

The CHAIRMAN asked the Secretary to read out the proposed amendments to the draft resolution contained in document A65/22.

Dr ONDARI (Secretary) said that the delegate of Nigeria had proposed that in subparagraph 2(1), the words “paying particular attention to improving EPI performance and” should be inserted before the words “according to the epidemiological situation in their respective countries”, and that in paragraph 3, a new subparagraph 3(1)*bis* should be inserted to read “to ensure that support to the global vaccine action plan’s implementation at regional and country level includes a strong focus on strengthening routine immunization”. The delegate of the United Arab Emirates had proposed that in paragraph 3 a new subparagraph 3(5) should be inserted to read “to mobilize more financial resources in order to support implementation of the global vaccine action plan in low-income and middle-income countries”.

Dr FIKRI (United Arab Emirates) said that the amendment just read out had been proposed on behalf of the Member States of the Eastern Mediterranean Region.

The CHAIRMAN said that, in the absence of any objection, he would take it that the Committee wished to approve the draft resolution.

The draft resolution, as amended, was approved.²**Dr Tayag took the Chair.**

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States: Item 13.13 of the Agenda (Documents A65/23 and EB130/2012/REC/1, resolution EB130.R13)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board), introducing the item, reported that at its 130th session in January 2012 the Executive Board had considered the report of the Working Group of Member States on Substandard/Spurious/Falsely-Labelled/Falsified/Counterfeit medical products and had adopted resolution EB130.R13. Both the report and the resolution acknowledged and reaffirmed WHO’s role in the area of substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products and proposed the establishment of a new, transparent Member State mechanism to encourage international collaboration in ensuring access to affordable, safe, efficacious and quality medical products and in the prevention and control of SSFFC products and associated activities. Many countries had expressed support for the draft resolution contained in resolution EB130.R13, and one Member State had pledged to participate in the mechanism on a voluntary basis. The Board had welcomed the proposal by the Government of Argentina, supported by the delegate of Brazil, to host the first meeting of the Member State mechanism, on the understanding that a preparatory meeting would be held in Geneva. The Health Assembly was invited to consider the draft resolution contained in resolution EB130.R13.

Ms KRARUP (Denmark), speaking on behalf of the European Union and its Member States, the acceding country Croatia, the candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process and potential candidates Albania and Bosnia and Herzegovina, as well as Ukraine, the Republic of

¹ Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA65.18.

² Transmitted to the Health Assembly in the Committee’s second report and adopted as resolution WHA65.17.

Moldova, Armenia and Georgia, congratulated the Working Group on breaking the deadlock on the issue of SSFFC medical products, an area in which WHO had an active role to play. The European Union supported the draft resolution and wanted the new Member State mechanism to be set up swiftly in order to provide an effective, results-oriented platform for coordinated, multisectoral cooperation to prevent SSFFC medical products from undermining the credibility of health systems. The mechanism should be practical, adapted to the needs of Member States and based on transparent consultation and collaboration with stakeholders; any meetings that it held outside Geneva must be cost-efficient. The dates of the first meeting should not overlap with those of the 15th International Conference of Drug Regulatory Authorities, which was a partner in the combat against SSFFC products. The European Union endorsed WHO's fundamental role in ensuring the quality, safety and efficacy of medical products and in promoting access to affordable, quality, safe and efficacious medicines, and was actively cooperating with developing countries in that regard. It requested WHO to identify, using transparent methods, adequate funding for the fight against SSFFC medical products under the approved Programme budget 2012–2013.

Dr HASAN (Bahrain) said that her country's activities relating to SSFFC medical products were focused on providing protection for potential victims. WHO had a key role to play in ensuring the quality of medical products but lacked sufficient resources to do so. Pharmaceutical products should be sold at reasonable prices. She supported the establishment of a subcommittee of the WHO Expert Committee on Specifications for Pharmaceutical Preparations to provide technical advice on SSFFC medical products. Product monitoring was a collective responsibility and cooperation was required among all stakeholders, including governments and civil society, in order to train health workers and build capacities to reduce the availability of poor-quality medicines. Measures taken by her Government to control SSFFC medical products included laboratory monitoring of products that entered the country and studying the by-products of those products. In addition, the countries in the Gulf region and the Regional Office for the Eastern Mediterranean would be working together to monitor medical products. She supported the draft resolution.

Dr KUDO (Japan), endorsing the draft resolution, said that the Organization's efforts to prevent and control SSFFC medical products were among its most important activities for attaining the goal of improving the quality of and access to medical products and technologies, and should be expanded. In view of the involvement of international organized crime and the piracy of trademarks and product design, cooperative efforts among the various stakeholders combating SSFFC products – including the private sector, and in particular the pharmaceutical industry – must be strengthened and transparency and accountability ensured. Japan was providing technical cooperation to some developing countries to improve their access to medicines, but SSFFC products were always more affordable and accessible. Comprehensive measures to provide greater access to affordable, quality medicines were needed, including ensuring the integrity of the supply chain, developing more effective monitoring systems, raising public awareness and improving health systems. Japan would willingly join in international efforts to implement the new Member State mechanism.

Dr RONQUILLO (Philippines) asked the Committee to include in the draft resolution a reference to the importance of information-sharing among Member States and to reconsider use of the SSFFC rapid alert system to fight against counterfeit medical products. Regional regulatory infrastructure and capacity must be strengthened in order to tackle cross-border regulatory issues and combat intelligence operations and terrorism. Participation on a voluntary basis in the proposed new mechanism would demonstrate Member States' commitment to its operation and funding.

Dr CUI Enxue (China) said that effective cooperation was required to combat SSFFC medical products, which posed a threat to human health. National medicine regulatory bodies should strengthen their information exchange and communication networks and enhance cooperation in order to bolster their capacities to prevent and control SSFFC products. A more accurate and more widely

acceptable definition of SSFFC products was needed in order to combat them effectively. Furthermore, SSFFC products should be defined in accordance with national laws, taking into account the criteria of affordability, efficacy and safety. His Government welcomed the draft resolution, in particular the establishment of a mechanism to strengthen cooperation between the Secretariat and Member States, in which it planned to participate actively.

Ms MWAPE (Zambia), speaking on behalf of the Member States of the African Region, said that rapid globalization had exacerbated the long-standing problem of SSFFC medical products, from which no country was immune. Despite the complexity of the matter and the challenges arising from interpretation of terms, she was confident that agreement on working definitions could be reached quickly. WHO had a vital role to play in providing technical guidance, and its commitment to support national capacity-building was welcome, as was the proposal to establish a Member State mechanism. According to the International Medical Products Anti-Counterfeiting Taskforce (IMPACT), counterfeiting was most prevalent in countries where regulatory and legal oversight was weak. The potentially lucrative business of counterfeiting attracted organized crime, and the penalties in most countries were not severe enough to act as a deterrent. Moreover, counterfeit medical products were becoming more difficult to detect owing to advances in manufacturing technology. Other challenges included flaws in the systems designed to manage pharmaceutical supply chains, corruption and lack of transparency in procurement practices, unregulated marketing of medicines on the Internet, and weak national and international cooperation mechanisms. The Member States of the Region pledged to join forces to combat the proliferation of SSFFC medical products and were willing to cooperate with WHO and other stakeholders at all levels to that end. They supported the draft resolution and expressed confidence that sufficient funds would be mobilized to support the establishment and operation of the Member State mechanism.

Dr ORHII (Nigeria), endorsing the draft resolution, said that no country was free from the current proliferation of SSFFC medical products, which undermined efforts in Africa to treat malaria, HIV/AIDS and tuberculosis. The situation was exacerbated by regulatory gaps and poor technical capacity in many countries. Access to safe, efficacious and affordable essential medicines of good quality was one of the most cost-effective aspects of modern health care and an important indicator of progress towards the health-related Millennium Development Goals; in contrast, lack of access could jeopardize the credibility of health care systems. Effective national and international cooperation was needed to combat the transnational criminal networks involved in counterfeiting. The establishment of the West African Drug Regulatory Authority Network, the appointment of independent analysts to re-certify medicines for export to Nigeria, and Nigeria's sustained campaign for an international convention against drug counterfeiting were changing the attitudes of regulators, the pharmaceutical industry and customs and crime-fighting organizations.

Dr SLAMET RIYADI YUWONO (Indonesia), speaking on behalf of the Member States of the South-East Asia Region, applauded the Organization's efforts to ensure the quality, safety and efficacy of medical products and promote access to affordable, safe and efficacious medicines of good quality. WHO should continue to support capacity-building and the strengthening of national and regional drug regulatory infrastructures, especially in developing and least developed countries. The Organization also had a crucial role to play with regard to SSFFC medical products from a public health perspective, with the exception of trade and intellectual property issues. The draft resolution merited support, as did the proposed Member State mechanism, which should be transparent and inclusive and include expertise in national regulation of medical products.

Dr SHOHANI (Iraq) said that prevention and control of SSFFC medical products was an important aspect of food and health security. Iraq had set up an effective, law-based national system for the control of medical products that included selection procedures and a monitoring mechanism. Samples of medicines were analysed at national laboratories, and medicines were marketed only after

tests based on international scientific criteria had proved their efficacy and ensured that they met quality standards. Medicines were purchased from approved providers and the process was continuously monitored. WHO had an important role to play in regularly compiling and circulating information on spurious products and companies. He endorsed the draft resolution.

Mr McIFF (United States of America) said that his delegation had participated in the Working Group and supported the draft resolution. It welcomed the proposed Member State mechanism and was committed to its success. SSFFC medical products were both a domestic and an international concern and represented a considerable share of the drugs used to treat serious diseases in some countries. Better surveillance and pharmacovigilance were required in order to collect the data needed to assess and manage all aspects of the problem. Drug counterfeiting and diversion, cargo theft and intentional adulteration were flourishing because of recent global changes. Greater cooperation between regulation and enforcement experts was needed to ensure proper manufacturing and distribution practices and deter criminal activity. The pharmaceutical industry had shifted manufacturing and supply sourcing operations into new geographical areas in recent years, resulting in a more complex supply chain that was providing new entry points for contaminated, adulterated and other substandard products. National regulatory systems and cross-border cooperation must therefore be strengthened. WHO was well positioned to lead the effort using a data-driven approach based on sound scientific evidence. He thanked the Government of Argentina for its offer to host the first meeting of the proposed Member State mechanism in November 2012 and supported the call for preparatory meetings in Geneva to ensure its success.

Dr BRENNEN (Bahamas) said that, although the Bahamas did not have a large drug manufacturing sector, SSFFC medical products were traded into and out of the country. The situation was exacerbated by parallel importation without appropriate documentation and weak regulatory capacity. The Working Group had recommended the creation of national networks with international links and national programmes to prevent counterfeiting, which would include training plans and indicators. At the same time, greater support would be needed from the international community to ensure that standards in manufacturing countries were the same as those in importing countries. Small island developing countries found it difficult to set up the requisite drug testing facilities in each territory, and support was needed to promote harmonization of legislative and regulatory frameworks and to build pharmacovigilance capacity. The Bahamas would welcome cooperative agreements to take that process forward. Convinced that the programmes endorsed by the Working Group would benefit countries in their combat against SSFFC medical products, he endorsed its report and the draft resolution. He urged the Secretariat to take into account the particular challenges faced by small island States such as his own.

Mr AGHAZADEH KHOEI (Islamic Republic of Iran) commended the Working Group's efforts and endorsed the goals, objectives and terms of reference of the proposed Member State mechanism. He urged the Director-General to expedite its establishment and to provide it with the necessary operational support. The new mechanism should be the sole official international mechanism for preventing and controlling the production of medical products that were compromised in terms of quality and safety and should enhance collaboration between Member States and the Secretariat. WHO should continue building the capacity of national drug regulatory authorities and health systems. Nevertheless, the lack of sufficient funding for WHO's work concerning the quality, safety and efficacy of medicines was a serious concern.

Mr SILLO (United Republic of Tanzania) reported that his country had taken a number of steps to strengthen its national drug regulatory systems. Its quality control laboratory, run by the national food and drugs authority and prequalified by WHO in 2011, played a critical role in testing suspected SSFFC medical products in the African Region. National efforts were complemented by the East African Community Medicines Registration Harmonization Project, launched in March 2012 with the

aim of harmonizing medicines registration with recognized policies and standards. He commended WHO's efforts to prevent and control SSFFC medical products which, despite the progress made, remained a major public health concern. His own country, for example, had recently discovered that quinine tablets containing metronidazole rather than quinine sulfate were being used to manage severe and life-threatening malaria in unsuspecting impoverished patients. Endorsing the draft resolution, he urged the Secretariat to convene the first meeting of the proposed Member State mechanism as soon as possible to ensure rapid implementation of the resolution, in which regional and subregional groups would have a critical role to play.

Ms POLL (Costa Rica) said that SSFFC medical products could have serious consequences for patients; every effort must therefore be made to prevent their production, distribution and consumption. Fortunately, her country had managed to counter serious threats in that area: efforts to introduce SSFFC products had been detected and their distribution prevented. Health authorities in Costa Rica were currently cooperating with other sectors and with international organizations such as INTERPOL to improve the country's prevention and control system, under which criminal penalties could be applied. She supported WHO's coordinating role in promoting national measures to ensure the availability of safe and efficacious medical products of good quality, and endorsed the proposed Member State mechanism. The international community, working with WHO, must set up mechanisms to identify the criminal organizations responsible for trade in SSFFC medical products. Training in that regard would be needed to establish effective cooperation networks among Member States.

Mr BEN AMMAR (Tunisia), speaking on behalf of the Member States of the Eastern Mediterranean Region, agreed that SSFFC medical products represented a danger to all countries, particularly when they could be obtained through public and private health systems and in pharmacies. Even registered distributors were sometimes found to be involved in the distribution of SSFFC medical products, and they were now being encouraged to cooperate in efforts to determine the source. The growing international trade in medical products, especially through the Internet, was facilitating the entry into the market of compromised products. The Region needed greater resources to meet the challenges it faced, which included absence of appropriate legislation, lack of cooperation between legislative bodies and law enforcement and customs officials, and reduced national representation at international meetings. Furthermore, priority should be given to: mobilizing sufficient resources to fund WHO field activities; identifying differences between procedures used for manufacturing and marketing SSFFC medical products and those for legal medicines; and adopting a unified Member State position on combating related criminal activities. He endorsed the proposals to establish a Member State mechanism and to set up a subcommittee of the WHO Expert Committee on Specifications for Pharmaceutical Preparations to give technical advice on SSFFC medical products.

Dr TSECHKOVSKY (Russian Federation), endorsing the draft resolution, said that his country had had first-hand experience with SSFFC medical products and attached great importance to the establishment of appropriate international cooperation to combat the threat they posed, especially in view of the global nature of the production and distribution process. Studies were needed to determine the extent to which SSFFC products were available since they were capable of undermining the authority of public health systems. The 2011 Medicrime Convention,¹ which was the first pan-European instrument on counterfeiting of medical products, gave priority to protecting public health and stressed the importance of international cooperation, information exchange and coordination of activities. The global monitoring and integrated notification system established under

¹ The Council of Europe Convention on counterfeiting of medical products and similar crimes involving threats to public health, signed in Moscow in October 2011.

the aegis of WHO should increase the effectiveness of measures to combat trafficking in SSFFC products and create new prevention opportunities.

Dr ST. JOHN (Barbados), endorsing the draft resolution, said that efforts must be made to ensure that the definition of counterfeit medical products did not cause generic competition to shrink, since that would result in higher prices and reduced access to medicines. She urged the Director-General to continue supporting national drug regulatory and inspection authorities in order to ensure their capacity to prevent licensing and entry of SSFFC products and, if necessary, to remove them from the market. Other challenges included bridging the Organization's funding gap for its work in prevention and control of SSFFC products; providing additional resources for the pharmacovigilance training launched by WHO in the Caribbean region in 2006; expanding the WHO drug prequalification programme to new products; and ensuring continued WHO support for national efforts to monitor good manufacturing practices in drug producing countries. The Pan American Network for Drug Regulatory Harmonization was a potential source of support but tapping it would require language training for the region's English-speaking countries. She hoped that the joint WHO/European Union renewed Partnership on Pharmaceutical Policies would be launched soon since Barbados still had work to complete under that programme. She asked WHO to facilitate training on Internet pharmacy regulation in all Member States. The Caribbean Pharmaceutical Policy, approved by the Caribbean Community in April 2011, should be supported.

Mr DESIRAJU (India) said that for the past two years, Member States had been seeking innovative solutions to combat the growing international trade in SSFFC medical products. The draft resolution and, in particular, the proposal to establish a Member State mechanism, was welcome in that regard. Once the mechanism had been set up, WHO should dissociate its activities from those of the International Medical Products Anti-Counterfeiting Taskforce (IMPACT). Cooperation between the Member State mechanism and other partners would be beneficial but the mechanism's first task was to review the definitions, which still needed clarification. Further information from the Secretariat in that regard would be appreciated.

The meeting rose at 17:30.

FIFTH MEETING

Friday, 25 May 2012, at 18:45

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

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

Substandard/spurious/falsely-labelled/falsified/counterfeit medical products: report of the Working Group of Member States: Item 13.13 of the Agenda (Documents A65/23 and EB130/2012/REC/1, resolution EB130.R13) (continued)

Miss PATCHAREEWAN PHUNGNIL (Thailand) welcomed the establishment of the Member State mechanism. The fight against substandard/spurious/falsely-labelled/falsified/counterfeit (SSFFC) medical products must focus on protecting public health and improving access to efficacious, quality medical products and should not be linked to intellectual property and trade issues. Increased Internet sales of medical products and false media claims were facilitating the entry of SSFFC products into the supply chain, calling for increased public awareness-raising of the issue in order to protect consumers. Effective collaboration free from conflicts of interest among stakeholders at the country, regional and global levels was required. The objectives set out in Appendix 2 of document A65/23 should be translated into action plans with a view to their implementation and strengthening of the rapid alert system against SSFFC medical products. She endorsed the draft resolution contained in resolution EB130.R13, notwithstanding the unusual request in subparagraph 6(2), urging Member States to provide financial resources rather than requesting the Director-General to mobilize such resources.

Mrs GOONERATNE (Sri Lanka) said that the availability of quality generic medicines was crucial to her Government's ability to continue providing its population with free health care. Efforts were under way to enhance national capacity for the production of medical products with a view to reducing costs and ensuring optimum use of the health care budget. It was to be hoped that the new Member State mechanism, which her Government welcomed, would contribute to national capacity-building through the transfer of technology between countries. Further Secretariat collaboration with Member States was needed to ensure that efforts to combat SSFFC products did not result in reduced availability of legitimate, affordable generic medicines and other medical products. She supported the draft resolution.

Ms SAMIYA (Maldives), expressing support for WHO's role in the prevention and control of medical products of compromised quality, safety and efficacy, noted that patents and trade agreements might hinder the availability and decrease the affordability of medicines in countries such as hers. She urged WHO to prioritize action to ensure the availability and accessibility of safe, quality and efficacious medical products in countries that had insufficient pharmaceutical manufacturing capacity or none at all. Her Government supported the establishment of a Member State mechanism, which would establish links between pharmaceutical regulatory authorities and facilitate the exchange of important information at the regional and international levels. That, in turn, would benefit import-dependent countries. As a developing country, Maldives required guidance and capacity-building support from WHO to prevent SSFFC medical products from entering the country and to ensure the availability of safe, quality products.

Mr GARCÍA DE ZÚÑIGA (Paraguay), speaking on behalf of the member countries of the Union of South American Nations, endorsed the creation of the new mechanism to tackle the issue of SSFFC medical products and asked the Secretariat to promote Member States' active participation in the mechanism. The countries of the Union were in favour of holding the first meeting of the mechanism in Argentina. Endorsing the draft resolution, he reaffirmed his Government's commitment to regional cooperation to prevent and combat SSFFC products.

Mr PIPPO (Argentina) welcomed the creation of the Member State mechanism and called on Member States to collaborate actively in it and to make every effort to secure the necessary agreements and formulate specific proposals to enable WHO to sustain its global activities aimed at combating SSFFC medical products. He reaffirmed his Government's offer to host the first meeting of the mechanism in November 2012 in Buenos Aires. His Government wished to encourage the participation of low-income countries in the meeting and, to that end, was working with the Secretariat to facilitate the attendance of technical and regulatory experts from around the world.

Mr TOSCANO VELASCO (Mexico), underscoring the importance of international action to combat the problem of SSFFC medical products, welcomed the offer by the Government of Argentina to host the first meeting of the Member State mechanism, to be preceded by a preparatory meeting in Geneva.

Ms WISEMAN (Canada) endorsing the draft resolution, said that the new mechanism would enhance coordination of national, regional and multilateral efforts to combat the issue of SSFFC medical products. Its objectives must be clearly focused on the public health elements of such products and the scope of its activities should be appropriately scaled in view of the resource constraints facing WHO. Her country appreciated the offer by the Government of Argentina to host the first formal meeting of the mechanism, in which it looked forward to participating.

Dr SEAKGOSING (Botswana) said that registration of medicines was key to evaluating and ensuring their safety, efficacy and quality. All medicines manufactured, imported or exported, distributed or sold in Botswana had to be registered. The country had limited capacity to conduct post-market surveillance and lacked a fully functional testing laboratory, which made it difficult to detect SSFFC medical products. It was therefore imperative to strengthen enforcement capacity and ensure that law enforcement agencies had the necessary technical know-how and equipment to deal with SSFFC products, especially at points of entry, as Botswana was mainly a medicine-importing country. He strongly supported the draft resolution.

Dr AGUILAR (Ecuador) said that as demand for and consumption of medicines increased throughout the world, industrial and commercial interests were seeking to relax regulatory mechanisms, which could hinder efforts to control SSFFC medical products. It was important to improve access to medicines for diseases considered to be public health issues, such as malaria, HIV/AIDS and tuberculosis, but Member States' technical and regulatory capacity must be strengthened in order to ensure the safety and quality of such medicines.

Dr OPUNI (Ghana) expressed support for the establishment of a subcommittee of the WHO Expert Committee on Specifications for Pharmaceutical Preparations to give technical advice on SSFFC medical products, and the establishment of a Member State mechanism to address the problem. He encouraged Member States to prioritize and intensify post-market surveillance activities and subregional and regional collaboration in the fight against SSFFC products. The mechanism should be established as soon as possible, and the Secretariat should be responsible for convening and coordinating its meetings.

Mr MESBAH (Algeria) said that one of the most effective means of combating SSFFC medical products was to ensure access for all, especially the most vulnerable, to safe medicines. WHO had a critical role to play in that regard. Strategies to combat SSFFC products should be shaped by the way in which such products entered the supply chain. To prevent them from entering the formal market, increased surveillance and the establishment or strengthening of quality control laboratories at country level was needed. Preventing products from permeating the informal market required cooperation among the institutions and authorities concerned at the international level, and effective intersectoral law enforcement and quality control mechanisms at the national level. As for the emerging threat posed by the availability of SSFFC products via the Internet, the experiences of countries that were already grappling with the issue should be taken into account. Algeria's national pharmaceutical quality control laboratory served as a WHO collaborating centre, and his Government stood ready to share its expertise in that area with other Member States.

Dr DAOUDA (Niger) said that his Government's medicines policy focused on providing access for all to quality essential medical products and encouraging their rational use, ensuring the quality of pharmaceutical products and developing local pharmaceutical production. The national quality assurance system was based on registration, inspection and quality control. Globalization and trade growth, however, were increasing the risk that SSFFC products would find their way onto the market, and regional and subregional cooperation efforts to combat illicit trade in such products had proved insufficient. Niger therefore supported the draft resolution, which sought to protect public health and enhance access to products that were safe, efficacious and of high quality.

Dr NORHAYATI RUSLI (Malaysia), commending the work of the Working Group on SSFFC medical products, said that her Government recognized the need to strengthen its national capacity to combat such products. In 2005, Malaysia had introduced the mandatory hologram labelling of all registered medical products in order to facilitate the identification of counterfeits. She welcomed the draft resolution.

Mr NEVES SILVA (Brazil) welcomed the Working Group's decision to recommend the establishment of a Member State mechanism and its clear definition of the goal, objectives and terms of reference of the mechanism, which would ensure that it addressed the scourge of SSFFC products from a public health perspective. His Government fully supported the establishment of the mechanism and welcomed the offer by the Government of Argentina to host its first meeting. His Government was prepared to assist in organizing the event. In order to prevent and control SSFFC products effectively, the root cause of the problem – unequal access to essential medicines – had to be tackled. Trade in falsified medicines would not thrive where quality, affordable medicines were available to the entire population.

Dr Guey-Ing DAY (Chinese Taipei) said that strategies used to combat SSFFC medical products in Chinese Taipei included monitoring the supply chain and setting up pre-market registration and post-market surveillance systems. An interagency law enforcement task force had been established and national pharmaceutical legislation had been amended to impose stricter penalties on those who manufactured or imported SSFFC products. Furthermore, a public awareness campaign had been launched to inform senior citizens of the risks associated with illicit medical products. In 2011, her Government had hosted a regional workshop at which experts and officials from Asian countries had exchanged information and shared best practices. Chinese Taipei would continue striving to combat SSFFC medical products.

Mr BESANÇON (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, expressed strong support of WHO's role in ensuring the availability of quality, safe, efficacious and affordable medical products and urged that adequate financing be provided so that the Organization could continue to fulfil that role. Special expertise and multisectoral support were required in order to deal with emerging channels for the sale of SSFFC products, such as the Internet. He therefore recommended that the new Member State mechanism should make provision for the collaboration of civil society organizations like his own, which had such expertise.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, welcomed the proposed new mechanism. The use of fake medicines could turn a treatable condition into a fatal one and could foster drug resistance. Fake versions of both generic and branded medicines had entered the supply chain in developed as well as developing countries, a trade facilitated by the Internet. In more than 50% of cases, medicines purchased over the Internet from illegal sites had been found to be counterfeit. His organization encouraged governments and other stakeholders to develop education and public awareness-raising programmes on the potential dangers of fake medicines and on ways of purchasing medicines safely. Multistakeholder and multidisciplinary collaboration were required at the local and global levels. The Federation stood ready to share its expertise on the subject.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that a global, multistakeholder approach was essential in order to reduce the proliferation of SSFFC medical products and protect patients, especially those in the least developed countries with limited access to the necessary information to protect themselves. Her organization supported the establishment of the Member State mechanism and welcomed the inclusion among its objectives of action to strengthen regulatory capacity in developing and least developed countries, to ensure the integrity of the supply chain and to develop tools in the areas of prevention, detection and control. It was concerned, however, that the mechanism's terms of reference did not adequately provide for the participation of key stakeholders, including health professionals, regulators and patients, whose involvement was crucial to addressing the issues surrounding SSFFC products.

Ms RASMUSSEN (International Pharmaceutical Students' Federation), speaking at the invitation of the CHAIRMAN, said that innovative, simple and affordable technologies were required to detect SSFFC medical products, together with solid regulatory systems and appropriate enforcement. Methods should be developed to enable patients to verify the legitimacy of pharmacies trading via the Internet. Pharmacists should be included in the detection process. The Federation had conducted an anti-counterfeit drug campaign to educate pharmacy students, other health professionals and the wider health community. She welcomed the draft resolution which constituted a step forward in combating SSFFC medical products. Her organization would continue to support WHO's efforts to protect patients.

Ms WANIS (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, welcomed the establishment of the Member State mechanism, which was an appropriate mechanism for dealing with the problem of compromised medicines. With the establishment of the mechanism, WHO should dissociate its activities from those of the International Medical Products Anti-Counterfeiting Taskforce. She urged Member States, through the mechanism, to find solutions to the problems associated with the lack of affordable, high-quality medicines, which was one of the root causes of the proliferation of SSFFC products. The Organization should support the development of regulatory capacity at the global, regional and national levels, with particular emphasis on countries that lacked the capacity to control the quality of medicines circulating in their markets. The Organization should focus on regulation of the quality, safety and efficacy of medicines, not on the regulation of intellectual property rights. Adequate financial resources could be ensured by increasing assessed contributions and non-earmarked funding.

Dr ETIENNE (Assistant Director-General) said that Member States clearly attached high priority to ensuring the availability of safe, quality, efficacious and affordable medical products. She welcomed the consensus reached with regard to establishing the Member State mechanism, which would be a valuable complement to WHO's existing work in relation to substandard medicines, and which also was endorsed by Member States. That work encompassed the Expert Committees, pharmacovigilance, rational use of medicines, quality and safety of medical products and regulatory capacity-building. The first meeting of the Member State mechanism had been provisionally scheduled to be held in the week beginning 19 November 2012 in Argentina. A preparatory meeting would be held in Geneva. The Member State mechanism and its associated activities would entail high costs, which could not be covered out of the current biennial budget; the Secretariat undertook to mobilize the additional funds required. The Secretariat remained committed to working with Member States in a spirit of transparency, responsiveness and accountability, using evidence-based approaches, and would focus exclusively on the public health aspects of SSFFC products.

Dr YUSUFU (Nigeria) said that resource constraints would make it difficult for representatives from the African Region to attend the first meeting of the Member State mechanism if it were held in Argentina. Since most Member States were well represented in Geneva, and since the mechanism was linked to the International Conference of Drug Regulatory Authorities, he strongly believed that the first and second meetings should be held in Geneva.

Mr CAVALERI (Argentina) said that his Government stood ready to work with the Secretariat to ensure that experts from countries with limited resources would be able to attend the meeting. Fund-raising activities were envisaged especially for that purpose. He expressed the hope that the delegate of Nigeria would thus be able to support his Government's proposal to hold the first meeting in Buenos Aires.

The CHAIRMAN said that the Secretariat would follow up on the offer by the Government of Argentina to assist in further planning of the meeting. As no amendments had been proposed, he took it that the Committee was prepared to approve the draft resolution recommended by the Executive Board in resolution EB130.R13.

The draft resolution was approved.¹

WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies: Item 13.15 of the Agenda (Documents A65/25 and EB130/2012/REC/1, resolution EB130.R14)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board) said that the Board had considered an earlier version of the report on the item at its 130th session. Discussions had highlighted the need to support Member States in meeting needs in disaster-struck areas; strengthen local capacities to improve disaster preparedness; develop WHO's surge capacity; make better use of Member States' existing capacities and expertise and develop a mechanism for utilizing them in the event of an emergency; enhance coordination and accountability; ensure the adequacy of resources; and address the issue of health worker safety in emergencies and conflicts. The Board had adopted resolution EB130.R14, which recommended a resolution for adoption by the Health Assembly.

Mr SMIDT (Denmark), speaking on behalf of the European Union and its Member States, said that the acceding country Croatia, candidate countries Turkey, the former Yugoslav Republic of Macedonia, Montenegro, Iceland and Serbia, the countries of the Stabilisation and Association Process

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.19.

and potential candidates Albania and Bosnia and Herzegovina, as well as Armenia and Georgia, aligned themselves with his statement.

WHO played a crucial role, including as global health cluster lead, in coordinating with numerous national, multilateral and nongovernmental health actors to respond to and prepare for growing humanitarian health needs in emergencies. Close cooperation under the leadership of the United Nations Office for the Coordination of Humanitarian Affairs, and with other relevant partners, was essential for strengthening the international humanitarian architecture and improving the efficiency and effectiveness of response. He therefore welcomed the Director-General's firm commitment to implement the Inter-Agency Standing Committee's humanitarian reform agenda.

WHO reform was on the right track towards improving governance, leadership and transparency in humanitarian assistance. However, some challenges remained, a key one being enhancement of the Organization's field-level response, notably in preventing and mitigating excess mortality and morbidity through effective coordination and leadership. WHO's surge capacity should be strengthened, which required pre-established arrangements between the different levels of the Organization. Sufficient numbers of qualified senior health cluster coordinators and other humanitarian experts needed to be immediately available, especially for sudden-onset emergencies. Further policy and technical guidance was required, and a means of ensuring the rapid availability of reliable epidemiological data, including in transition periods, needed to be in place. The European Union offered to support WHO in implementing its new corporate approach and emergency response framework and urged all Member States and other partners to increase the predictability and flexibility of their funding for WHO's humanitarian work in order to bridge the current funding gap.

Bangladesh, Canada, Mexico, Monaco, Republic of Moldova, Russian Federation, Switzerland and Turkey had joined as cosponsors of the resolution EB130.R14 since its adoption by the Board. Several amendments had been proposed, namely: in the fifth preambular paragraph, the words "and the guiding principles thereof" should be deleted, and "in full respect of the guiding principles therein" should be added after "by humanitarian emergencies"; a new subparagraph 1(5) should be inserted, to read: "to establish health response teams on a voluntary basis and develop a mechanism for deployment in case of humanitarian emergencies, depending on the choice of each Member State"; subparagraph 2(2) should be replaced with: "to strengthen WHO's surge capacity with global health cluster partners and Member States, including developing standby rapid-response arrangements and mechanisms to deploy and sustain response teams with appropriate resources in response to humanitarian emergencies"; and in subparagraph 2(8), the words "the International Committee of the Red Cross" in line 4 should be replaced with "other relevant actors".

Dr SAÍDE (Mozambique), speaking on behalf of the Member States of the African Region, said that the Region faced an increasing number of crises and natural disasters, causing population displacements, destruction of health facilities and disruption of services. In 2010, 69 catastrophes had occurred, affecting 9.9 million people.

Since the roll-out of the United Nations cluster approach in 2006, WHO, in collaboration with health ministries and other partners, had significantly improved health coordination and management of humanitarian response in the African Region. Strong sectoral and intersectoral collaboration at country level had improved response efficiency and increased resource mobilization, while capacity-building had empowered health ministries. WHO had also forged strategic alliances with key partners, especially among United Nations agencies and international nongovernmental organizations.

Although the approach was having a positive impact, some aspects could be improved. The multiplicity of humanitarian actors present during crises made joint planning and consensus-building a challenge. It resulted in weak inter-cluster information management; lack of a common framework for gap analysis; difficulties in working effectively with host governments owing to weak capacity and skills; and lack of meaningful participation by national and local nongovernmental organizations. Lack of cohesion and communication among donors often resulted in coordination difficulties, and low levels of funding had led to the closure of health clusters in a number of countries still afflicted by

crises. The health clusters were meant to be temporary structures, yet had no defined exit strategies and no clear role in initiating transition and early recovery within the health sector.

Dr THITIKORN TOPOTHAI (Thailand) thanked the Secretariat and fellow Member States for their humanitarian support during the severe flood in his country in 2011. He welcomed the WHO emergency response framework, which would serve as a common operational platform for the Organization's work. However, there was an urgent need to define the term "humanitarian emergencies" and the scope of WHO's role and response in such situations. Greater clarity was needed concerning the roles and responsibilities of the new Department of Emergency Risk Management and Humanitarian Response and its relationship with other internal departments and with external agencies. It was critical to ensure the timeliness of support. Rapid response was a core principle of the South-East Asia Regional Health Emergency Fund, which Thailand had helped to establish. The Fund's experience had demonstrated the importance of effective management, sustainability and a demand-driven approach.

Mr PRASAD (India) expressed appreciation of WHO's role, as health cluster lead, in meeting growing health demands in humanitarian emergencies and welcomed the proposed emergency response framework, which would strengthen the Secretariat's internal capacity for a sustained response to protracted emergencies. The proposed assessment of local capacities to support the framework would not only give WHO the opportunity to judge the level of intervention required but could also help regional or inter-country support systems to mount an effective response. WHO's response to emergencies should reflect the need to increase community resilience and should incorporate a primary health care approach.

In the present economic climate, it was heartening to learn that WHO had managed to double the funding received through the Consolidated Appeal Process from 2006 to 2010. The Regional Emergency Response Fund might be further strengthened by establishing clear norms and procedures for equitable assessment, transfer and disbursement to support timely response. He endorsed the draft resolution with the amendments proposed by the delegate of Denmark, but would like to know the precise meaning of "surge capacity".

Mr SMIDT (Denmark), speaking on behalf of the European Union, said that it was his understanding that "surge capacity" meant the capacity to deploy experienced experts swiftly and in a coordinated manner in an emergency.

Mr RUSH (United Kingdom of Great Britain and Northern Ireland) said that he welcomed WHO's support of the Inter-Agency Standing Committee's transformative agenda and the new emergency response framework. The Organization should promptly establish the capacity it would need to fulfil its leadership role in health emergencies, particularly at country level. It was urgent to take steps to strengthen WHO's surge capacity. Recent experience in health emergencies, particularly in the Horn of Africa and Somalia, underlined the need for the reforms identified in the report contained in document A65/25 and envisaged under the emergency response framework. The draft resolution outlined some of the mechanisms that would enable the Secretariat to establish stronger accountability mechanisms for the health cluster at all three levels. The suggested year-end review of the new corporate approach to humanitarian response should be as broad as possible in its scope. Strongly condemning all attacks on humanitarian workers, he welcomed WHO's efforts to develop methods for systematic collection and dissemination of data on attacks on health facilities, health workers and patients in emergencies, in coordination with other relevant bodies, including the International Committee of the Red Cross.

Dr SHOHANI (Iraq), emphasizing the importance of WHO's technical role and of the sharing of expertise between WHO regions, said that steps should be taken to put in place a common work strategy in which all regions could participate, engage with the international community and create an

interregional fund for promoting the common work strategy. It was important to prioritize action in humanitarian emergencies and to ensure that strategies were results-based to allow for performance assessments and also to contribute to the development of the countries concerned.

Mr KAZI (Bangladesh) said that his country had experienced first-hand the benefits of the health cluster approach in recent humanitarian emergencies and that the health cluster had also been helpful in assessing Bangladesh's health sector preparedness in normal times. The emergency response framework should enable WHO to deliver an effective, speedy and predictable response to humanitarian and public health emergencies. Its efficacy, however, would depend on increased investment in resources and trained personnel. He requested the Secretariat to consult Member States about the two processes to be undertaken in 2012 – development of a corporate approach to humanitarian emergencies and of a comprehensive work programme for emergency risk management – and report to the Sixty-sixth World Health Assembly through the Executive Board on their progress and outcomes. He would also like regular updates on progress made and challenges encountered in streamlining WHO's emergency humanitarian response through the new Department of Emergency Risk Management and Humanitarian Response.

Dr HAO Yang (China) conveyed China's appreciation of WHO's support following two major earthquakes in recent years. His Government had taken a number of actions in response to those events and had carefully analysed the lessons learnt in order to prepare for and mitigate the effects of future disasters. To enhance its response and role in meeting growing health-related demands in humanitarian emergencies, the Organization should strengthen reserves of medical supplies and step up capacity-building efforts in emergency-affected regions, including strengthening the capacity of health ministries to provide technical advice, public information, and communicable disease surveillance and control. WHO should evaluate countries' emergency response capacity and make recommendations for improvement, and should continue to promote the construction of disaster-resilient hospitals. The Organization should convene an annual meeting for health ministries to share their emergency response experiences.

Mr BLAIS (Canada) expressed strong support for the efforts of the Inter-Agency Standing Committee to strengthen overall humanitarian response through improved coordination, leadership, accountability, preparedness and advocacy. He welcomed the creation of the Emergency Risk Management and Humanitarian Response Department and encouraged WHO, as the lead agency of the health cluster, to continue providing strong support for leadership and coordination efforts in the health sector at both global and country levels, and to work with relevant health actors, including the International Red Cross and Red Crescent Movement and nongovernmental organizations.

Mr KOLKER (United States of America) said that his Government strongly supported the Organization's efforts to improve its response to humanitarian emergencies. At a time of change within the Organization, the draft resolution was a timely reaffirmation of the commitment of the Secretariat and Member States to meeting health needs in humanitarian emergencies. He urged the Secretariat to hone its role as the health cluster lead and to clearly define and harmonize its role and that of the regional and country offices vis-à-vis partners. His Government supported the resolution and particularly appreciated its inclusion of the issue of health worker safety. WHO, in cooperation with partners and governments, had an important role to play in ensuring that health care providers could work in safety and in documenting threats to and violations of their security.

Ms SANDHU (Australia), welcoming WHO's efforts to better fulfil its health cluster lead role and its commitment to work with the United Nations Office for the Coordination of Humanitarian Affairs on system-wide reform of humanitarian activities, supported the draft resolution. She particularly welcomed efforts to boost the capacity of country offices and urged the Secretariat to move quickly to implement that aspect of the emergency response framework. The Secretariat should

remain focused on the twin objectives of supporting emergency response and empowering countries and regions through capacity-building. Progress in implementing the framework should be measured against performance benchmarks.

Dr NORHAYATI RUSLI (Malaysia) congratulated the Secretariat on its strong leadership and persistence in building consensus on health priorities, policies and best practices in humanitarian emergencies and in strengthening the capacity of all health sector stakeholders to deliver effective and predictable responses in humanitarian emergencies. She endorsed the draft resolution, particularly its emphasis on strengthening national-level risk management, health emergency preparedness and contingency planning processes, and disaster management units in health ministries. Lessons could be drawn from the experience of nongovernmental organizations in responding to humanitarian emergencies, especially the use of local resources and capacities. It was important to encourage active participation by the local community in response activities and to respect local customs and culture. Further efforts should be made to reduce vulnerability to public health emergencies.

Mr THOMSON (Switzerland), noting that his country had a long tradition of working to ensure respect for international humanitarian law, said that he fully supported the draft resolution. Although WHO had limited operational capacity, it must carry out its role in leading and providing technical support to the health cluster. Recruitment and deployment of health cluster coordinators, technical experts and support teams would be the key to fulfilling that role, as would mobilizing the necessary financial resources. He drew attention to WHO's duty to protect humanitarian response personnel, including its own staff, in line with international humanitarian law.

Dr SIMSEK (Turkey) expressed appreciation for the Organization's decisive role as the health cluster lead in humanitarian emergencies. The Organization's surge capacity could be strengthened by putting in place a mechanism to ensure rapid mobilization of global health cluster partners and Member States in humanitarian emergencies. National capacities and expertise should be identified and security issues, such as the system for issuing visas, should be resolved in advance in order to ensure a rapid, effective response. A shift system should be implemented for field staff in order to ensure the continuity of response operations. Education and training programmes should be provided at the country level in order to strengthen capacity; such programmes should be administered and coordinated by an office set up specifically to deal with issues relating to the health sector response in humanitarian emergencies. His Government stood ready to collaborate with Member States in the event of humanitarian emergencies. It had considerable experience in managing disaster and emergency response operations and could play a leading role in training and research related to disaster risk reduction. He supported the draft resolution with the amendments proposed by the delegate of Denmark.

Mr BEN AMMAR (Tunisia) said that in 2010 his Government had grappled with a range of humanitarian emergency situations as a result of the influx of some one million refugees from Libya and natural disasters in the north of the country. It had been able to provide an effective response to those emergencies with technical support from WHO. The capacity of the national health ministry had been strengthened as a result, in particular its capacity to deal with large numbers of refugees. A national strategic centre had been established in 2010 to deal with health needs in humanitarian disasters. He encouraged WHO to continue its capacity-building efforts and to promote knowledge-sharing activities in order to strengthen national capacity.

Dr YEHYA ELABASSI (Sudan), speaking on behalf of the Member States of the Eastern Mediterranean Region, said that the Region had endured numerous natural and man-made disasters and therefore had considerable experience of WHO-supported humanitarian response. Despite the efforts of bilateral and multilateral partners, the response provided had fallen short of what had been needed, particularly in terms of funding and technical preparedness. The Secretariat and Member

States needed to make additional efforts and strategic investments that took into account community involvement, which was crucial to an effective response. Member States should share experience with one another. WHO needed support to be prepared financially, technically and culturally to lead and coordinate response.

Dr Tsung-Hsi WANG (Chinese Taipei) said that in the wake of a devastating earthquake in 1999, Chinese Taipei had set up disaster medical assistance teams, which could perform triage, on-site first aid, emergency resuscitation, field medicine and outbreak monitoring in a disaster area. It had also established an international health action team, which participated in international emergency relief efforts. In addition, many nongovernmental organizations from Chinese Taipei provided humanitarian medical assistance in other regions and countries.

Mr RUBENSTEIN (The World Medical Association, Inc), speaking at the invitation of the CHAIRMAN and on behalf of the World Health Professions Alliance, said that health workers were on the front line during conflicts and other humanitarian emergencies and deserved protection. In crises, health workers were at high risk of assault, arrest, obstruction of their duties, kidnapping and even death. Health facilities and ambulances were also at risk of attack. Information was the foundation for protection and prevention of attacks on health workers. WHO had a unique role to play in collecting and disseminating data on such attacks, as described in subparagraph 2(8) of the draft resolution. Adoption of the resolution by the Health Assembly would be an affirmation of Member States' commitment to safeguard health workers, facilities and patients.

Mr LUCHESI (World Vision International), speaking at the invitation of the CHAIRMAN, said that his organization had a long history of responding to major emergencies and was a partner of the global health cluster. WHO's role in leading the health cluster and in providing technical support before and during crises was increasingly important as disasters became more frequent and the number of people affected by humanitarian emergencies increased. WHO played an important role in gathering and disseminating information and in monitoring, which enabled an effective, efficient and targeted humanitarian response and helped in the protection of health workers. Building resilient communities with local capacities to respond to disasters was crucial. The central principles of national ownership and accountability should be strengthened through investment in human resources and technologies in areas at risk of disasters. The draft resolution represented an opportunity to build stronger accountability mechanisms at all levels, ensuring that emergency actors were compliant with the highest standards of practice. World Vision International encouraged Member States to adopt the resolution and to fully fund the reforms it outlined, which would require significant investment.

Dr AYLWARD (Assistant Director-General), thanking delegates for their expressions of support for WHO's humanitarian response work, said that the preceding 12 months had seen major structural reform of the Organization's policies and approaches in relation to emergencies, with the aim of improving the predictability, effectiveness and speed of response. Those changes had been fully in line with the reforms and recommendations of the Inter-Agency Standing Committee's transformative agenda and had focused on improving leadership, coordination and accountability. The process had also been in line with the WHO reform goals and principles, with special emphasis on improving country outcomes and cross-organizational coherence. He agreed that there was a lack of clarity in the area of cluster transitions and exit strategies. Addressing that issue was a major part of the Inter-Agency Standing Committee's reform agenda, which was being reviewed by the global health cluster partners. A number of suggestions had been made as to how the emergency response framework could be improved, and he assured Member States that all guidance received would be fully considered.

WHO had been working closely with the Emergency Relief Coordinator on reforms aimed at increasing accountability. The emergency response framework laid out specific commitments and benchmarks; recording and reporting performance transparently would be a key part of the reform

process. Some delegates had made suggestions in relation to broadening the year-end review and expanding participation in it. He would welcome specific proposals in that regard.

Ensuring that WHO had adequate surge capacity was one of his greatest concerns. To that end, a four-pronged approach had been adopted, which included repurposing country offices, which were the front line for any response; improving the Secretariat's internal surge capacity, both within the new Emergency Risk Management Department and in regional offices; cooperation with global health cluster partners to combine surge capacities; and a new standby arrangements policy that would enable much faster and more effective deployment. Performance in emergency response ultimately depended on a good state of readiness and preparedness. With the new emergency response framework in place, the target for 2012 was to develop a companion framework for emergency risk management that clearly laid out roles, commitments and mechanisms for enhancing readiness and preparedness.

He wished to assure Member States that the Secretariat was moving quickly to implement the reform measures and build capacities. New leadership of the Emergency Risk Management Department was in place, and a major cross-organizational simulation had been held in April 2012, involving all levels of WHO. That exercise had confirmed the soundness of the new response framework and pointed up areas where improvement was needed. The Secretariat was dealing with those areas. The framework had also been tested practically by the situations in the Syrian Arab Republic and in the Sahel, and those experiences had yielded valuable lessons. The Secretariat could accelerate the implementation of the reforms needed to fulfil its role as a global health cluster lead, but it would require greater funding in order to do so. Thanking Member States for the support received thus far, he appealed for their continued support as the Secretariat worked to make the emergency risk framework fully operational and developed the emergency risk management framework.

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution contained in resolution EB130.R14, as amended.

The draft resolution, as amended, was approved.¹

Elimination of schistosomiasis: Item 13.11 of the Agenda (Documents A65/21 and EB130/2012/REC/1, resolution EB130.R9)

Mrs HANJAM DA COSTA SOARES (representative of the Executive Board) said that, at its 130th session in January 2012, the Executive Board had considered a report on the elimination of schistosomiasis and had adopted resolution EB130.R9, in which it recommended a draft resolution for adoption by the Health Assembly. The draft resolution incorporated several amendments proposed by Member States reflecting the view that the call for elimination of the disease in some countries was premature and that control interventions, including sanitation and hygiene education, should be strengthened, and elimination activities launched only where appropriate. The Board had agreed that progress should be reported every three years.

Dr EL MENZHI (Morocco), speaking on behalf of the Member States of the Eastern Mediterranean Region, welcomed WHO's continued support for activities aimed at controlling and eliminating schistosomiasis, which remained a serious public health concern in the Region. Many countries, including his own, had launched programmes to eliminate schistosomiasis and had made significant headway. The implementation of a well-defined procedure for certifying the interruption of transmission would encourage the countries concerned to redouble their efforts to prevent and control the disease. The draft resolution could provide a useful basis for the discussion of mechanisms and procedures for the elimination of schistosomiasis, a goal which he considered feasible. It could be strengthened, however, through the addition of two new subparagraphs under paragraph 3, to read: "to

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.20.

elaborate a procedure to evaluate the interruption of transmission in the countries concerned with a view to certifying that transmission has been eliminated in these countries” and “during the post-elimination phase, to support countries that have been certified free of schistosomiasis to pursue preventive actions designed to avoid the reintroduction of transmission of the disease”.

Dr SUPATRA CHADBUNCHACHAI (Thailand), noting that schistosomiasis remained a significant public health problem, although it was largely preventable, supported the draft resolution. Many countries lacked the technical capacity to develop effective surveillance programmes that dealt not only with the risks to human health but also the environmental aspects of the disease; the Organization should support countries in enhancing that capacity. Both natural and human-made environmental changes could affect the transmission of schistosomiasis. Thailand carried out sentinel surveillance activities every three years in high-risk areas and was investigating the contamination risks posed by a variety of animals, including dogs. A comprehensive impact assessment should be carried out prior to the commencement of any project that could have a detrimental effect on health and well-being, and mechanisms should be strengthened to ensure that the evidence provided by such assessments were communicated to all relevant sectors and policy-makers.

Dr DIAKHABY (Guinea), speaking on behalf of the Member States of the African Region, said that schistosomiasis remained a serious problem in sub-Saharan Africa, which accounted for 90% of all schistosomiasis cases in the world. Significant progress had been made, however, in controlling the disease; several African countries had substantially lowered transmission levels and some had reported no new autochthonous cases in recent years. The interruption of transmission thus appeared feasible. To that end, interventions should be strengthened in countries with high endemicity and the availability of praziquantel ensured. The Member States of the African Region considered that the goal of elimination as envisaged in the draft resolution could be achieved in some epidemiological settings, provided that there was strong political commitment, adequate supplies of antihelminthic medicines, and support for hygiene, sanitation and water supply measures by Member States. She endorsed the draft resolution.

Dr DECOCK (United States of America) said that, although the goals set out in resolution WHA54.19 had not been fully achieved, commendable progress had been made towards control and elimination of schistosomiasis. While noting the advances made to increase the availability of praziquantel, including the ongoing efforts of private-sector pharmaceutical partners, he stressed the need for Member States and the international community to focus on ensuring the medicine’s availability and to employ a multisectoral approach to schistosomiasis control programmes, including post-treatment surveillance. He supported the draft resolution.

Mr NEVES SILVA (Brazil) observed that there was a clear and direct link between schistosomiasis and social determinants of health, as evidenced by its concentration in poor areas with deficient sanitation. His country was committed to eliminating schistosomiasis and other neglected diseases and strongly endorsed the draft resolution. He suggested that the topic of neglected diseases should be discussed during the Sixty-sixth World Health Assembly with a view to strengthening action and adopting a coordinated approach to the control and elimination of such diseases, with due attention to their relationship with poverty and other social determinants of health. A coordinated approach and the efforts and commitment of all Member States were essential if schistosomiasis was to be eliminated.

Dr SAKAMOTO (Japan) said that adoption of the draft resolution would send a message highlighting the importance of increasing access to medicines for schistosomiasis and provide an impetus for the development of guidelines and policy measures in respect of the disease. Comprehensive measures, including vector control and health system strengthening, were needed to eliminate schistosomiasis and other neglected tropical diseases. Insufficient progress had been made in

developing medicines to combat such diseases, and public–private partnerships for that purpose should be encouraged.

Dr YU Jingjin (China) said that, of the 12 provinces in his country that had been endemic for schistosomiasis, five had eliminated the disease and the remaining seven had set control targets. His Government had implemented a plan to control schistosomiasis nationwide by 2015. Its cross-cutting approach focused on four areas: health, agriculture, irrigation and forestry. China would continue to cooperate with WHO and other international partners to achieve the elimination of schistosomiasis. He supported the draft resolution.

Mr OTTIGLIO (International Federation of Pharmaceutical Manufacturers and Associations), speaking at the invitation of the CHAIRMAN, said that the pharmaceutical industry, which had long been engaged in the fight against neglected tropical diseases, had recently pledged 14 000 million treatments annually until 2020 to control or eliminate nine major diseases responsible for 90% of the overall burden of neglected diseases. One company had increased its annual donation of praziquantel from 20 million to 250 million tablets. He acknowledged, however, that much larger quantities of praziquantel would be required over the coming decade in order to eliminate schistosomiasis. An essential prerequisite for increasing supplies of the medicine was ensuring the availability, in sufficient quality and quantity, of the active ingredient. In addition, appropriate dosage forms for very young children were needed. The targets set by WHO were clear and could be achieved through a concerted and dedicated multistakeholder approach.

Dr NAKATANI (Assistant Director-General) said that he had taken careful note of all comments and suggestions made. He welcomed the proposals by the delegate of Morocco regarding procedures for certification of the interruption of transmission and support for schistosomiasis-free countries to prevent reintroduction of the disease. With respect to the suggestion by the delegate of Brazil regarding the inclusion of neglected tropical diseases in the agenda of the Sixty-sixth World Health Assembly, he noted that the subject had been discussed at a technical briefing held earlier in the week and suggested that Member States should confer among themselves in order to advise the Secretariat on the approach they wished to take to the topic.

Dr ONDARI (Secretary) said that the amendments to the draft resolution proposed by the delegate of Morocco would become subparagraphs 3(4) and 3(5) and the existing subparagraph 3(4) would become paragraph 3(6).

The CHAIRMAN said that, in the absence of any objection, he took it that the Committee wished to approve the draft resolution, as amended.

The draft resolution, as amended, was approved.¹

The meeting rose at 21:35.

¹ Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA65.21.

SIXTH MEETING

Saturday, 26 May 2012, at 09:45

Chairman: Professor M.H. NICKNAM (Islamic Republic of Iran)

1. SECOND REPORT OF COMMITTEE B: (Document A65/56)

Dr ONDARI (Secretary) read out the draft second report of Committee B.

The report was adopted.¹

2. THIRD REPORT OF COMMITTEE B: (Document A65/57)

Dr ONDARI (Secretary) read out the draft third report of Committee B.

The report was adopted.¹

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

Global mass gatherings: implications and opportunities for global health security: Item 13.8 of the Agenda (Document A65/18)

Dr SURACHART KOYADUN (Thailand) said that he admired the efforts and expertise of the Government of Saudi Arabia in protecting the safety and security of millions of pilgrims participating in the hajj every year. Following consultation with national partners, his Government had concluded that in order to draw up effective plans for ensuring health safety at mass gatherings, three aspects had to be taken into account: the type of event, the potential health risks, and the size and duration of the gathering. At mass gatherings in public spaces, participants needed to comply with national laws on a tobacco-free environment in order to protect the health of non-smokers; similarly, in order to reduce the incidence of alcohol-related violence and accidents, the availability of alcohol should be controlled. Sports organizers should not be allowed to permit the sale of alcohol and other harmful products at sports events, which were supposed to promote health and healthy lifestyles, but should instead align themselves with the common purpose of health promotion activities.

Dr MEMISH (Saudi Arabia), speaking on behalf of the Member States of the Eastern Mediterranean Region, stressed the importance of examining the health issues arising from mass gatherings. The hajj was a unique annual gathering that brought together 10 million people from more than 83 countries, many of whom were elderly or in need of special care. In October 2010, his

¹ See page 277.

Government had hosted the Global Forum on Mass Gathering Medicine. He hoped that the Health Assembly would adopt the evidence-based recommendations contained in the declaration adopted at the Forum, which should help to improve security at mass events. Given that some mass gatherings took place annually, a specialized institute should be set up to review preparatory activities and conduct research in order to help event organizers to better coordinate operations and to identify and implement the health measures needed to check the spread of disease. His Government would be willing to host such an institute.

Dr ZAKARIAH (Ghana), speaking on behalf of the Member States of the African Region, said that the Region recognized the complex nature of the challenges and opportunities presented by mass gatherings, whether planned or spontaneous. Mass gatherings posed significant risks to health security in the Region owing to a weak health infrastructure and lack of effective control methods and support systems. Public health systems in the African Region would need continued capacity-building and restructuring, backed by the political will of governments, if they were to implement effective evidence-based risk assessment, communication and information sharing, and contingency and response planning. Strategies for dealing with mass gatherings in African countries therefore required a more complex framework than had been proposed in the Secretariat's report, which should include a strong focus on decentralized control; significant investment in information and communication technologies; and new and effective vaccines for prevention campaigns.

She urged WHO, in collaboration with its partners, to develop standards, guidelines and protocols for the implementation of preventive measures and vaccine campaigns during mass gatherings; provide technical support to countries for the development of strategies that met their sociocultural needs; build capacity for epidemiological surveillance; and develop a monitoring and evaluation framework to identify lessons learnt and share information. She requested the Secretariat to inform the Health Assembly two years hence on progress made on the recommendations set out in its report.

Dr HAO Yang (China) endorsed the analyses contained in the report with regard to public health planning, preparedness, risk evaluation and control, disease spread and prevention, and raising public awareness about mass gatherings. The public health security work entailed in hosting the Olympic Games in 2008 and the Shanghai Expo in 2010 had shown China that different types of gatherings in different places required different approaches. Risk analyses and evaluations should be carried out at least two years before an event in order to gather reliable disease control and prevention data. Moreover, global mass gatherings required a multisectoral, multisystem, multiprofessional and multidisciplinary approach, so coordination was needed with all sectors in order to have a management overview. Experiences in dealing with health security at all levels should be compiled and shared. His Government's Ministry of Health was willing to cooperate with other countries in order to contribute to global health security.

Mr STUPPEL (United Kingdom of Great Britain and Northern Ireland) said that in assessing the global health security implications of hosting the 2012 Olympic and Paralympic Games, which were expected to attract seven million visitors, the United Kingdom had benefited directly from WHO's work in that domain and from the experience of China and other countries. It was an extremely fruitful area for shared expertise and learning. His Government was proud that its Health Protection Agency had been designated as a WHO collaborating centre on mass gatherings and hoped that the 2012 Olympic Games would leave a sustainable public health legacy.

Ms KOROTKOVA (Russian Federation) said that the subject of global mass gatherings was important, not only because there was an increased risk that disease would spread during such events, but also because of the need to monitor local health conditions that might give rise to negative economic and political consequences. The Russian Federation had experience in preparing for mass gatherings, the next one being the Winter Olympics in 2014. When such events were held, her

Government took into account the possibility of new, unknown diseases emerging, biological agents being used, and epidemics breaking out. Various departments and ministries were working together to deal with the possible threats and risks by taking preparatory measures and setting up laboratory networks before the mass gathering took place. The epidemiological surveillance unit put together special mobile teams able to respond to problems wherever they arose; they had proved very successful in controlling particularly dangerous outbreaks of disease. Her Government supported the pre-emptive and preventive measures described in the report.

Dr SHOHANI (Iraq) stressed the importance of achieving global health security through the integration of national health security and food safety within the application of the International Health Regulations (2005). In support of that objective, information on communicable diseases and epidemics should be exchanged using a reliable mechanism that guaranteed the coherence of surveillance, early detection and management of diseases. Follow-up activities should be undertaken, with an emphasis on global measures to prevent disease transmission and ensure effective procedures for food inspection, monitoring of travellers and investigation of disease notifications between countries. Mechanisms should be developed for joint coordination and cooperation between neighbouring countries, and for the control of trade mechanisms in line with the standards set by the International Health Regulations (2005). In addition, cooperation between the regions on controlling epidemics and disease outbreaks, ensuring food safety and promoting measures would limit disease spread for surveillance, early detection and management. WHO had a role to play in strengthening health security and linking it with food security through effective partnership with countries, provision of technical advice, promotion of research and an emphasis on the role of local communities in improving health security and monitoring food security. The subject should also be given weight in relation to human rights and the achievement of the Millennium Development Goals. Priority should be given to the health of crowds, especially during ritual visits. The Ministry of Health of Iraq was supporting local authorities to protect and promote the health status of the crowds that visited holy sites every year; however, an exchange of experiences was needed with partners so that the relevant plans and policies could be developed.

Dr PACKOU (Gabon), speaking on behalf of the Member States of the African Region, said that Gabon had acquired experience in mass gatherings when it had co-hosted the Africa Cup of Nations early in 2012. The health security preparations had been assessed by a WHO support mission shortly before the event and a policy plan had been drawn up on the basis of the recommendations made. A health command post had been set up and given the task of gathering data, and strengthening and debriefing the teams on the ground. A medical coverage plan had been put in place to monitor and evaluate diseases, prevent risks of infection, ensure food health security, train food handlers, and enhance health capacities at points of entry into the country. Medical posts had been established at the country's two international airports and thousands of information leaflets produced. Hosting the event had strengthened both human and material health capacities and had provided an opportunity to test the effectiveness of the medical model although there had been no need to activate any catastrophic event plans. Her Government was in favour of establishing, under the auspices of WHO, a platform for exchange and collaboration among countries habitually hosting or planning to host mass gatherings.

Mr KOLKER (United States of America) said that the emphasis in the report on the opportunities, as well as the risks and challenges, associated with mass gatherings was particularly welcome. The most commonly reported health problems at mass gatherings, which included injuries, respiratory and cardiac problems and alcohol and drug effects, could be dealt with by on-site clinics or nearby health facilities. Fortunately, circumstances resulting in mass casualties or the transmission of communicable diseases were rare, but the potential for disease amplification and relocation existed; his Government was therefore pleased that enhanced international cooperation had become part of the planning for annual and special events. It also appreciated the training programmes and tools developed by the

Secretariat's interdepartmental mass gatherings group. WHO's Virtual Interdisciplinary Advisory Group and the Observer Programme had raised awareness of the important implications of mass gatherings and had provided expertise to event organizers. His Government was committed to working with the Secretariat and with other Member States to ensure global health security in all areas that might be affected by mass gatherings. Public interest in such events offered a unique opportunity to communicate a wide range of health-related messages.

Mr NGANTCHA (Cameroon) said that the report gave an accurate view of the risks inherent in mass gatherings, including those arising from the particular sociocultural circumstances of African countries. However, health security issues arising from catastrophic and non-catastrophic emergencies, the latter of which were generally the result of epidemics, required clearer definition. Furthermore, a distinction should be made between short gatherings, such as festivals, football matches and funerals, and longer, planned gatherings such as the hajj. Vaccination was a vital part of disease-prevention strategies, particularly when organizing mass gatherings. National strategies should give priority to drawing up structural and emergency plans, thereby ensuring that effective and efficient preparation, prevention and intervention mechanisms were in place.

Dr EL ISMAIL LALAOUI (Morocco) welcomed the report and the suggestions made by previous speakers. Global mass gatherings had different characteristics: some were regular events with well-known dates and venues, while others were one-off events; they also differed greatly in scale. He endorsed the suggestion by the delegate of Saudi Arabia that a dedicated research institute should be established for the purpose of gaining greater understanding of the health implications of the different types of mass gatherings.

Mr ÁLVAREZ LUCAS (Mexico) said that Mexico's recent experience with mass gatherings had included the Pan-American Games, the FIFA U-17 World Cup and a visit by Pope Benedict XVI. It had received support on those occasions from PAHO and other international authorities. In terms of WHO's contribution, he requested the Organization to gather and disseminate information about similar experiences for use in planning mass gatherings; set aside funding for preparation and response; and promote the training of human resources. Those measures could help to prevent the negative health impacts resulting from exposure to toxic agents, the importation of disease associated with epidemics or pandemics, and unexpected health risks. Clarification of the concept of global health security would be welcome.

Dr YEHYA ELABASSI (Sudan) thanked Saudi Arabia, the host of the annual hajj, for offering health protection and promotion, disease prevention, and care to pilgrims. Mass gatherings involved multisectoral and multidimensional risks that went beyond health care. They presented risks and challenges, as well as opportunities to promote health education and behavioural health. His Government supported the offer by the delegate of Saudi Arabia to host a dedicated research centre to enrich global experience.

Dr Li-Jen LIN (Chinese Taipei) underscored the need to reinforce disease surveillance systems in order to communicate information on disease- and health-related incidents to participants in mass gatherings in a timely manner, and to ensure that adequate laboratory capacity was in place to meet surge capacity needs. Chinese Taipei had established a central epidemic command centre, which had played a critical role in planning for public health emergency preparedness at two global mass gatherings that had taken place while the pandemic (H1N1) 2009 influenza was active. Mass gathering preparedness and response plans should be drawn up as far in advance as possible; their content would vary according to the time and location of the event, as well as the health resources available to the host community. Intersectoral involvement was equally important. Chinese Taipei would like to participate in WHO training programmes on global mass gatherings as a means of strengthening its own capacity to respond effectively in such situations and to plan for the 2017 World University Games.

Dr NUTTALL (Global Capacities, Alert and Response) thanked Member States for their contributions and assured them that WHO was well aware of the increasing importance of mass gatherings, which had significant public health implications, both in terms of prevention and preparedness before the event and the need for response and correct management during the event. Mass gatherings required a coordinated multisectoral approach which, as indicated in the International Health Regulations (2005), was the basis for maintaining global health security. Thanking Member States for their guidance, she welcomed their request that the Secretariat should be involved early in the planning and preparation for such events and assured them that the Organization was ready to do so. The offers of support from Member States were greatly appreciated, especially in view of the need for additional studies.

The Committee took note of the report.

Progress reports: Item 13.16 of the Agenda (Document A65/26)

Health systems and research

- A. Health system strengthening (resolutions WHA64.9, WHA64.8, WHA63.27, WHA62.12 and WHA60.27)**
- B. WHO's role and responsibilities in health research (resolution WHA63.21)**
- C. Global strategy and plan of action on public health, innovation and intellectual property (resolution WHA61.21)**

Ms KATJIVENA (Namibia) speaking on behalf of the Member States of the African Region, welcomed the report on WHO's role and responsibilities in health research, and in particular the work being done on guidelines that drew on the Framework for the Implementation of the Algiers Declaration to Strengthen Research for Health: Narrowing the Knowledge Gap to Improve Africa's Health. Research was central to economic development and global health security and should therefore be multidisciplinary and intersectoral. The global health agenda should be based on national priorities and regional agendas and supported by global and regional development banks. Research was essential in order to bring about health system strengthening and the Region appreciated WHO's call for attention to the research needs of low-income and developing countries, for instance through technology transfer, workforce enhancement and infrastructure development. The weakness of health systems in many countries remained a major challenge, and the lack of evidence-based information was impeding attainment of the Millennium Development Goals. A lack of institutional capacity, human resources and insufficient funding contributed to difficulties in developing national research strategic plans, functional national health research systems and supporting research policies and guidelines. The Region therefore called on WHO to scale up support, especially technical support, and to facilitate partnerships. Moreover, while it welcomed WHO's support to countries to strengthen health system research using the Evidence-Informed Policy Network, only 20% of African countries had a functional network of researchers and policy decision makers through that Network. It therefore urged WHO to expand support to strengthen the other countries in that regard. Following the 25th Meeting of the African Advisory Committee for Health Research and Development (Brazzaville, 17–19 November 2011), a plan of action should be fast-tracked to improve poor implementation capacities and inadequate understanding of the requisites of health systems research. The African Region was committed to intensifying its efforts to initiate and support comprehensive research programmes and surveys in order to improve policy and action; to promote research on the relationship between social determinants and equity; and to promote the use and sharing of research information and results. She urged WHO to set a timeline and targets to ensure that country-driven research agendas were in place. It was also essential to set up a monitoring and evaluation system.

Dr HIRAOKA (Japan) said that his Government appreciated WHO's efforts to strengthen health systems and attached particular importance to universal health coverage that included health-related human resources and health care financing. Japan's good health indicators were the result of its universal health care system which guaranteed fair access to health care services. Obstacles to health system strengthening included the flow of human resources away from front-line fields, a problem in both developed and developing countries, and inequitable distribution of human resources between urban and rural areas due to migration of skilled workers. Furthermore, in order to improve health indicators, good-quality health and medical services had to be delivered for vulnerable groups. His Government was willing to continue providing support aimed at achieving universal coverage, with due regard for human health resources.

Dr SHEKU DAOH (Sierra Leone), speaking on behalf of the Member States of the African Region, said that the Member States welcomed the global strategy and plan of action on public health, innovation and intellectual property, which aimed to increase access to medicines, vaccines and diagnostics that were important to public health. The greatest obstacles to the implementation of the global strategy in Africa were the inadequacy of well-established structures, the lack of a framework to coordinate all those involved, and the limited capacities of Member States to identify priorities. The Member States of the Region continued to face a daunting lack of capacity in the areas of innovation and intellectual property. Their research efforts did not usually meet national needs because of lack of targeted external funding and limited indigenous resources. Research centres needed to pool their resources in order to tackle regional health priorities. Further attention must be paid to the root causes of the communicable and noncommunicable diseases burden and immediate action taken to combat it. At its fifty-ninth session in 2009, the Regional Committee for Africa had suggested strengthening regional cooperation on issues related to intellectual property and to research and development of health products, including traditional medicine, to meet the specific needs of the Region. To that end, research and development networks within and across Member States had been identified and plans for launching the Pharmaceutical Manufacturing Plan for Africa were under way. Since funding for the global strategy remained uncertain, it was to be hoped that the recommendations contained in the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination (document A65/24) would be implemented rapidly.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) said that, as the United Kingdom and other Member States had highlighted during the discussion on WHO reform, it was important for the Organization to demonstrate its contribution at all levels of the results chain, including outcomes and impact. Recalling the comments made at the 130th session of the Executive Board about the quality of the progress report on health system strengthening, she expressed thanks to WHO for having added to the report more information about action that had been taken to support countries in strengthening their health systems. In future, however, reports should focus more on results as that would provide clear evidence that health systems, including information systems and financing systems, were being strengthened at country level.

Mr HEROLD (Germany) welcomed the progress report on health system strengthening. The number of resolutions to which it referred and the variety of topics it covered underlined the central role of health system strengthening in shaping countries' responses to health needs. The impressive number of activities mentioned in the report testified to the important role the Organization played in guiding and supporting countries in that core area. Also welcome was the increasing emphasis on universal coverage from the perspective of financing for health and the availability of and access to services. His Government was firmly committed to health system strengthening under its partner country cooperation strategy and would continue to maintain its human rights-centred approach.

Dr SAÍDE (Mozambique) said that his Government recognized the important role of research and scientific data in improving health, notably in achieving the Millennium Development Goals. However, its research funding was limited and it also faced additional obstacles to the implementation of research priorities, namely a shortage of trained human resources and management capacity, difficulty in retaining human resources, and absence of a health research system. Having signed the Algiers Declaration to Strengthen Research for Health, his Government was aiming to finalize by December 2012 the country's first national agenda for health research, the main objectives of which were to identify priority areas, improve health research coordination and management, and attract research funding. Research institutions, international and nongovernmental organizations, civil society and decision makers were involved in drafting the agenda and he asked the Secretariat to continue providing support in that area.

Dr GUTERRES CORREIA (Timor-Leste) said that, in comparison with other Member States in the South-East Asia Region, his country lacked sufficient good-quality human resources. His Government was therefore grateful to the WHO Country Office for the support provided during the planning for the recently established health research and development cabinet in Timor-Leste. His Government had also set up an ethics team and technical committee composed of health professionals, academics and representatives of civil society. The cabinet, which was supervised by a research advisory group of national and foreign academics, had been conducting research throughout the country; it had established research focal points in community health centres and referral hospitals and assigned priority research topics and budgets to each of the country's districts with a view to encouraging new researchers to get started. It was in the process of signing a memorandum of understanding with two academic institutions in the Region. By conducting research, Timor-Leste aimed to collect the data needed to elaborate evidence-based policies, strategies and plans. Continuing support from the Secretariat and Member States to ensure the sustainability of the cabinet would be welcome.

Dr SHOHANI (Iraq) stressed the need for the Organization to help developing countries to participate more fully in health research activities, including in cooperation with the developed countries. WHO could support the technical and other aspects of theoretical and applied research to improve health services, including primary health care. Research could be a useful adjunct to joint WHO/country programmes, and joint regional and interregional research projects should be encouraged. His Government had implemented a programme to modernize the country's health systems and policies. The health ministry's strategic plan 2009–2013 had been updated, and its research strategy provided operational guidance on specific health problems. The emphasis in the global strategy and plan of action should be placed on individual rights of research participants and the granting of patents, which were vital to furthering research and innovation. The global strategy would help to clarify the subject for local health workers in developing countries.

Ms HALÉN (Sweden), speaking on behalf of Denmark, Finland, Iceland, Norway and Sweden, said that the progress reports were important for oversight and results-based management within WHO; in addition, their demonstration of how resolutions contributed to the achievement of Organization-wide expected results made them an increasingly powerful monitoring and evaluation tool. The starting point for analysis of progress should be the situation at the time the particular resolution was adopted, and the associated targets should be spelled out. With regard to health system strengthening, efficient and sustainable health systems offering both health promotion and disease prevention were crucial to good health. In the context of an increasing tendency towards vertical, disease-specific initiatives, WHO had a central role to play in supporting developed and developing countries in their efforts to build efficient health systems. The Nordic countries appreciated the increased support being provided to Member States for promoting leadership and governance for health, in particular the operative support provided in the field. She welcomed the proposed expansion

in 2012 of the programme aimed at strengthening long-term support to health policy dialogue at the country level.

Ms JESSE (Estonia) welcomed the progress report on health system performance assessment and strengthening of regulatory capacities. Performance assessment, which had been carried out by many European Member States with WHO support, was at the core of the Tallinn Charter adopted at the ministerial-level conference on health systems hosted by her Government in 2008. It was a useful tool for assessing progress and identifying weaknesses, which could guide countries in their efforts to strengthen health systems, and it was also a valuable accountability instrument. Estonia looked forward to future cooperation with WHO in that field.

Dr NORHAYATI RUSLI (Malaysia) said that her Government acknowledged the need for Member States to map activities, prioritize research and development needs, and promote research and development. She welcomed WHO's efforts to set standards and provide benchmarks for research ethics; the progress achieved in the field of innovation and protection of intellectual property; and the drive to strengthen technology transfer and career development, and to build intellectual property management capacities, which would maximize health-related innovation and broaden access to health products. Her Government supported the OPEN project initiative to deal with failure to publish negative research findings, and hoped that it could be extended to developing countries.

Ms KOCHLEF (Tunisia) said that her Government endorsed the Organization's approach to health system strengthening as reflected in the progress reports. However, greater efforts were needed at country level to implement the recommendations made, which included intensifying material and technical support to Member States, ensuring that people were at the centre of service delivery, moving towards universal coverage by drafting programmes that took account of the particular circumstances and policy orientation of each community, and enhancing health information systems in order to increase accuracy and improve follow-up. Despite its important achievements in the area of primary health care, Tunisia still needed additional support in order to reach those targets and provide high quality services.

Dr RAPEEPONG SUPHANCHAIMAT (Thailand) commended the Secretariat's development of a plan of action to support Member States in the assessment of their universal health coverage. That coverage could be achieved even in countries with limited resources, provided that there was adequate health system financing, and strategies and funding for research and development. The WHO strategy on research for health should be harmonized with other global strategies to ensure its effectiveness. The Consultative Expert Working Group on Research and Development: Financing and Coordination, whose balanced and comprehensive approach merited recognition, had reported promising results in terms of a sustainable research and development financing mechanism; such a mechanism would provide an opportunity to work towards a binding instrument on health research and development focusing on diseases disproportionately affecting the developing and least developed countries. Triennial follow-up reporting to the Board on health system and research strategies should continue.

Mrs GROVES (International Alliance of Patients' Organizations), speaking at the invitation of the CHAIRMAN, said that a sustainable approach to health system design and delivery needed to be based on patient-centred health care. Patients' organizations were crucial allies in the campaign to strengthen health systems as they were well-placed to understand the realities patients faced on a daily basis. Member States should harness that resource by continuing to engage in broad consultation with all relevant stakeholders which would, in turn, lay the foundation for the establishment of robust health policies and strategies. WHO should take the lead by involving patient groups in its own work and supporting governments in developing models of patient involvement to strengthen national health dialogue.

Dr ETIENNE (Assistant Director-General) expressed gratitude for the support received from Member States in the area of health system strengthening. Strong and well-functioning health systems were central to the achievement of universal health coverage, which was a key priority for many Member States. Vital inputs in that regard included not only appropriate health financing mechanisms but also trained, motivated and well-distributed health workers; health information systems that supported patient care, programme definition and policy-making; and a health infrastructure that gave patients access to available services – all within a context of solidarity, equity and fairness. WHO was moving increasingly towards a holistic approach to health system strengthening, with an emphasis on balance and coherence.

Efforts were under way to develop mechanisms for embedding health system research into decision-making at all levels, to build capacity for identifying gaps with a view to promoting health system research, and to provide support for the translation and dissemination of the research findings. WHO was seeking to increase the focus on results by building countries' capacity to report on the impact and outcomes of health system strengthening. Progress reports were essentially restricted in length and should therefore be read in conjunction with the more detailed performance assessments.

Dr KIENY (Assistant Director-General) said that, to the extent of its capacity, the Secretariat was committed to offering technical support to Member States in order to promote their efforts to strengthen health research systems. It looked forward to scaling up implementation of the global strategy and plan of action on public health, innovation and intellectual property, as well as to further deliberation among Member States concerning the development of appropriate mechanisms for strengthening financing and coordination of research on diseases affecting developing countries in particular.

Disease eradication, prevention and control

- D. Smallpox eradication: destruction of variola virus stocks (resolution WHA60.1)**
- E. Eradication of dracunculiasis (resolution WHA64.16)**
- F. Chagas disease: control and elimination (resolution WHA63.20)**
- G. Viral hepatitis (resolution WHA63.18)**
- H. Prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis (resolution WHA62.15)**
- I. Cholera: mechanisms for control and prevention (resolution WHA64.15)**
- J. Control of human African trypanosomiasis (resolution WHA57.2)**
- K. Global health sector strategy on HIV/AIDS, 2011–2015 (resolution WHA64.14)**
- L. Prevention and control of sexually transmitted infections: global strategy (resolution WHA59.19)**

Dr MEMISH (Saudi Arabia) said that the progress report on the prevention and control of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis was far from satisfactory as it ignored the fact that 90% of cases went undetected owing to insufficient laboratory capacity for systematic drug susceptibility testing, which was conducted in only an estimated 2% of all cases. Efforts to ensure testing for all new cases must therefore be stepped up. Treatment of diagnosed cases was another concern because second-line drugs tended to be toxic, weak and expensive. Another progress report including information on the overall tuberculosis response should be issued in 2014. New international targets for the post-2015 period were needed as was a new global strategy using modern technology and innovations and taking into account such matters as general health system policies and services, research and socioeconomic perspectives.

Mr NETO (Angola), speaking on behalf of the Member States of the African Region, said that viral hepatitis was a major cause of morbidity and mortality in African countries, where it was frequently endemic and its sequelae common. The global figures for cases of viral hepatitis infection ran into the hundreds of millions and the already high burden of related diseases, such as liver cancer and cirrhosis, was expected to rise. Coinfection with hepatitis B or C adversely affected the prognosis for those infected with HIV, and vice versa, and led to complex interactions in antiretroviral therapy. Coinfections were common in sub-Saharan Africa, although prevalence data were scarce. Studies suggested that the hepatitis B virus in Africa was transmitted predominantly in childhood by the horizontal route. As to hepatitis A and E infections, they were usually transmitted by the faecal-oral route, signalling a need for safe drinking-water and improved sanitary and hygienic practices.

The significant progress achieved in the African Region in preventing and controlling viral hepatitis infection included the development of immunization strategies. Immunization against hepatitis B was routine in 45 countries and regional coverage of children under the age of one year with three doses of the vaccine had increased from 5% to more than 70% in a decade, with eight countries delivering one dose at birth. Auto-disable syringes were being used, and seroprevalence surveys had been launched in four countries. Remaining challenges included limited diagnostic capacity and weak surveillance systems; low rate of birth-dose vaccination coverage; shortage of funding for vaccine purchases; unsafe injection and blood-transfusion practices; and lack of integrated prevention and control strategies. In the interest of building on the progress already achieved, he urged the Secretariat to provide continuing support to build the Region's capacity to prevent and control viral hepatitis, including research, programme performance and access to vaccines.

Dr KUMEH (Liberia), speaking on behalf of the Member States of the African Region, said that they stood by the recommendation they had made at the previous Health Assembly, namely that variola virus stocks in existing repositories should be retained in order to complete vital research. The deliberate or accidental release of the variola virus could originate from unauthorized stocks, and less than half the world's population was immunized against smallpox, despite the risk of crossover to humans of the monkeypox virus present in parts of western and central Africa. The following measures were therefore needed: preparation of global and country level preparedness and response plans to counter any release of unauthorized stocks or use of such stocks for bioterrorism; development of a global surveillance system focused on laboratory networking and vigilance; elaboration of a strong advocacy strategy to mobilize support for destruction of the virus stocks; introduction of a carefully monitored destruction plan with realistic timelines; and consideration of sanctions for violators.

Mr KÜMMEL (Germany) welcomed the advances made with respect to the integration of services and programmes relating to sexual and reproductive health and HIV/AIDS. Health interventions in those areas should aim towards a closely integrated approach, which should be reflected in regional operational plans, as well as in the global strategy on sexually transmitted infections. The value of an integrated approach should be made clear, in particular the importance of incorporating a human rights dimension into all HIV-prevention efforts. HIV/AIDS could not be combated effectively without tackling the stigmatization and discrimination associated with the disease. He therefore supported gender-oriented interventions aimed, inter alia, at reducing women's vulnerability to HIV infection and mitigating the negative social and economic impacts of the epidemic.

Mr NGANTCHA (Cameroon), speaking on behalf of the Member States of the African Region, said that the number of reported cases of cholera in Africa had fallen for the first time in decades. Vigilance must be increased nonetheless, as the overall situation remained worrying, especially in view of the numerous outbreaks notified to WHO since 2010. Challenges to be met included the failure to report cases on a timely basis, which had implications for surveillance and which clearly delayed response; lack of access to and quality of care and treatment; mobilization of funding,

particularly in emergency situations; and the ongoing threat of outbreaks as a result of large-scale internal and cross-border population movements. The Member States of the Region endorsed resolution WHA64.15, in particular its emphasis on the need to ameliorate living conditions and ensure access to and availability of oral cholera vaccines. The planning process should be integrated into the prevention and control structure in order to make the most of available resources and stakeholder contributions.

Dr MOTEETEE (Lesotho), speaking on behalf of the Member States of the African Region, said that the increasing burden of sexually transmitted infections in the Region was often overlooked as a public health priority owing to lack of reliable data. The socioeconomic costs of that burden were substantial, constituting a drain on national health budgets and household incomes. Lacking knowledge about sexually transmitted infections, infected persons did not seek treatment, and preventive measures such as condom use were slow to be adopted. The inferior quality of services was compounded by lack of access to medicines and the widespread failure to institutionalize surveillance and monitoring of antimicrobial sensitivity. One positive aspect was that prevention and control of sexually transmitted infections was often integrated into HIV prevention and sexual and reproductive health activities. Nevertheless, the Region's health systems clearly required strengthening and an infusion of additional resources to ensure that its targets for the control of sexually transmitted diseases were attained. Other challenges included removing obstacles such as stigmatization and health workers' inadequate interpersonal skills that prevented people from seeking treatment for sexually transmitted diseases; educating the public about preventive measures; and institutionalizing drug-resistance monitoring.

Mr BLAIS (Canada) said that, although his country had one of the lowest rates of tuberculosis worldwide, it continued to face challenges, among them reduction of the high number of cases among populations most at risk, including First Nations. His Government's commitment to that goal was evidenced by its new strategy for combating tuberculosis in First Nations communities. The strategy was closely aligned with guidelines for tuberculosis prevention and control developed by Canada's Public Health Agency, in collaboration with Canadian provinces and territories, as a basis for an overall approach to tuberculosis-related activities across Canada. While rates of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis remained comparatively low in Canada, his Government would continue to support WHO's efforts to prevent and treat cases of both forms of tuberculosis at national and international levels.

Dr AGUILAR (Ecuador) said that efforts to control Chagas disease in the Region of the Americas were set to continue in the medium term and the long term. Despite the achievements of recent years with respect to interrupting the transmission of *Trypanosoma cruzi* by *Rhodnius prolixus* and *Triatoma infestans*, special attention was still needed in areas of Andean countries where the disease remained endemic and transmission persisted; in areas where transmission had been interrupted but threatened to recur; in areas where secondary vector species could still transmit *T. cruzi* to humans; and in areas where *T. cruzi* was transmitted by non-domiciliated vectors. Monitoring and assessment were therefore vital to progress in combating the disease, as were additional control efforts. A biennial progress report on the situation in the Americas would serve as a valuable tool in that regard.

Dr MWANSAMBO (Malawi), speaking on behalf of the Member States of the African Region, said that the major public health problem of tuberculosis had been complicated by the advent of multiple and extensive drug-resistance. The notable achievements attained in controlling the problem were therefore welcome; regional efforts to scale up the activities included the elaboration of a regional control framework and the organization of regional action plan workshops for countries with a high burden of multidrug-resistant tuberculosis. Where culture and drug-sensitivity testing

capabilities were non-existent, training had been provided to all tuberculosis reference laboratories with a view to establishing such services routinely.

Remaining challenges for the Region included a severe lack of capacity for diagnosis since laboratories were ill-equipped to perform such activities as microscopy, antigenic or molecular analysis and anti-tuberculosis drug susceptibility testing. Even where second-line medicines were available despite the shortage of international suppliers for them, it was difficult to ensure patient compliance with and follow-up to the minimum two years of treatment. Infection control was another challenge; isolation facilities were generally lacking in health institutions and at the community level.

Dr NORHAYATI RUSLI (Malaysia) said that her Government's work on strengthening its strategies to curb viral hepatitis would continue, guided by WHO's recommendations. In July 2011, the Regional Office for the Western Pacific had verified Malaysia's achievement of the regional goal of reducing chronic hepatitis B infection rates to under 1% among children of five years of age and over. Her country was committed to combating hepatitis B, notably through the management of infants born to HBsAg-positive mothers and the immunization of infants and at-risk adults. Health care workers were also immunized and surveillance had been strengthened as a result of the now mandatory requirement to report cases of hepatitis B and C. She urged WHO to pursue its scientific research on the development of a hepatitis C vaccine. Current treatment was costly and WHO should take the lead in ensuring that medicines were available at affordable prices. Stronger collaboration with international organizations and relevant stakeholders would help to achieve the target of reducing the incidence of viral hepatitis more rapidly.

Ms ERSHADI (Islamic Republic of Iran) expressed her consternation at the outcome of the thirteenth meeting of the WHO Advisory Committee on Variola Virus Research, which had clearly failed to heed the conclusion drawn from WHO's major review of the smallpox situation in 2010 and the public health assessment conducted by the Advisory Group of Independent Experts to review the smallpox research programme, namely that no compelling scientific reasons remained for the retention of variola virus stocks. Furthermore, the smallpox research programme had ended. The Advisory Committee nonetheless continued to approve a wide range of projects that used the virus, which was inconsistent with the global consensus concerning the destruction of remaining stocks and indeed with the Committee's own conclusions. Those projects should therefore be wound down to zero by 2014 at the latest. The failure of the Advisory Group of Independent Experts to comment further on the smallpox research programme since reporting to the Sixty-fourth World Health Assembly was another matter of concern.

With respect to the progress report on the global health sector strategy on HIV/AIDS, 2011–2015, the fact that 97.5% of new HIV/AIDS cases occurred in low- and middle-income countries meant that they would shoulder the main burden of the disease in the years to come. Given the significant reduction in resources for combating HIV/AIDS, collaborative efforts were needed to seek solutions to emerging issues and maintain the disease's downward trend. New and inexpensive diagnostic and therapeutic measures merited careful consideration in that regard. Those measures were among the focuses of her country's third national HIV/AIDS strategic plan, in place since 2011, which also included attention to family education, high-risk groups and risk-reduction programmes.

Concerning the progress report on the global health sector strategy, she wished to register a strong reservation to paragraph 126; the issues that it addressed had no place in the sociocultural contexts of countries such as the Islamic Republic of Iran.

Dr DJABAR (Chad), speaking on behalf of the Member States of the African Region, said that the statistics presented in the progress report on control of human African trypanosomiasis were encouraging but did not reflect the full reality of the situation; although some African countries had reported no new case since 2009, others had reported up to as many as 1000. Surveillance and treatment in disease-endemic countries were hampered by weak health systems, as well as by the insecurity in certain areas and the inaccessibility of others. The absence of strategies for combating the

disease threatened to compromise efforts to reduce the number of reported cases and to discourage nongovernmental organizations and donors from getting involved in bilateral cooperation. Countries still reporting cases of the disease must work with those partners to analyse and overcome weaknesses and risk factors that were hindering them from achieving the target of eradication by 2020. Support must also be provided to affected African countries to enable them to strengthen their surveillance and health systems, develop outreach strategies and promote research into new methods of fighting the disease.

Mr XABA (Swaziland) said that Swaziland had the highest burden of tuberculosis in the world and in about 80% of cases the subjects were coinfecting with HIV. Multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis had become a threat to public health of unprecedented scope in some countries in the southern African region, including his own, and would become a major global problem if decisive and drastic action to combat it was not taken. Despite the progress worldwide in combating tuberculosis, gaps still remained in detection and treatment, in particular of multidrug-resistant tuberculosis. Since it was unlikely that the tuberculosis targets under the Millennium Development Goals would be met by 2015 it was vital to develop a broad new multisectoral strategy covering all forms of tuberculosis, and to set new targets based on recent advances in diagnosis and treatment. For the Sixty-seventh World Health Assembly in 2014, the Secretariat was therefore requested to carry out a comprehensive review of the global tuberculosis situation, and to provide an update on progress made at the regional and country levels, the challenges still to be met and possible new strategic approaches.

Dr SAÍDE (Mozambique) said that tuberculosis was on the rise in Mozambique and remained a serious public health issue. Recent surveys in his country had shown an increase in the incidence of drug-resistant tuberculosis. He urged the Secretariat to continue strengthening both its support for tuberculosis research and control and its advocacy for resource mobilization and a more stable supply of medicines.

Mrs OTIENO (Kenya), speaking on behalf of the Member States of the African Region, said that the Member States were endeavouring to adopt strategies that were in line with the global health sector strategy on HIV/AIDS, with particular emphasis on zero new infections, zero deaths and zero discrimination and, in particular, the elimination of mother-to-child transmission of HIV, a factor not yet included in the global strategy. The challenges of providing antiretroviral therapy were great: health systems must be strengthened to cope with the increasing number of chronically-infected persons and point-of-care viral load testing must be made available. The benefits of early treatment were well known; advocacy for antiretroviral use should therefore be stepped up and treatment and care costs calculated. Accurate, high-quality data were needed to monitor the course of the epidemic. HIV was recognized as a chronic disease and therefore required high-quality integrated services. Development partners were urged to ensure that predictable external funding was available for the period covered by the global strategy.

Miss SULADDA PONGUTTA (Thailand) said that, despite significant progress in combating viral hepatitis, efforts to control that disease should be integrated more closely with those to control HIV and cancer, and WHO was encouraged to lend support to that end.

With regard to resolution WHA61.17 on the health of migrants, Member States should recognize the importance of migrants' health problems and include the health needs of migrants in their migration policies.

With respect to the progress report on the global strategy for the prevention and control of sexually transmitted infections, the Secretariat was requested to provide guidance on how to deal with the shortage of benzathine penicillin in many countries which, if it persisted, could hinder efforts to eradicate congenital syphilis worldwide.

Dr SAKAMOTO (Japan), emphasizing the importance of the directly observed treatment, short course (DOTS) strategy in the prevention of multidrug-resistant tuberculosis, said that it had been found that the disease burden of tuberculosis in the Asian region was higher than expected as a result of the trend of ageing populations in the Region; those findings should be taken into account in order to ensure the effective and efficient implementation of tuberculosis programmes.

Turning to the progress report on the global health sector strategy on HIV/AIDS, she said that, although she welcomed the progress made under the leadership of WHO, the strategy should be also aligned with the objectives of the United Nations General Assembly High-Level Meeting on AIDS.

Dr CICOONA (Italy) said that WHO's working model on tuberculosis, which focused on the establishment of a global, standardized drug resistance monitoring and surveillance system, policy recommendations for containing drug resistance, and support for Member States in implementing those recommendations, should also be applied to other areas. The progress made in notification of cases of multidrug-resistant tuberculosis and enrolment of patients in proper treatment protocols was welcome but its pace was too slow, particularly in high-burden countries. His Government was endeavouring to define, in conjunction with the Secretariat, how WHO collaborating centres might contribute to efforts in the area of rapid diagnosis of multidrug-resistant tuberculosis. Another significant concern was the growing threat of extensively drug-resistant tuberculosis. The proposal by the delegate of Swaziland that the results of a review of the global tuberculosis situation should be submitted to the Sixty-seventh World Health Assembly was therefore welcome. A new strategy for combating tuberculosis should be drawn up to ensure continuation of efforts beyond 2015.

He supported the proposal of the delegate of Ecuador for biennial reporting on Chagas disease to the Health Assembly.

Mr KAZI (Bangladesh) said that vaccination could be an effective means of controlling cholera, especially when safe water and adequate sanitation could not be ensured as a result of flooding or other disasters. His Government had been conducting studies on the efficacy of different control methods from a public health perspective and it had successfully completed a large trial vaccination programme in urban areas, resulting in high coverage rates. A feasibility study with regard to cholera vaccination campaigns in rural settings was also planned. The progress report had made no mention of any efforts to revitalize the Global Task Force on Cholera Control; regular updates to the governing bodies on that subject would be welcome.

Ms CADGE (United Kingdom of Great Britain and Northern Ireland) shared the concerns expressed by many other Member States about the threat of drug-resistant tuberculosis, and supported the comments made by the delegate of Italy on the issue. Although there had been significant progress since 1990 built on partnership, innovation and country leadership, the global burden of tuberculosis remained considerable and the gains made would be under threat if strategic steps were not taken to tackle drug-resistant forms of the disease.

Mr VIEGAS (Brazil) said that, if efforts to reduce the incidence of tuberculosis continued at the current pace, many more years would be required to eliminate it completely. He was therefore in favour of commencing discussion on a new strategy that would keep the positive aspects of the current one but also deal with issues such as social determinants, access to diagnosis and treatment for the most vulnerable populations, and tuberculosis/HIV coinfection; furthermore, the issue should be included on the agenda of the next Health Assembly.

His Government supported the proposal by the delegate of Ecuador to institute a schedule of regular reporting on Chagas disease, since it was important to build on the momentum sparked by the adoption of resolution WHA63.20.

Dr EL MENZHI (Morocco) said that the recrudescence of multidrug-resistant tuberculosis and extensively drug-resistant tuberculosis put achievement of the objectives of resolution WHA62.15 at

risk. Member States were urged to implement psychosocial support programmes and adopt sustainable funding mechanisms for management and care of those two forms of tuberculosis. In addition, to facilitate implementation of the Global Plan to Stop TB 2006–2015, the Secretariat should provide strategic guidelines and technical support to Member States; facilitate the sharing of experience and exchange of information among Member States; strengthen knowledge hubs and centres of excellence; and support Member States in obtaining quality-assured second-line medicines.

Dr DAULAIRE (United States of America), noting the support expressed on behalf of the African Region for ongoing research into effective countermeasures against smallpox, said that it was regrettable that an intervention had been made by another Member State using a mistaken, selective and misleading reading of resolutions WHA60.1 and WHA64.11, both of which actually endorsed ongoing research until modern, proven and effective countermeasures had been developed. In addition, the WHO Advisory Committee on Variola Virus Research continued to act within its mandate under resolution WHA60.1.

With regard to the progress report on viral hepatitis, his Government was committed to supporting the Global Hepatitis Programme through the secondment of staff and the provision of financial and technical support, and he urged other Member States to do the same. He encouraged the Secretariat to continue monitoring the implementation of resolution WHA63.18 on viral hepatitis at country level and to identify points of contact in each region.

Dr WILLIAMS (Barbados) said that the countries most affected by HIV/AIDS, namely the developing countries, were the least able to conduct research on that subject and depended on external partners, and WHO in particular, for research funding. Progress had been made in the use of antiretroviral medicines to prevent mother-to-child transmission of HIV. Development of a vaccine should nevertheless remain a priority and pharmaceutical companies and research institutions were urged to concentrate on that task, despite the more attractive gains to be had from developing control methods. He would welcome a global programme to reduce the social stigmatization and exclusion experienced by people with HIV/AIDS.

Dr SHOHANI (Iraq) said that cases of HIV and tuberculosis needed to be screened early. In his country, first-line medicines for tuberculosis were available and monitoring and care of patients was ensured thanks to the involvement of all stakeholders, including schools. The incidence of HIV/AIDS was low, although there were some cases resulting from contaminated blood transfusions. HIV screening and antiretroviral medicines were provided free of charge. Technical support from WHO for screening was nevertheless required in order to ensure that HIV/AIDS rates did not increase.

Dr Li-Jen LIN (Chinese Taipei) said that Chinese Taipei had, in 1984, been the first to introduce free, mass hepatitis B vaccination campaigns for infants, followed subsequently by the introduction of routine screening for pregnant women to prevent mother-to-child hepatitis B transmission. That had enabled Chinese Taipei to reach the goal set by the Western Pacific Region, namely reducing chronic hepatitis B infection rates to below 2% in children under five years of age by 2012. A pilot project for the treatment of chronic hepatitis B and C had been launched in 2000 to help to reduce the complications of liver cirrhosis and hepatocellular carcinoma. Despite the overall progress made, Chinese Taipei required adequate resources and commitment from partners to maintain its success.

Chinese Taipei was a long-standing advocate of efforts to prevent and control sexually transmitted infections and had compiled a list of clinics recommended for their open approach to sexually transmitted diseases.

Mr GORE (World Hepatitis Alliance), speaking at the invitation of the CHAIRMAN, commended WHO's efforts to establish the Global Hepatitis Programme and to develop a broad global hepatitis strategy. Although the strategy had yet to be formally launched, both PAHO and the Regional Office for South-East Asia had already begun developing regional strategies and it was hoped that the

other regional offices would shortly follow suit. In 2010, Member States had agreed on the need to raise awareness about hepatitis in order to strengthen disease prevention and diagnosis; his organization was eager to work in partnership with Member States to do so. Participation in World Hepatitis Day on 28 July was an important aspect of that work and demonstrated Member States' commitment to tackling hepatitis.

Ms CHILDS (MSF International), speaking at the invitation of the CHAIRMAN, called on Member States to scale up screening of Chagas disease, and to diagnose and treat it at the primary health care level. Follow-up and treatment of babies born to mothers with Chagas disease was also needed. Recent breakdowns in the supply of the first-line treatment benznidazole had hindered the efforts of Médecins sans Frontières and national health programmes. A commitment to forecasting demand for medicines on the part of PAHO and the Latin American health ministries was needed in order to facilitate continuous and sustainable drug production. Just as it had spearheaded the public health response to HIV/AIDS, WHO should mobilize interest in hepatitis C for which treatment and care guidelines were lacking. Because price was a barrier to obtaining care, wide access to and affordability of treatment needed to be ensured. On the whole, country plans on multidrug-resistant and extensively drug-resistant tuberculosis were not ambitious enough and only a small fraction of people with multidrug-resistant tuberculosis were being diagnosed and treated. Irrational use and over-the-counter availability of tuberculosis medicines in many countries made it likely that drug resistance would increase. Work on a new tuberculosis strategy should start immediately, as the current one would end in 2015. An easier to use single-dose cholera vaccine still needed to be developed. With regard to human African trypanosomiasis, insufficient surveillance in remote and insecure areas meant that disease prevalence, mortality and active transmission were undoubtedly higher than reported. She urged Member States to bolster surveillance in central African countries and to provide adequate funding to control programmes.

Dr NAKATANI (Assistant Director-General) said that the Secretariat would give consideration to the request for biennial reporting on Chagas disease but pointed out that its workload had already been increased by the newly adopted resolution on schistosomiasis. The Secretariat would consult with Member States on the development of a new tuberculosis strategy. The information requested by the delegate of Germany on a comprehensive approach and human rights issues was already included in the global strategy on HIV/AIDS; more information was available on the WHO HIV/AIDS department web site.

Dr NEIRA (Protection of the Human Environment) acknowledged the request made by the delegate of Thailand regarding assistance with integration of HIV issues and welcomed the offer from the delegate of Angola regarding the sharing of experience. With respect to smallpox eradication, she assured the Committee that all research using the variola virus was closely monitored and strictly regulated in accordance with the recommendations of the WHO Advisory Committee on Variola Virus Research. She took note of the request for an update on revitalizing the Global Task Force on Cholera Control and the scaling up of access to the oral cholera vaccine.

Dr BUSTREO (Assistant Director-General), having noted the comments made on the global strategy for the prevention and control of sexually transmitted infections, said that WHO planned to strengthen its efforts in areas such as improving monitoring and surveillance systems; implementing evidence-based responses, particularly for multidrug-resistant *Neisseria gonorrhoeae*; and scaling up cervical cancer prevention and screening in developing countries. There was currently a new opportunity for funding from the GAVI Alliance for the human papillomavirus vaccine that would make new resources available to countries for the prevention and control of sexually transmitted infections.

Other

- M. Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets (resolution WHA57.12)**
- N. Advancing food safety initiatives (resolution WHA63.3)**
- O. Climate change and health (resolutions EB124.R5 and WHA61.19)**
- P. Partnerships (resolution WHA63.10)**
- Q. Multilingualism: implementation of action plan (resolution WHA61.12)**

Ms HALÉN (Sweden), speaking on behalf of Denmark, Finland, Iceland, Norway and Sweden, said that sexual and reproductive health and rights were fundamental to the promotion of gender equality, the reduction of maternal mortality, the prevention of the spread of HIV and the achievement of the Millennium Development Goals. Despite the progress made since the implementation of the strategy, Member States continued to report significant barriers to improving sexual and reproductive health, which contributed to uneven progress and inequity. Provision of modern contraceptives and access to safe abortion services were crucial and the unmet needs in those spheres, particularly in sub-Saharan Africa, required urgent attention.

Turning to the progress report on climate change and health, she welcomed the initiatives on climate change undertaken by the Secretariat, particularly in cooperation with the Intergovernmental Panel on Climate Change, the United Nations Framework Convention on Climate Change and the World Meteorological Organization. Increasing knowledge and building capacity should be WHO's key focus, particularly in developing countries.

Mr XABA (Swaziland), speaking on behalf of the Member States of the African Region, expressed concern that little progress had been made in the area of reproductive health and that significant disparities existed between regions. Some progress had nonetheless been made owing to strategic partnership assistance for strengthening health systems, advocacy for allocating resources to reproductive health, and better monitoring and evaluation of evidence-based programming. However, a greater focus on client-centred strategies was needed. Some key reproductive health programme elements had apparently not been adequately implemented, which indicated a need to review and redefine essential sexual and reproductive health services. Member States were encouraged to take advantage of the funding opportunities offered by the United States President's Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria. The health-related Millennium Development Goals could not be achieved without strengthening health systems and integrating HIV/AIDS and sexual and reproductive health policies and services.

Dr DANKOKO (Senegal), speaking on behalf of the Member States of the African Region, commended the Secretariat's recent efforts to promote multilingualism in pursuance of the plan of action adopted in resolution WHA61.12, and welcomed the launching of the staff language skills database and the web page on multilingualism and staff training. WHO staff in the African Region had responded positively to the database, providing contributions and indicating a desire for training in a wide variety of languages. The universities of Geneva and Nairobi were jointly running a project on using information technology to facilitate the translation of documents from English into Swahili and to improve communication between health personnel and health service users across Africa. He urged the Secretariat to consolidate those achievements and to implement the provisions of the Medium-term strategic plan 2008–2013 in order to ensure that multilingualism became a reality in the Organization. Cultural and linguistic diversity should not be an obstacle to obtaining the information and knowledge needed to ensure effective health policies. He also urged WHO to endorse the recommendations contained in the 2011 United Nations Joint Inspection Unit report on multilingualism in the United Nations system organizations, in particular in relation to the recruitment of staff.

Dr SAENGNAPHA UTHAISAEANGPHAISAN (Thailand) said that her Government's experience during the 2011 floods had raised its awareness of the need for health emergency and disaster management. She called on the Secretariat to develop programme activities involving international collaboration in sharing experience and transferring knowledge, and to provide feedback on those activities in future progress reports. The work being done under the "healthy hospitals" project to ensure an environment-friendly health sector was commendable and Member States were urged to make further progress in that direction.

Professor AHMED (Bangladesh) said that his Government attached great importance to the health effects of climate change, which was shifting the health paradigm and affecting disease patterns. WHO was providing support for studies to assess the Bangladeshi population's vulnerability to climate change, and for research on climate-related and non-climate-related determinants of health, the results of which would shape future policies and adaptation strategies. Health care facilities in Bangladesh had been equipped to cope with extreme weather events and a special health ministry unit had been set up with a view to reducing risk and increasing the capacity to adapt to climate-sensitive diseases. Most south-east Asian countries that were vulnerable to the detrimental effects of climate change still lacked the scientific expertise and human and financial resources needed to deal with them effectively. The industrialized countries, which were historically responsible for global greenhouse emissions, must fulfil their commitments to provide the necessary financial and technological support to help those countries.

Dr ONDO EFUA (Equatorial Guinea), speaking on behalf of the Member States of the African Region, said that the Region had seen considerable growth in the number of organizations involved in the health sector and was therefore grateful to WHO for its technical support and guidelines on partnership building. WHO was the lead agency for interagency health coordination committees in 25 of the Region's 46 Member States and had a good reputation and an active presence. The countries of the Region had adopted the WHO's 2010 policy framework for engaging and working with the commercial private sector. WHO was pursuing its efforts to strengthen and coordinate international support at the regional level, and the Regional Office for Africa had supported the development of a framework for building partnerships for health in Africa, with a view to strengthening national health systems. A new partnership agreement had been negotiated within the restructured African Union, which should strengthen cooperation between the Regional Office for Africa and the African Union, and with regional economic communities, which were gaining importance in the Region.

Mr BLAIS (Canada) said that partnerships were a useful global health mechanism and an important component in Canada's development efforts. He therefore hoped that consideration by the Board of the progress report on partnerships at its 132nd session in January 2013 would lead to more effective management of partnerships, the development of clear guidelines for joining and exiting partnerships, and closer collaboration with other international organizations such as UNDP and the World Bank on partnership management.

His Government continued to support implementation of resolution WHA63.3 on advancing food safety initiatives and appreciated the support provided by WHO to the work of the Codex Alimentarius Commission. It was concerned, however, by the lack of support for the provision of expert scientific advice, which was essential for standard-setting. International standards based on sound science were vital to protecting consumers' health. WHO should therefore reaffirm its commitment to expert committees such as the Joint FAO/WHO Expert Committee on Food Additives and give priority to the identification of sustainable funding for expert scientific advice.

Mr KÜMMEL (Germany) urged the Secretariat to support countries in developing integrated programmes for maternal, neonatal and child health within broad health sector plans and a wider intersectoral development framework. Such programmes should promote measures to eliminate

harmful obstacles to women's health, including discriminatory laws and practices that blocked access to health services and violated women's right to health.

Dr SAÍDE (Mozambique) welcomed the collaboration between WHO and the World Meteorological Organization, in particular under the Global Framework for Climate Services. By providing targeted climate services under its health section, the Global Framework would strengthen health protection and services through better management of climate risks, and would ensure that the needs of the health community for information and services were met.

Mr KAYITAYIRE (Rwanda), speaking on behalf of the Member States of the African Region, said that the food safety risk in the Region remained elevated for a variety of reasons. An unprecedented number of foodborne disease outbreaks had been recorded in recent years. Such outbreaks should be monitored through disease surveillance systems, and research conducted to support the development of evidence-based standards and guidelines, in particular for chemical residues in vegetables. Globalization of the food trade, changes in eating patterns, climate change and natural and human-made disasters were giving rise to new challenges. For example, street food vending provided access to affordable food but food safety regulators were concerned about poor food hygiene in that sector. In terms of progress made, cross-sectoral collaboration had been strengthened through the establishment of multisectoral food safety and nutrition coordination teams and the decentralization of food safety risk assessment and management, and regional capacity-building tools had been developed. Despite those efforts and the political will of the Member States, foodborne disease continued to be a major cause of morbidity and mortality in the Region. Greater efforts must be made in that area, including by elaborating national food safety policies.

Ms KOROTKOVA (Russian Federation) commended the progress achieved since the adoption of resolution WHA61.12, which called for action to promote multilingualism at WHO. The increase in translations into Russian was welcome but still did not meet her country's needs and in that regard she stressed ongoing cooperation between Member States, WHO headquarters and regional offices. The Russian Federation's Ministry of Health and Social Development stood ready to provide assistance. Requirements for Russian translations of WHO documents were determined by means of surveys sent out to specialists in member countries of the Commonwealth of Independent States. The WHO web site was informative, and efforts were being made to translate into Russian the web pages relating to priority areas of the Organization's work. Her Government was particularly interested in the quality of the translations as their contents were vitally important to health experts in Russian-speaking countries; those experts, in turn, might assist with the translations, thereby reducing expenditure at headquarters. Her Government would continue its cooperation with a view to expanding the range of WHO publications in Russian and had already contributed US\$ 2 million for that purpose.

Mr LE GOFF (France) thanked the Secretariat for having organized informal consultations among Member States on WHO's contribution to the United Nations Conference on Sustainable Development in June 2012. The aim had been to ensure that health issues were accorded adequate importance at the Conference. He requested the Secretariat to prepare a report on the conclusions reached during the informal consultations.

He endorsed the views of the delegate of Senegal on multilingualism, a subject to which France accorded great importance, and saluted the Secretariat's efforts to guarantee high-quality interpretation and translations, which were essential for the effective functioning of the Organization.

Dr NORHAYATI RUSLI (Malaysia) commended WHO's leadership in the area of climate change and health. Her Government was committed to tackling the threats to human health from climate change, in line with strategies advocated by WHO. With the Organization's support, it had implemented a project to develop a health impact risk assessment tool. It had also earmarked funding

in 2012 for in-service training of health care providers in the public health sector to increase their awareness and understanding of the practical impact of climate change on health.

At the Regional Forum on Environment and Health in Southeast and East Asian Countries in July 2010, member countries, including Malaysia, had agreed to develop and implement national environmental health action plans, with a special focus on the effects of climate change on health.

Dr DAULAIRE (United States of America) said that the programme of action adopted at the 1994 International Conference on Population Development continued to provide the foundations for international action. According priority to women's sexual and reproductive health and rights was essential to sustainable development and achievement of the Millennium Development Goals. Reproductive health continued to be a cornerstone of his country's own domestic health policy and of President Obama's Global Health Initiative. His Government looked forward to expanding its partnerships with the Secretariat and Member States in the area of maternal health, family planning and other reproductive health services.

Ms LANTERI (Monaco) endorsed the views expressed by the delegates of France, Senegal and the Russian Federation in respect of multilingualism and the recent report of the United Nations Joint Inspection Unit on multilingualism in the United Nations system organizations.

She endorsed the views expressed by the delegate of France in relation to climate change and health, in particular in respect of the forthcoming United Nations Conference on Sustainable Development.

Mr USTINOV (Russian Federation) endorsed the views of the delegate of the United States in reference to the progress report on smallpox eradication. Continued research was required to provide the international community with safe and reliable ways of treating and diagnosing the disease.

Mr SEADAT (Islamic Republic of Iran), speaking in exercise of the right of reply under Rule 59 of the Rules of Procedure of the World Health Assembly, said that, although he respected the right of Member States to express their agreement or disagreement with others, it was unacceptable for a delegation to brand the statement of another as misleading, and he urged delegates to avoid such an approach.

The CHAIRMAN said that the remark by the delegate of the Islamic Republic of Iran had been noted.

Dr BUSTREO (Assistant Director-General) thanked delegates for their positive and encouraging comments on the progress report on reproductive health, in particular the recognition by many Member States of the importance of reproductive health services, universal access to those services by women and men, and the links between universal access and maternal and child mortality reduction and overall development.

Dr NEIRA (Protection of the Human Environment), responding to comments on the progress report on advancing food safety initiatives, said that WHO recognized the importance of setting food safety standards based on sound science and was committed to giving that matter the attention requested. She agreed that multisectoral collaboration was also essential.

She thanked delegates for their comments on the progress report on climate change and health. WHO would continue to ensure that health was on the climate change agenda. The Organization would work closely with other international organizations, especially the World Meteorological Organization, and provide support to countries, in particular those most vulnerable to climate change. The Secretariat would consider, in consultation with Member States, how best to report on the informal consultations on the WHO contribution to the United Nations Conference on Sustainable Development.

Dr AL SHORBAJI (Knowledge Management and Sharing) thanked the delegates of France, Monaco, Senegal and the Russian Federation for their comments on the progress report on multilingualism, which would be integrated into the Organization's efforts to strengthen multilingualism in order to transmit medical information effectively to Member States. The United Nations Joint Inspection Unit report on multilingualism in the United Nations system organizations would also guide those efforts.

Mr LÚCIO (World Meteorological Organization) said that understanding the relationship between climate and health was a precondition for taking preventive action to mitigate climate-related health risks especially in view of current climate changes. Challenges included the health community's ability to recognize, interpret and use available climate information and the climate sector's sometimes inadequate appreciation of public health concerns. WMO was collaborating with WHO on drawing up an implementation plan for the Global Framework for Climate Services, which had a specific section on health. The draft implementation plan would be available for review up to mid-July 2012 and WHO Member States were invited to comment on it.

Dr DOEBBLER (CMC – Churches' Action for Health), speaking at the invitation of the CHAIRMAN, welcomed the Organization's climate change activities but noted that the WHO Secretariat and the secretariat of the United Nations Framework Convention on Climate Change did not list each other as partners in their reports on cooperation. It was to be hoped that cooperation between the two bodies would be strengthened in future, in particular the ongoing cooperation on projects concerning the protection of individuals from climate change, conducted under the auspices of the secretariat of the Framework Convention. Climate change and health should be included in WHO reform plans as a programme priority, and a written report should be prepared, as requested by the delegate of France, on the consultations held prior to the United Nations Conference on Sustainable Development.

The Committee noted the progress reports.

4. CLOSURE OF THE MEETING

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 13:20.

PART II

REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly has been replaced by the serial number (in square brackets) under which they appear in document WHA65/2012/REC/1. The verbatim records of plenary meetings at which these reports were approved are available on the WHO web site, governance page.

COMMITTEE ON CREDENTIALS

Report¹

[A65/51 – 23 May 2012]

The Committee on Credentials met on 22 May 2012. Delegates of the following Member States were present: Guyana; Kyrgyzstan; Luxembourg; Malawi; Mexico; San Marino; Sao Tome and Principe; United Arab Emirates; Viet Nam.²

The Committee elected the following officers: Dr Tran Thi Giang Huong (Viet Nam) – Chairman, and Dr Robert Goerens (Luxembourg) – Vice-Chairman.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly. It noted that the Secretariat had found these credentials to be in conformity with the Rules of Procedure.

The credentials of the delegates of the Member States shown at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials and the Committee therefore proposed that the Health Assembly recognize their validity.

States whose credentials it was considered should be recognized as valid (see fourth paragraph above)

Afghanistan; Albania; Algeria; Andorra; Angola; Argentina; Armenia; Australia; Austria; Azerbaijan; Bahamas; Bahrain; Bangladesh; Barbados; Belarus; Belgium; Benin; Bhutan; Bolivia (Plurinational State of); Bosnia and Herzegovina; Botswana; Brazil; Brunei Darussalam; Bulgaria; Burkina Faso; Burundi; Cambodia; Cameroon; Canada; Cape Verde; Central African Republic; Chad; Chile; China; Colombia; Comoros; Congo; Cook Islands; Costa Rica; Côte d'Ivoire; Croatia; Cuba; Cyprus; Czech Republic; Democratic People's Republic of Korea; Democratic Republic of the Congo; Denmark; Djibouti; Dominica; Dominican Republic; Ecuador; Egypt; El Salvador; Equatorial Guinea; Eritrea; Estonia; Ethiopia; Fiji; Finland; France; Gabon; Gambia; Georgia; Germany; Ghana; Greece; Guatemala; Guinea; Guyana; Haiti; Honduras; Hungary; Iceland; India; Indonesia; Iran (Islamic Republic of); Iraq; Ireland; Israel; Italy; Jamaica; Japan; Jordan; Kazakhstan; Kenya; Kiribati; Kuwait; Kyrgyzstan; Lao People's Democratic Republic; Latvia; Lebanon; Lesotho; Liberia; Libya; Lithuania; Luxembourg; Madagascar; Malawi; Malaysia; Maldives; Mali; Malta; Marshall Islands; Mauritania; Mauritius; Mexico; Micronesia (Federated States of); Monaco; Mongolia; Montenegro; Morocco;

¹ Approved by the Health Assembly at its sixth plenary meeting.

² See decision WHA65(1).

Mozambique; Myanmar; Namibia; Nauru; Nepal; Netherlands; New Zealand; Nicaragua; Niger; Nigeria; Norway; Oman; Pakistan; Palau; Panama; Papua New Guinea; Paraguay; Peru; Philippines; Poland; Portugal; Qatar; Republic of Korea; Republic of Moldova; Romania; Russian Federation; Rwanda; Saint Kitts and Nevis; Samoa; San Marino; Sao Tome and Principe; Saudi Arabia; Senegal; Serbia; Seychelles; Sierra Leone; Singapore; Slovakia; Slovenia; Solomon Islands; Somalia; South Africa; South Sudan; Spain; Sri Lanka; Sudan; Swaziland; Sweden; Switzerland; Syrian Arab Republic; Thailand; The former Yugoslav Republic of Macedonia; Timor-Leste; Togo; Tonga; Trinidad and Tobago; Tunisia; Turkey; Turkmenistan; Tuvalu; Uganda; Ukraine; United Arab Emirates; United Kingdom of Great Britain and Northern Ireland; United Republic of Tanzania; United States of America; Uruguay; Uzbekistan; Vanuatu; Venezuela (Bolivarian Republic of); Viet Nam; Yemen; Zambia; Zimbabwe.

GENERAL COMMITTEE

Report¹

[A65/52 –24 May 2012]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 23 May 2012, the General Committee, in accordance with Rule 100 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members,² in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Australia, Azerbaijan, Belgium, Chad, Croatia, Cuba, Islamic Republic of Iran, Lebanon, Lithuania, Malaysia, Maldives, and Panama.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution of the Board as a whole.

COMMITTEE A

First report¹

[A65/50 – 23 May 2012]

Committee A held its second and third meetings on 22 May 2012. These meetings were held under the chairmanship of Dr Zangley Dukpa (Bhutan) and Dr Fenton Ferguson (Jamaica).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of two resolutions relating to the following agenda items:

¹ Approved by the Health Assembly at its ninth plenary meeting.

² The Health Assembly considered the list at its ninth plenary meeting and elected the 12 Members.

13. Technical and health matters
 - 13.1 Prevention and control of noncommunicable diseases
Strengthening noncommunicable disease policies to promote active ageing [WHA65.3]
 - 13.2 The global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level [WHA65.4].

Second report¹

[A65/54 – 25 May 2012]

Committee A held its seventh meeting on 24 May 2012. This meeting was held under the chairmanship of Mr Herbert Barnard (Netherlands).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of one decision relating to the following agenda item:

13. Technical and health matters
 - 13.1 Prevention and control of noncommunicable diseases.
Prevention and control of noncommunicable diseases: follow-up to the High-level meeting of the United Nations General Assembly on the Prevention and Control of Non-communicable diseases [WHA65(8)].

Third report¹

[A65/55 – 26 May 2012]

Committee A held its eighth, ninth and tenth meetings on 25 May 2012. These meetings were held under the chairmanship of Mr Herbert Barnard (Netherlands) and Dr Zangley Dukpa (Bhutan).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of one decision and four resolutions relating to the following agenda items:

12. WHO reform [WHA65(9)]
13. Technical and health matters
 - 13.10 Poliomyelitis: intensification of the global eradication initiative [WHA65.5]
 - 13.3 Nutrition
Maternal, infant and young child nutrition [WHA65.6]
 - 13.5 Monitoring of the achievement of the health-related Millennium Development Goals
Implementation of the recommendations of the Commission on Information and Accountability for Women's and Children's Health [WHA65.7]
 - 13.6 Social determinants of health: outcome of the World Conference on Social Determinants of Health (Rio de Janeiro, Brazil, October 2011)
Outcome of the World Conference on Social Determinants of Health [WHA65.8].

¹ Approved by the Health Assembly at its tenth plenary meeting.

Fourth report¹

[A65/58 – 26 May 2012]

Committee A held its eleventh meeting on 26 May 2012. This meeting was held under the chairmanship of Dr Zangley Dukpa (Bhutan).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of two resolutions relating to the following agenda items:

13. Technical and health matters
 - 13.14 Follow up of the report of the Consultative Expert Working Group on Research and Development: Financing and Coordination [WHA65.22]
 - 13.7 Implementation of the International Health Regulations (2005) [WHA65.23].

COMMITTEE B

First report¹

[A65/53 – 24 May 2012]

Committee B held its first and second meetings on 23 May 2012 under the chairmanship of Professor Mohammad Hossein Nicknam (Islamic Republic of Iran), Professor Charles Kondi Agba (Togo) and Dr Enrique Tayag (Philippines).

In accordance with Rule 34 of the Rules of Procedure of the World Health Assembly, the Committee elected Professor Charles Kondi Agba (Togo) and Dr Enrique Tayag (Philippines) Vice-Chairmen, and Dr Paul Gully (Canada) Rapporteur.

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of five resolutions relating to the following agenda items:

15. Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan [WHA65.9]
16. Programme budget and financial matters
 - 16.2 Financial report and audited financial statements for the period 1 January 2010 – 31 December 2011 [WHA65.10]
 - 16.3 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA65.11]
Special arrangements for settlement of arrears [WHA65.12]
17. Audit and oversight matters
 - 17.1 Report of the External Auditor [WHA65.13].

¹ Approved by the Health Assembly at its tenth plenary meeting.

Second report¹

[A65/56 – 26 May 2012]

Committee B held its third and fourth meetings on 25 May 2012 under the chairmanship of Professor Mohammad Hossein Nicknam (Islamic Republic of Iran) and Dr Enrique Tayag (Philippines).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of five resolutions and one decision relating to the following agenda items:

18. Staffing matters
 - 18.3 Amendments to the Staff Regulations and Staff Rules
Salaries of staff in ungraded posts and of the Director-General [WHA65.14]
 - 18.4 Appointment of representatives to the WHO Staff Pension Committee
United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA65(10)]
19. Management and legal matters
 - 19.1 Election of the Director-General of the World Health Organization: Report of the Working Group [WHA65.15]
 - 19.2 Agreements with intergovernmental organizations [WHA65.16]
13. Technical and health matters
 - 13.12 Draft global vaccine action plan
Global vaccine action plan [WHA65.17]
World Immunization Week [WHA65.18].

Third report¹

[A65/57 – 26 May 2012]

Committee B held its fifth meeting on 25 May 2012 under the chairmanship of Professor Mohammad Hossein Nicknam (Islamic Republic of Iran).

It was decided to recommend to the Sixty-fifth World Health Assembly the adoption of three resolutions relating to the following agenda items:

13. Technical and health matters
 - 13.13 Substandard/spurious/false-labelled/falsified/counterfeit medical products: report of the Working Group of Member States
Substandard/spurious/false-labelled/falsified/counterfeit medical products [WHA65.19]
 - 13.15 WHO's response, and role as the health cluster lead, in meeting the growing demands of health in humanitarian emergencies [WHA65.20]
 - 13.11 Elimination of schistosomiasis [WHA65.21].

¹ Approved by the Health Assembly at its tenth plenary meeting.

LIST OF PARTICIPANTS

**COMPOSITION DE L'ASSEMBLEE DE LA SANTE
MEMBERSHIP OF THE HEALTH ASSEMBLY**

**LISTE DES DELEGUES ET AUTRES PARTICIPANTS
LIST OF DELEGATES AND OTHER PARTICIPANTS**

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