



WORLD HEALTH ORGANIZATION

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# **EXECUTIVE BOARD**

**114TH SESSION**

**GENEVA, 24-26 MAY 2004**

**RESOLUTIONS AND DECISIONS**

**SUMMARY RECORDS**

GENEVA  
2004

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WORLD HEALTH ORGANIZATION

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## ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

ACHR	– Advisory Committee on Health Research	PAHO	– Pan American Health Organization
ASEAN	– Association of South East Asian Nations	UNAIDS	– Joint United Nations Programme on HIV/AIDS
CEB	– United Nations System Chief Executives Board for Coordination (formerly ACC)	UNCTAD	– United Nations Conference on Trade and Development
CIOMS	– Council for International Organizations of Medical Sciences	UNDCP	– United Nations International Drug Control Programme
FAO	– Food and Agriculture Organization of the United Nations	UNDP	– United Nations Development Programme
IAEA	– International Atomic Energy Agency	UNEP	– United Nations Environment Programme
IARC	– International Agency for Research on Cancer	UNESCO	– United Nations Educational, Scientific and Cultural Organization
ICAO	– International Civil Aviation Organization	UNFPA	– United Nations Population Fund
IFAD	– International Fund for Agricultural Development	UNHCR	– Office of the United Nations High Commissioner for Refugees
ILO	– International Labour Organization (Office)	UNICEF	– United Nations Children’s Fund
IMF	– International Monetary Fund	UNIDO	– United Nations Industrial Development Organization
IMO	– International Maritime Organization	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

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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 114th session of the Executive Board was held at WHO headquarters, Geneva, from 24 to 26 May 2004.

The Fifty-seventh World Health Assembly elected 12 Member States to be entitled to designate a person to serve on the Executive Board in place of those whose term of office had expired,<sup>1</sup> giving the following new composition of the Board:

Designating country	Unexpired term of office <sup>2</sup>	Designating country	Unexpired term of office <sup>2</sup>
Australia .....	3 years	Kenya .....	3 years
Bahrain .....	3 years	Kuwait.....	1 year
Bolivia .....	3 years	Lesotho.....	3 years
Brazil .....	3 years	Libyan Arab Jamahiriya.....	3 years
Canada .....	2 years	Luxembourg.....	3 years
China.....	1 year	Maldives.....	1 year
Czech Republic.....	2 years	Nepal.....	2 years
Ecuador.....	2 years	Pakistan.....	2 years
France .....	2 years	Romania .....	3 years
Gabon .....	1 year	Russian Federation.....	1 year
Gambia .....	1 year	Spain .....	1 year
Ghana.....	1 year	Sudan .....	2 years
Guinea.....	1 year	Thailand .....	3 years
Guinea-Bissau.....	2 years	Tonga. ....	3 years
Iceland .....	2 years	United States of America .....	1 year
Jamaica .....	3 years	Viet Nam.....	2 years

Details regarding members designated by the above Member States will be found in the list of members and other participants.

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<sup>1</sup> By decision WHA57(8). The retiring members were those designated by Colombia, Cuba, Egypt, Eritrea, Ethiopia, Grenada, Kazakhstan, Myanmar, Philippines, Republic of Korea, Saudi Arabia, and the United Kingdom of Great Britain and Northern Ireland.

<sup>2</sup> At the time of the closure of the Fifty-seventh World Health Assembly.



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## AGENDA<sup>1</sup>

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2. Election of Chairman, Vice-Chairmen and Rapporteurs
3. Outcome of the Fifty-seventh World Health Assembly
4. Technical and health matters
  - 4.1 Cancer control
    - Review of possible establishment of an international fund to support cancer control in developing countries
  - 4.2 Disability, including management and rehabilitation
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  - 4.10 Social health insurance
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<sup>1</sup> As adopted by the Board at its first meeting.

6. Management and financial matters

6.1 Implementation of multilingualism in WHO

6.2 Committees of the Executive Board

- Merger of committees: terms of reference and options for membership
- Filling of vacancies on committees

6.3 Future sessions of the Executive Board and the Health Assembly

6.4 Nongovernmental organizations: reconsideration of two applications for admission into official relations with WHO

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7.1 Expert committees and study groups

8. Closure of the session

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## LIST OF DOCUMENTS

EB114/1 Rev.1	Agenda <sup>1</sup>
EB114/1(annotated)	Provisional agenda (annotated)
EB114/2	Outcome of the Fifty-seventh World Health Assembly
EB114/3	Cancer control
EB114/4	Disability, including management and rehabilitation
EB114/5	Recruitment of health workers from the developing world
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EB114/8	Implementation of multilingualism in WHO
EB114/9 and EB114/9 Add.1	Committees of the Executive Board – Merger of committees: terms of reference and options for membership
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EB114/15	Manufacture of antiretrovirals in developing countries and challenges for the future
EB114/16	Social health insurance

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<sup>1</sup> See page ix.

EB114/17	Human resources in health
EB114/18	Review of possible establishment of an international fund to support cancer control in developing countries
EB114/19	Nongovernmental organizations: reconsideration of two applications for admission into official relations with WHO. Report of the Standing Committee on Nongovernmental Organizations

#### **Information documents**

EB114/INF.DOC./1	Meeting of Interested Parties, 2003
EB114/INF.DOC./2	Statement by the representative of the WHO staff associations on matters concerning personnel policy and conditions of service

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## **PART I**

# **RESOLUTIONS AND DECISIONS**



## RESOLUTIONS

### **EB114.R1      Sustainable financing for tuberculosis prevention and control**

The Executive Board,

Having considered the report on sustainable financing and tuberculosis control,<sup>1</sup>

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

Having considered the report on sustainable financing and tuberculosis control;

Aware of the need to diminish the global burden of tuberculosis and thereby lower this barrier to socioeconomic development;

Welcoming the progress made towards achieving the global tuberculosis-control targets for 2005 following the establishment, in response to resolution WHA51.13, of the Stop Tuberculosis Initiative;<sup>2</sup>

Noting the need to strengthen health systems development for the successful delivery of tuberculosis-control activities;

Stressing the importance of engagement of the full range of health providers in delivering the international standard of tuberculosis care in line with the strategy of directly observed treatment, short-course (DOTS);

Concerned that lack of commitment to sustained financing for tuberculosis control will impede the sound long-term planning necessary to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

Encouraging the development of a global plan for the period 2006-2015, which will address the need for sustained financing in order to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;

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<sup>1</sup> Documents EB114/14 and Corr.1.

<sup>2</sup> Now known as the Stop TB Partnership.

1. ENCOURAGES all Member States:

- (1) to fulfil the commitments made in endorsing resolution WHA53.1 and hence the Amsterdam Declaration to Stop Tuberculosis, including their commitment to ensure the availability of sufficient domestic resources and of sufficient external resources to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
- (2) to ensure that all tuberculosis patients have access to the universal standard of care based on proper diagnosis, treatment and reporting consistent with the DOTS strategy by promoting both supply and demand;
- (3) to strengthen prevention of, and social mobilization against, tuberculosis;

2. REQUESTS the Director-General:

- (1) to intensify support to Member States in developing capacity and improving the performance of national tuberculosis-control programmes within the broad context of strengthening health systems in order:
  - (a) to accelerate progress towards reaching the global target of detecting 70% of new infectious cases and successfully treating 85% of those detected;
  - (b) to sustain achievement of that target in order to reach the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration;
- (2) to strengthen cooperation with Member States with a view to improving collaboration between tuberculosis programmes and HIV programmes, in order:
  - (a) to implement the expanded strategy to control HIV-related tuberculosis;
  - (b) to enhance HIV/AIDS programmes, including delivery of antiretroviral treatment for patients with tuberculosis who are also infected with HIV;
- (3) to implement and strengthen strategies for the effective control of, and management of persons with, drug-resistant tuberculosis;
- (4) to take the lead under national health authorities in working with partners to strengthen and support mechanisms to facilitate sustainable financing of tuberculosis control;
- (5) to enhance WHO's support to the Stop TB Partnership in its efforts to achieve the internationally agreed development goal relevant to tuberculosis contained in the United Nations Millennium Declaration.

(Fourth meeting, 25 May 2004)

**EB114.R2 Cancer prevention and control**

The Executive Board,

Having examined the report on the prevention and control of cancer,<sup>1</sup>

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

Having examined the report on the prevention and control of cancer;

Recalling resolutions WHA51.18 and WHA53.17 on the prevention and control of noncommunicable diseases, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA56.1 on tobacco control, and WHA57.12 on the reproductive health strategy, including control of cervical cancer, and WHA57.16 on health promotion and healthy lifestyles;

Recognizing the suffering of cancer patients and their families and the extent to which cancer threatens development when it affects economically active members of society;

Alarmed by the rising trends of cancer risk-factors, the number of new cancer cases, and cancer morbidity and mortality worldwide, in particular in developing countries;

Recognizing that many of these cases of cancer and deaths could be prevented, and that the provision of palliative care for all individuals in need is an urgent, humanitarian responsibility;

Recognizing that the technology for diagnosis and treatment of cancer is mature and that many cases of cancer may be cured, especially if detected earlier;

Recognizing that tobacco use is the world's most avoidable cause of cancer and that control measures, such as legislation, education, promotion of smoke-free environments, and treatment of tobacco dependence, can be effectively applied in all resource settings;

Recognizing that among all cancer sites cervical cancer, causing 11% of all cancer deaths in women in developing countries, has one of the greatest potential for early detection and cure, that cost-effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health;

Recognizing the value of multidisciplinary management and the importance of surgery, radiotherapy, chemotherapy and other approaches in the treatment of cancer;

Recognizing the contribution of IARC, over 40 years, to research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the causes of cancer, mechanisms of carcinogenesis, and effective strategies for cancer prevention and early detection;

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<sup>1</sup> Document EB114/3.

Mindful of the need for careful planning and priority-setting in the use of resources in order to undertake effective activities to reduce the cancer burden;

Recognizing the importance of adequate funding for cancer prevention and control programmes, especially in developing countries;

Encouraged by the prospects offered by partnerships with international and national organizations within the Global Alliance for Cancer Control, and other bodies such as patient organizations;

Recognizing the support given by IAEA to combat cancer, and welcoming the initiative by the Agency to establish a programme of action for cancer therapy, and research efforts of national cancer institutes in various Member States,

1. URGES Member States:

(1) to collaborate with the Organization in developing and reinforcing comprehensive cancer control programmes tailored to the socioeconomic context, and aimed at reducing cancer incidence and mortality and improving the quality of life of cancer patients and their families, specifically through the systematic, stepwise and equitable implementation of evidence-based strategies for prevention, early detection, diagnosis, treatment, rehabilitation and palliative care, and to evaluate the impact of implementing such programmes;

(2) to integrate national cancer-control programmes in existing health systems that set out outcome-oriented and measurable goals and objectives for the short, medium and long term, as recommended in the Annex to the present resolution, to identify evidence-based, sustainable actions across the continuum of care, and to make the best use of resources to the benefit of the entire population by emphasizing the effective role of primary health care in promoting prevention strategies;

(3) to encourage and to frame policies for strengthening and maintaining technical equipment for diagnosis and treatment of cancer in hospitals providing oncology and other relevant services;

(4) to pay special attention to cancers for which avoidable exposure is a factor, particularly exposure to chemicals in the workplace and the environment, certain infectious agents, and ionizing and solar radiation;

(5) to encourage the scientific research necessary to increase knowledge about the burden and causes of human cancer, giving priority to tumours, such as cervical cancer, that have a high incidence in low-resource settings and are amenable to cost-effective interventions;

(6) to give priority also to research on cancer prevention, early detection and management strategies, including, where appropriate, traditional and herbal medicine;

(7) to consider an approach in the planning, implementation and evaluation phases of cancer control that involves all key stakeholders representing governmental, nongovernmental and community-based organizations, including those representing patients and their families;

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- (8) to ensure access to appropriate information in relation to preventive, diagnostic and treatment procedures and options, especially by cancer patients;
  - (9) to develop appropriate information systems, including outcome and process indicators, that support planning, monitoring and evaluation of cancer prevention and control programmes;
  - (10) to assess periodically the performance of cancer prevention and control programmes, allowing countries to improve the effectiveness and efficiency of their programmes;
  - (11) to participate actively in implementing WHO's integrated health promotion and prevention strategies targeting risk factors for noncommunicable diseases, including cancer, such as tobacco use, unhealthy diet, harmful use of alcohol and exposure to biological, chemical and physical agents known to cause cancer, and to consider signing, ratifying, accepting, approving, formally confirming or acceding to the WHO Framework Convention on Tobacco Control;
  - (12) to determine cost-effective minimum standards, adapted to local situations, for cancer treatment and palliative care that use WHO's strategies for nationwide provision of essential drugs, technologies, diagnostics and vaccines;
  - (13) to ensure the medical availability of opioid analgesics according to international treaties and recommendations of WHO and the International Narcotics Control Board and subject to an efficient monitoring and control system;
  - (14) to ensure, where appropriate, availability of safe and efficacious traditional and herbal medicine;
  - (15) to develop and strengthen health system infrastructure, particularly related to human resources for health, in order to build adequate capacity for effective implementation of cancer prevention and control programmes, including a cancer registry system;
  - (16) to accord high priority to cancer control planning and implementation for high-risk groups, including relatives of patients and those having experienced long-duration and high-intensity carcinogen exposure;
2. REQUESTS the Director-General:
- (1) to develop WHO's work and capacity in cancer prevention and control and to promote effective, comprehensive cancer prevention and control strategies in the context of the global strategy for the prevention and control of noncommunicable diseases, the Global Strategy on Diet, Physical Activity and Health, and resolution WHA57.16 on health promotion and healthy lifestyles, with special emphasis on less developed countries;
  - (2) to strengthen WHO's involvement in international partnerships and collaboration with Member States, other bodies of the United Nations system and actors from a wide variety of related sectors and disciplines in order to advocate, mobilize resources, and build capacity for a comprehensive approach to cancer control;

- (3) to continue developing WHO's strategy for the formulation and refinement of cancer prevention and control programmes by collecting, analysing and disseminating national experiences in that regard, and providing appropriate guidance, upon request, to Member States;
- (4) to contribute to drawing up recommendations on early diagnosis of cancer, especially in order to define and reach the target populations that should benefit from such diagnosis;
- (5) to consider allocating additional resources so that the knowledge provided by research is translated into effective and efficient public-health measures for cancer prevention and control;
- (6) to promote and support research that evaluates low-cost interventions that are affordable and sustainable in low-income countries;
- (7) to support the further development and expansion of a research agenda in IARC and other bodies that is appropriate to the framing of integrated policies and strategies for cancer control;
- (8) to promote guidelines on the ethical care of patients with terminal cancer;
- (9) to provide adequate resources and leadership support to the International Programme on Chemical Safety for its active role in international multisectoral mechanisms for chemical safety, including support for capacity building in chemical safety at country level;
- (10) to support and strengthen mechanisms to transfer to developing countries technical expertise on cancer prevention and control, including surveillance, screening and research;
- (11) to advise Member States, especially the developing countries, on development or maintenance of a national cancer registry containing the type, location of the cancer and its geographical distribution;
- (12) to collaborate with Member States in their efforts to establish national cancer institutes;
- (13) to explore appropriate mechanisms for adequately funding cancer prevention and control programmes, especially in developing countries.

## ANNEX

### **NATIONAL CANCER CONTROL PROGRAMMES: RECOMMENDATIONS FOR OUTCOME-ORIENTED OBJECTIVES**

National health authorities may wish to consider the following outcome-oriented objectives for their cancer control programmes, according to type of cancer:

- preventable tumours (such as those of lung, colon, rectum, skin and liver): to avoid and reduce exposure to risk factors (such as tobacco use, unhealthy diets, harmful use of alcohol,

sedentariness, excess exposure to sunlight, infectious agents, including hepatitis B virus and liver fluke, and occupational exposures), thus limiting cancer incidence;

- cancers amenable to early detection and treatment (such as oral, cervical, breast and prostate cancers): to reduce late presentation and ensure appropriate treatment, in order to increase survival, reduce mortality and improve quality of life;
- disseminated cancers that have potential of being cured or the patients' lives prolonged considerably (such as acute leukaemia in childhood): to provide appropriate care in order to increase survival, reduce mortality and improve quality of life;
- advanced cancers: to enhance relief from pain and other symptoms and improve quality of life of patients and their families.

(Fifth meeting, 26 May 2004)

### **EB114.R3      Disability, including prevention, management and rehabilitation**

The Executive Board,

Having considered the report on disability, including management and rehabilitation,<sup>1</sup>

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

Having considered the report on disability, including management and rehabilitation;

Noting that about six hundred million people live with physical and mental disabilities of various types;

Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, ageing, chronic conditions, malnutrition, war, violence, road-traffic, domestic and occupational injuries and other causes often related to poverty;

Stressing that 80% of people with disabilities live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment;

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<sup>1</sup> Document EB114/4

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure good quality of life regardless of disability;

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;<sup>1</sup>

Recalling also the United Nations World Programme of Action concerning Disabled Persons,<sup>2</sup> indicating inter alia that the sphere of responsibility of WHO includes disability prevention and medical rehabilitation;

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012) and the European Year of People with Disabilities (2003);

Recalling the United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

Mindful that the internationally agreed upon development goals as contained in the United Nations Millennium Declaration would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities;

Recognizing the importance of the early conclusion of the United Nations comprehensive and integral international convention on protection and promotion of the rights and dignity of persons with disabilities;<sup>3</sup>

1. URGES Member States:

- (1) to strengthen national programmes, policies and strategies for the implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (2) to develop their knowledge base with a view to promoting the rights and dignity of persons with disabilities and ensure their full inclusion in society;
- (3) to promote early intervention and identification of disability, especially for children, and full physical, informational, and economic accessibility in all spheres of life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;
- (4) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;

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<sup>1</sup> Adopted by United Nations General Assembly resolution 48/96

<sup>2</sup> United Nations General Assembly resolution 37/52.

<sup>3</sup> United Nations General Assembly resolution 56/168.

- (5) to facilitate access to appropriate assistive technology and to promote its development and other means that encourage the inclusion of persons with disabilities in society;
- (6) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;
- (7) to coordinate policies and programmes on disability with those on ageing where appropriate;
- (8) to ensure gender equality in all measures, with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;
- (9) to participate in the preparatory work for the United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities;<sup>1</sup>

2. REQUESTS the Director-General:

- (1) to intensify collaboration within the Organization in order to work towards enhancing quality of life and promoting the rights and dignity of persons with disabilities inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;
- (2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (3) to support Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;
- (4) to further strengthen collaborative work within the United Nations system and with Member States, academia, private sector, and nongovernmental organizations, including organizations of people with disabilities;
- (5) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;
- (6) to produce a world report on disability and rehabilitation based on the best available scientific evidence;
- (7) to promote a clear understanding of the contributions that people with disabilities can make to society;

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<sup>1</sup> United Nations General Assembly resolution 56/168

(8) to report on progress in implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board.

(Fifth meeting, 26 May 2004)

**EB114.R4      Merger of committees of the Executive Board: terms of reference of the Programme, Budget and Administration Committee**

The Executive Board,

Having decided at its 113th session that the Administration, Budget and Finance Committee, the Audit Committee and the Programme Development Committee should be merged into a single committee;

Taking into account the need to strengthen the role of such a committee in the work of the Board,

1. DECIDES to abolish the Administration, Budget and Finance Committee, the Programme Development Committee and the Audit Committee and to establish a single committee, called the Programme, Budget and Administration Committee, with the terms of reference, periodicity of meetings, composition and terms of office, and requirements for membership as annexed;
2. DECIDES that the Programme, Budget and Administration Committee shall hold its first meeting from Wednesday to Friday before the opening of the 115th session of the Board.

ANNEX

**TERMS OF REFERENCE**

1. To review and, as appropriate, make recommendations to the Executive Board on:
  - (a) the general programme of work,
  - (b) the programme budget and performance assessment report,
  - (c) evaluations,
  - (d) the Interim Financial Report, the Financial Report and audited financial statements, together with the report of the External Auditor thereon,
  - (e) the audit plans of the External and Internal Auditors and any reports submitted by them to the Executive Board,
  - (f) the reports of the Joint Inspection Unit,
  - (g) the Secretariat's responses to matters referred to in subsections (b) to (f) above,

- (h) other financial and administrative matters on the proposed agenda for the next session of the Executive Board,
  - (i) any other matter referred by the Executive Board.
2. To act on behalf of the Executive Board:
- (a) to consider the situation of the Members in arrears to an extent that would justify invoking Article 7 of the Constitution,
  - (b) to examine the Interim Financial Report, the Financial Report and audited financial statements and the report of the External Auditor,
  - (c) to consider any other programme, administrative, budgetary or financial matter that the Board may deem appropriate,
  - (d) to make comments or recommendations on all these matters directly to the Health Assembly.

## **PERIODICITY OF MEETINGS**

The Committee shall meet twice annually: for up to three days (in budget years) before the January session of the Board, and for up to two days before the Health Assembly. The report of the Committee would be presented to the Board early in each session, so that any recommendations contained therein might be fully considered during the Board's deliberations.

## **COMPOSITION OF THE COMMITTEE**

Bearing in mind the need for geographical representation and a reasonably sized committee, thus providing a range of perspectives, the Committee shall be composed of 14 members, two from each region selected from among Board members, plus the Chairman and a Vice-Chairman of the Board, ex officio.

## **TERMS OF OFFICE OF MEMBERS**

Committee members should ideally serve for a two-year period, to allow for some continuity. There shall be two office-bearers: a Chairman and a Vice-Chairman. They would be nominated from among Committee members, for a one-year term, or two sessions of the Committee, in the first instance, with a possibility of extending for a further year if they were still members of the Board. A practice could eventually be established by which the Vice-Chairman would be selected from incoming members, and could then serve as Chairman during the second year in office.

(Sixth meeting, 26 May 2004)

## DECISIONS

### **EB114(1)      Membership of the Executive Board's Standing Committee on Nongovernmental Organizations**

The Executive Board appointed Dr A.A. Yoosuf (Maldives) and Mrs Le Thi Thu Ha (Viet Nam) as members of its Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Dr F. Huerta Montalvo (Ecuador), Dr F. Lamata Cotanda (Spain) and Dr A.B. Osman (Sudan), already members of the Committee. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the Government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(First meeting, 24 May 2004)

### **EB114(2)      Membership of the Léon Bernard Foundation Committee**

The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Dr D. Hansen-Koenig (Luxembourg) as a member of the Léon Bernard Foundation Committee for the duration of her term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Dr Hansen-Koenig was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Sixth meeting, 26 May 2004)

### **EB114(3)      Membership of the Jacques Parisot Foundation Selection Panel**

The Executive Board, in accordance with the Implementing Regulations of the Jacques Parisot Foundation, appointed Dr O. Brînzan (Romania) as a member of the Jacques Parisot Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Dr Brînzan was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.

(Sixth meeting, 26 May 2004)

### **EB114(4)      Membership of the State of Kuwait Health Promotion Foundation Selection Panel**

The Executive Board, in accordance with the Statutes of the State of Kuwait Health Promotion Foundation, appointed Mr M.N. Khan (Pakistan) as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman of the Board and a representative of the founder, members ex officio. It was understood that if Mr Khan was unable to attend, his successor or the alternate member of the Board

designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.

(Sixth meeting, 26 May 2004)

**EB114(5)            Membership of the Sasakawa Health Prize Selection Panel**

The Executive Board, in accordance with the Statutes of the Sasakawa Health Prize, appointed Dr V. Tangi (Tonga) as a member of the Sasakawa Health Prize Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman of the Board and a representative of the founder, members ex officio. It was understood that if Dr Tangi was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.

(Sixth meeting, 26 May 2004)

**EB114(6)            Membership of the United Arab Emirates Health Foundation Selection Panel**

The Executive Board, in accordance with the Statutes of the United Arab Emirates Health Foundation, appointed Dr N.A. Haffadh (Bahrain) as a member of the United Arab Emirates Health Foundation Selection Panel for the duration of her term of office on the Executive Board, in addition to the Chairman of the Board and a representative of the Founder, members ex officio. It was understood that if Dr Haffadh was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.

(Sixth meeting, 26 May 2004)

**EB114(7)            Membership of the Programme, Budget and Administration Committee of the Executive Board**

In accordance with resolution EB114.R4, Annex, the newly established Programme, Budget and Administration Committee of the Executive Board comprises 14 members, namely, two from each of WHO's six regions, together with the Chairman and a Vice-Chairman of the Board, members ex officio. The Board decided, having regard to those members of the Programme Development Committee, the Administration, Budget and Finance Committee and the Audit Committee who had not yet completed their two-year term of membership, to provide for membership of the Programme, Budget and Administration Committee as follows: Mr D.Á. Gunnarsson (Iceland), Chairman of the Board, member ex officio; Dr A.A. Yoosuf (Maldives), Vice-Chairman of the Board, member ex officio; Mr I. Shugart (Canada), Dr Yin Li (China), Professor B. Fišer (Czech Republic), Dr M. Camara (Guinea), Dr H.N. Acharya (Nepal) and Mr M.N. Khan (Pakistan), appointed for a one-year period; Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Professor W. Dab (France), Mr T. Ramotsoari (Lesotho) (alternate to Dr M. Phooko), Mrs Sudarat Keyuraphan (Thailand) and Dr W.R. Steiger (United States of America), appointed for a two-year period or until expiry of their membership on the Board, whichever occurs first. Subsequent appointments should, to the extent possible, be made with a view to renewing half the elected membership each year, that is, one member from each WHO region.

It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.

(Sixth meeting, 26 May 2004)

**EB114(8)      Appointment of representatives of the Executive Board at the Fifty-eighth World Health Assembly**

The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Mr D.Á. Gunnarsson (Iceland), *ex officio*, and its first three Vice-Chairmen, Dr A.B. Osman (Sudan), Dr Yin Li (China) and Dr A.A. Yoosuf (Maldives), to represent the Board at the Fifty-eighth World Health Assembly.

(Sixth meeting, 26 May 2004)

**EB114(9)      Date, place and duration of the 115th session of the Executive Board**

The Executive Board decided that its 115th session should be convened on Monday, 17 January 2005, at WHO headquarters, Geneva, and should close no later than Tuesday, 25 January 2005.

(Sixth meeting, 26 May 2004)

**EB114(10)      Place, date and duration of the Fifty-eighth World Health Assembly**

The Executive Board decided that the Fifty-eighth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 16 May 2005, and that it should close no later than Wednesday, 25 May 2005.

(Sixth meeting, 26 May 2004)

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**PART II**

**SUMMARY RECORDS**



## LIST OF MEMBERS AND OTHER PARTICIPANTS

### MEMBERS, ALTERNATES AND ADVISERS

#### ICELAND

Mr D.Á. GUNNARSSON, Permanent Secretary, Ministry of Health and Social Security, Reykjavik  
(Chairman)

*Alternates*

Mr S.H. JÓHANNESSON, Ambassador, Permanent Representative, Geneva

Mr I. EINARSSON, Director of Department, Ministry of Health and Social Security, Reykjavik

Ms V. INGÓLFSDÓTTIR, Chief Nursing Officer, Directorate of Health, Reykjavik

Mr E. MAGNÚSSON, Chief Pharmacist, Ministry of Health and Social Security, Reykjavik

Mr H.M. ARTHÚRSSON, Information Officer, Ministry of Health and Social Security,  
Reykjavik

Ms A. KNÚTSDÓTTIR, Adviser, Permanent Mission, Geneva

#### AUSTRALIA

Ms J. HALTON, Secretary, Department of Health and Ageing, Canberra

*Alternates*

Mr T. KINGDON, National Manager, Office of Hearing Services, Department of Health and  
Ageing, Canberra

Mr R. ECKHARDT, Director, International Policy and Communications Section, Department  
of Health and Ageing, Canberra

Mr M. SMITH, Ambassador, Permanent Representative, Geneva

Ms A. GORELY, Counsellor, Permanent Mission, Geneva

Mr M. SAWERS, First Secretary, Permanent Mission, Geneva

#### BAHRAIN

Dr A.W. MOHAMMED, Assistant Under-Secretary for Primary and Public Health, Ministry of  
Health, Manama (**alternate to Dr N.A. Haffadh**)

#### BOLIVIA

Dr. F. CISNEROS, Asesor General, Ministerio de Salud y Deportes, La Paz (**alternate to  
Dr. F. Antezana Aranibar**)

*Alternate*

Sr. G. RODRÍGUEZ SAN MARTÍN, Ministro Consejero, Misión Permanente, Ginebra

**BRAZIL**

Dr J.A. ZEPEDA BERMUDEZ, Director, National School of Public Health, Ministry of Health, Brasília

*Alternates*

Mr C.A. DA ROCHA PARANHOS, Alternate Permanent Representative, Geneva

Dr A.C. DO NASCIMENTO PEDRO, Minister Counsellor, Permanent Mission, Geneva

Dr J. BARBOSA DA SILVA Jr, Secretary, Health Surveillance Unit, Ministry of Health, Brasília

Dr A. DOMINGUES GRANJEIRO, Director, National Coordinator of STD/AIDS, Ministry of Health, Brasília

Mr P.M. DE CASTRO SALDANHA, Second Secretary, Permanent Mission, Geneva

Dr M. SIMÕES, Director, Division of International Cooperation - STD/AIDS Programme, Ministry of Health, Brasília

**CANADA**

Mr I. SHUGART, Assistant Deputy Minister of Health, Department of Health Canada, Ottawa

*Alternates*

Mr P. MEYER, Ambassador, Alternate Permanent Representative, Geneva

Ms C. GILDERS, Director-General, International Affairs Directorate, Department of Health Canada, Ottawa

Mr I. FERGUSON, Minister, Deputy Permanent Representative, Geneva

Dr J. LARIVIÈRE, Senior Medical Officer, International Affairs Directorate, Department of Health Canada, Ottawa

Mr D. MACPHEE, Counsellor and Consul, Permanent Mission, Geneva

Mr D. STRAWCZYNSKI, International Affairs Directorate, Department of Health Canada, Ottawa

**CHINA**

Dr YIN Li, Director-General, Department of International Cooperation, Ministry of Health, Beijing  
(**Vice-Chairman**)

*Alternates*

Mr YU Kangzhen, Director, National Animal Husbandry and Veterinarian Services, Ministry of Agriculture, Beijing

Dr QI Qingdong, Director, Department of International Cooperation, Ministry of Health, Beijing

Dr DENG Hongmei, Adviser, Permanent Mission, Geneva

Mr YANG Xiaokun, Second Secretary, Permanent Mission, Geneva

Ms LIU Guangyuan, Assistant Consultant, Department of International Cooperation, Ministry of Health, Beijing

**CZECH REPUBLIC**

Professor B. FIŠER, Head, Physiology Institute of the Masaryk University, Brno

*Alternate*

Mr I. PINTÉR, Counsellor, Permanent Mission, Geneva

**ECUADOR**

Dr. F. HUERTA MONTALVO, Presidente, Fundación “Eugenio Espejo”, Consejo Nacional de Educación Superior, Quito (**Vice-Chairman**)

*Alternates*

Sr. H. ESCUDERO MARTÍNEZ, Embajador, Representante Permanente, Ginebra

Sr. R. PAREDES PROAÑO, Ministro, Representante Permanente Alterno, Ginebra

Sr. D. MAYORGA, Primer Secretario, Misión Permanente, Ginebra

Sr. L. ESPINOSA SALAS, Segundo Secretario, Misión Permanente, Ginebra

**FRANCE**

Professeur W. DAB, Directeur général de la Santé, Ministère de la Santé et de la Protection sociale, Paris

*Alternates*

M. J.-B. BRUNET, Direction générale de la Santé, Ministère de la Santé et de la Protection sociale, Paris

M. M. GIACOMINI, Représentant permanent adjoint, Genève

Mme F. AUER, Conseiller, Mission permanente, Genève

Mme I. VIREM, Direction générale de la Santé, Ministère de la Santé et de la Protection sociale, Paris

Mme E. SICARD, Délégation aux Affaires européennes et internationales, Ministère de la Santé et de la Protection sociale, Paris

*Adviser*

Mme N. MATHIEU, Mission permanente, Genève

**GABON**

Dr J.-B. NDONG, Inspecteur général de la Santé, Ministère de la Santé publique, Libreville

*Alternates*

Mme Y. BIKÉ, Ambassadeur, Représentant permanent, Genève

Mme M. ANGONE ABENA, Conseiller, Mission permanente, Genève

**GAMBIA**

Dr Y. KASSAMA, Secretary of State for Health and Social Welfare, Banjul

*Alternates*

Mr E.A. KHAN, Permanent Secretary, Department of State for Health and Social Welfare, Banjul

Dr O. SAM, Director of Health Services, Department of State for Health and Social Welfare, Banjul

**GHANA**

Dr A.K. AFRIYIE, Minister of Health, Accra

*Alternates*

Mr F.K. POKU, Ambassador, Permanent Representative, Geneva

Dr K. AHMED, Chief Medical Officer, Ministry of Health, Accra

Dr A. NSIAH ASARE, Chief Executive Officer, Komfo Anokye Hospital, Kumasi  
Ms V. TETTEGAH, First Secretary, Permanent Mission, Geneva  
Ms M.A. ALOMATU, First Secretary, Permanent Mission, Geneva

## GUINEA

Dr M. CAMARA, Secrétaire général, Ministère de la Santé publique, Conakry

## GUINEA-BISSAU

Dr J.C. SÁ NOGUEIRA, Directeur général de la Santé publique, Ministère de la Santé publique,  
Bissau

## JAMAICA

Mr J. JUNOR, Minister of Health, Kingston

### *Alternates*

Mr R. SMITH, Ambassador, Permanent Representative, Geneva

Dr E. LEWIS-FULLER, Director of Cooperation in Health and Policy Analyst, Ministry of  
Health, Kingston

Ms S. BETTON, First Secretary, Permanent Mission, Geneva

## KENYA

Dr J. NYIKAL, Director for Medical Services, Preventive and Promotive Health Services, Ministry of  
Health, Nairobi (**Rapporteur**)

### *Alternates*

Mrs A.C. MOHAMED, Ambassador, Permanent Representative, Geneva

Mr P.R.O. OWADE, Deputy Permanent Representative, Geneva

Mrs L. NYAMBU, First Secretary, Permanent Mission, Geneva

## KUWAIT

Mr D.A.R. RAZZOOQI, Ambassador, Permanent Representative, Geneva (**alternate to  
Dr M.A. Al-Jarallah**)

### *Alternates*

Dr A. AL-SAIF, Assistant Under-Secretary for Public Health Affairs, Ministry of Public Health,  
Safat

Mr N. AL-BADER, First Secretary, Permanent Mission, Geneva

## LESOTHO

Mr T. RAMOTSOARI, Principal Secretary, Ministry of Health and Social Welfare, Maseru (**alternate  
to Dr M. Phooko**)

**LIBYAN ARAB JAMAHIRIYA**

Dr F. AL-KEEB, Director, General Planning Board for Primary Medical Care, General People's Committee, Jufra

*Alternates*

Mr A. BENOMRAN, Minister, Permanent Mission, Geneva

Mr M. HAMAIMA, Minister, Permanent Mission, Geneva

**LUXEMBOURG**

Dr D. HANSEN-KOENIG, Directeur de la Santé, Ministère de la Santé, Luxembourg

*Alternates*

Mme D. GREGR, Attaché, Mission permanente, Genève

Mme C. KAPP, Attaché, Mission permanente, Genève

Mme A. PESCH, Attaché, Mission permanente, Genève

Mme M. ROSSY, Attaché, Mission permanente, Genève

M. V. THURMES, Attaché, Mission permanente, Genève

**MALDIVES**

Dr A.A. YOOSUF, Director-General of Health Services, Ministry of Health, Malé (**Vice-Chairman**)

**NEPAL**

Dr H.N. ACHARYA, Chief, Policy Planning and International Cooperation Division, Ministry of Health, Kathmandu

*Alternate*

Mr G.B. THAPA, Minister Counsellor, Permanent Mission, Geneva

**PAKISTAN**

Mr M.N. KHAN, Federal Minister of Health, Islamabad

*Alternates*

Mr M. ASLAM, Director-General, Ministry of Health, Islamabad

Dr A. AHMED, Deputy Director-General, Ministry of Health, Islamabad

Mr R.S. SHEIKH, First Secretary, Permanent Mission, Geneva

**ROMANIA**

Mr R. CONSTANTINIU, Director-General, General Directorate for European Integration and International Relations, Ministry of Health, Bucharest (**alternate to Dr O. Brînzan**)

*Alternate*

Mrs D. IORDACHE, First Secretary, Permanent Mission, Geneva

## RUSSIAN FEDERATION

Mr S.M. FURGAL, Director, Department of International Cooperation, Ministry of Health, Moscow  
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*Alternates*

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Mr A.V. PIROGOV, Deputy Permanent Representative, Geneva

Mr V.M. ZIMYANIN, Senior Adviser, Department of International Organizations, Ministry of Foreign Affairs, Moscow

Mr A.A. PANKIN, Senior Counsellor, Permanent Mission, Geneva

Mr N.V. LOZINSKIY, Senior Counsellor, Permanent Mission, Geneva

Mr N.N. SIKACHEV, Counsellor, Permanent Mission, Geneva

## SPAIN

Dr. F. LAMATA COTANDA, Secretario General de Sanidad, Ministerio de Sanidad y Consumo, Madrid

*Alternates*

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Dra. P. ALONSO CUESTA, Subdirectora General de Relaciones Internacionales, Ministerio de Sanidad y Consumo, Madrid

Sr. G. LÓPEZ MAC-LELLAN, Consejero, Misión Permanente, Ginebra

## SUDAN

Dr A.B. OSMAN, Federal Minister of Health, Khartoum (**Vice-Chairman**)

## THAILAND

Dr VALLOP THAINEUA, Permanent Secretary, Ministry of Public Health, Bangkok (**alternate to Mrs Sudarat Keyuraphan**)

*Alternate*

Dr PAKDEE POTHISIRI, Deputy Permanent Secretary, Ministry of Public Health, Bangkok

*Advisers*

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Dr SOPIDA CHAVANICHKUL, Chief, International Health Group, Bureau of Policy and Strategy, Ministry of Public Health, Bangkok

Ms WARANYA TEOKUL, Office of National Economic and Social Development Board, Bangkok

Ms CHA-AIM PACHANEE, Bureau of Policy and Strategy, Ministry of Public Health, Bangkok

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Dr KRIT PONGPIRUL, Researcher, International Health Policy Programme, Ministry of Public  
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## **TONGA**

Dr V. TANGI, Minister of Health, Nuku'alofa

## **UNITED STATES OF AMERICA**

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Affairs, Department of Health and Human Services, Washington, DC

### *Alternates*

Ms A. BLACKWOOD, Director for Health Programs, Office of Technical Specialized  
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Miss D. GIBB, Senior Policy Adviser, Bureau for Global Health, Agency for International  
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Mr D.E. HOHMAN, Health Attaché, Permanent Mission, Geneva

Mr C. STONECIPHER, International Resource Management Officer, Permanent Mission,  
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Ms M.L. VALDEZ, Deputy Director for Policy, Office of Global Health Affairs, Office of the  
Secretary, Department of Health and Human Services, Washington, DC

## **VIET NAM**

Mrs LE THI THU HA, Deputy Director, Department of International Cooperation, Ministry of Health,  
Hanoi (**alternate to Executive Board member**)

## **MEMBER STATES NOT REPRESENTED ON THE EXECUTIVE BOARD<sup>1</sup>**

### **ALGERIA**

Mlle D. SOLTANI, Secrétaire diplomatique, Mission permanente, Genève

### **ANGOLA**

Dr E. NETO SANGUEVE, First Secretary, Permanent Mission, Geneva

Dr S. NETO DE MIRANDA, Assistant for Health, Permanent Mission, Geneva

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

**ARGENTINA**

Srta. A. DE HOZ, Ministro, Misión Permanente, Ginebra

**BANGLADESH**

Mr K.I. HOSSAIN, Counsellor, Permanent Mission, Geneva

Mr M.D. ISLAM, Second Secretary, Permanent Mission, Geneva

**BELIZE**

Ms A. HUNT, Chargé d'affaires, Permanent Mission, Geneva

Mr M. TAMASKO, Permanent Mission, Geneva

**BOSNIA AND HERZEGOVINA**

Mr M. VUKAŠINOVIĆ, Ambassador, Permanent Representative, Geneva

Mrs D. KREMENOVIĆ-KUSMUK, First Secretary, Permanent Mission, Geneva

**BOTSWANA**

Mr G. PITSO, First Secretary, Permanent Mission, Geneva

**CHILE**

Sr. J. MARTABIT, Embajador, Representante Permanente, Ginebra

Dr. F. MUÑOZ PORRAS, Jefe, División de Rectoría y Regulación Sanitaria, Ministerio de Salud, Santiago de Chile

Dr. R. TAPIA HIDALGO, Jefe, Oficina de Cooperación y Asuntos Internacionales, Ministerio de Salud, Santiago de Chile

Sr. J.E. EGUIGUREN, Ministro Consejero, Misión Permanente, Ginebra

Sr. P. UTRERAS, Primer Secretario, Misión Permanente, Ginebra

Sr. B. DEL PICÓ RUBIO, Segundo Secretario, Misión Permanente, Ginebra

**COLOMBIA**

Dra. C. FORERO UCRÓS, Embajadora, Representante Permanente, Ginebra

Sr. L.G. GUZMÁN VALENCIA, Ministro Consejero, Misión Permanente, Ginebra

**CUBA**

Sr. J.I. MORA GODOY, Embajador, Representante Permanente, Ginebra

Sr. O. LEÓN GONZÁLEZ, Segundo Secretario, Misión Permanente, Ginebra

**DENMARK**

Ms M. KRISTENSEN, Medical Adviser, Ministry of Health, Copenhagen  
Mr M.B. JENSEN, Secretary of Embassy, Permanent Mission, Geneva

**DOMINICAN REPUBLIC**

Dra. M. BELLO DE KEMPER, Consejero, Misión Permanente, Ginebra

**EGYPT**

Mrs N. GABR, Ambassador, Permanent Representative, Geneva  
Mr H. SELIM LABIB, Counsellor, Permanent Mission, Geneva  
Mr A.A. LATIF, Second Secretary, Permanent Mission, Geneva

**FINLAND**

Ms A. VUORINEN, Minister Counsellor, Permanent Mission, Geneva  
Ms K. HÄIKIÖ, Counsellor, Permanent Mission, Geneva  
Mr M. JASKARI, Counsellor, Ministry of Foreign Affairs, Helsinki  
Ms E. TAIPALE, Permanent Mission, Geneva

**GERMANY**

Mr I. VON VOSS, Counsellor, Permanent Mission, Geneva  
Mr R. KRECH, Section Head, Social Protection, German Society for Technical Cooperation,  
Eschborn

**GREECE**

Dr M. VIOLAKI-PARASKEVA, Honorary Director General, Ministry of Health and Social  
Solidarity, Athens  
Mr A. CAMBITSIS, Expert Minister Counsellor, Permanent Mission, Geneva

**INDIA**

Mr D. SAHA, Deputy Permanent Representative, Geneva  
Mr B.P. SHARMA, Joint Secretary, Department of Health, Ministry of Health and Family Welfare,  
New Delhi  
Mr R. BHUSHAN, Director, Department of Health, Ministry of Health and Family Welfare, New  
Delhi  
Mr A.K. CHATTERJEE, First Secretary, Permanent Mission, Geneva

**IRELAND**

Ms M. WHELAN, Ambassador, Permanent Representative, Geneva  
Mr C. KEENAN, International Unit, Department of Health and Children, Dublin  
Ms S. MANGAN, First Secretary, Permanent Mission, Geneva  
Ms M. AYLWARD, International Unit, Department of Health and Children, Dublin  
Ms S. CULLEN, International Unit, Department of Health and Children, Dublin

**ISRAEL**

Dr Y. SEVER, Director, Department of International Relations, Ministry of Health, Jerusalem  
Mr H. WAXMAN, Counsellor, Permanent Mission, Geneva  
Mrs E. ZARKA, Counsellor, Permanent Mission, Geneva  
Mrs S. HERLIN, Permanent Mission, Geneva

**ITALY**

M. P. BRUNI, Ambassadeur, Représentant permanent, Genève  
M. V. SIMONETTI, Ministre conseiller, Représentant permanent adjoint, Genève  
Mme L. FIORI, Premier conseiller, Mission permanente, Genève  
Professeur G. MAJORI, Directeur, Laboratoire de Parasitologie, Institut supérieur de la Santé, Rome  
Dr F. CICOGNA, Bureau des Relations internationales, Ministère de la Santé, Rome  
Dr A. GHIRARDINI, Direction générale de la Programmation, Ministère de la Santé, Rome  
Mme M.P. RIZZO, Ministère des Affaires étrangères, Rome  
Dr L. PECORARO, Institut d'Hygiène et de Santé publique, Rome  
Mme V. MARIDATI, Attaché, Mission permanente, Genève

**JAPAN**

Dr T. KASAI, Director, Office for WHO, International Affairs Division, Minister's Secretariat,  
Ministry of Health, Labour and Welfare, Tokyo  
Mr S. HEMMI, First Secretary, Permanent Mission, Geneva

**JORDAN**

Mr H. AL HUSSEINI, First Secretary, Permanent Mission, Geneva

**KAZAKHSTAN**

Mr N. DANENOV, Ambassador, Permanent Representative, Geneva  
Mr A. AKHMETOV, Minister Counsellor, Permanent Mission, Geneva

**KYRGYZSTAN**

Mrs Z. SHAIMERGENOVA, Ambassador, Permanent Representative, Geneva  
Mr A. ERKIN, First Secretary, Permanent Mission, Geneva

**LATVIA**

Ms G. VITOLA, Third Secretary, Permanent Mission, Geneva

**LEBANON**

Dr K. KARAM, Minister of State, Beirut

**LITHUANIA**

Mr E. PETRIKAS, Minister Counsellor, Permanent Mission, Geneva

Mrs R. KAZRAGIENE, Deputy Director, Ministry of Foreign Affairs, Vilnius

**MEXICO**

Dr. C. RUIZ, Coordinador de Asesores del Subsecretario de Prevención y Promoción de la Salud, Secretaría de Salud, México, DF

Sr. M. BAILÓN, Director General de Relaciones Internacionales, Secretaría de Salud, México, DF

Sra. D.M. VALLE, Consejero, Misión Permanente, Ginebra

Sra. A.L. CALDERÓN, Jefe de Departamento de enlace con la OMS, Dirección General de Relaciones Internacionales, Secretaría de Salud, México, DF

**MONACO**

M. G. NOGHES, Ambassadeur, Représentant permanent, Genève

Mlle C. LANTERI, Premier Secrétaire, Mission permanente, Genève

M. A. JAHLAN, Troisième Secrétaire, Mission permanente, Genève

**MOROCCO**

M. O. HILALE, Ambassadeur, Représentant permanent, Genève

Mme S. BOUASSA, Conseiller, Mission permanente, Genève

**MYANMAR**

Mr MYA THAN, Ambassador, Permanent Representative, Geneva

Mrs AYE AYE MU, Counsellor, Permanent Mission, Geneva

Mr THA AUNG NYUN, Counsellor, Permanent Mission, Geneva

Mr KYAW THU NYEIN, Second Secretary, Permanent Mission, Geneva

Miss FLORA SAITO, Attaché, Permanent Mission, Geneva

**NETHERLANDS**

Mr I. DE JONG, Ambassador, Permanent Representative, Geneva

Mr P. SCIARONE, Deputy Permanent Representative, Geneva

Ms M. MIDDELHOFF, First Secretary, Permanent Mission, Geneva

**NEW ZEALAND**

Mr N. KIDDLE, Deputy Permanent Representative, Geneva

**NICARAGUA**

Mr N. CRUZ, Chargé d'affaires, Permanent Mission, Geneva

Mrs M.P. HERNÁNDEZ, First Secretary, Permanent Mission, Geneva

Ms P. CAMPBELL, First Secretary, Permanent Mission, Geneva

**NORWAY**

Ms T. KONGSVIK, Counsellor, Permanent Mission, Geneva

Mr S.I. NESVÅG, Adviser, Permanent Mission, Geneva

**PHILIPPINES**

Dr M.M. DAYRIT, Secretary, Department of Health, Manila

Mr E.A. MANALO, Ambassador, Permanent Representative, Geneva

Ms J. MAHILUM-WEST, First Secretary, Permanent Mission, Geneva

Mr R.L. TEJADA, Second Secretary, Permanent Mission, Geneva

Dr Y. OLIVEROS, Head Executive Assistant, Director III, Department of Health, Manila

**PORTUGAL**

M. J.C. DA COSTA PEREIRA, Ambassadeur, Représentant permanent, Genève

Professeur J. PEREIRA MIGUEL, Directeur général de la Santé, Lisbonne

M. P. BÁRCIA, Conseiller, Mission permanente, Genève

**REPUBLIC OF KOREA**

Mr H.-H. AHN, Counsellor, Permanent Mission, Geneva

**SAN MARINO**

Mme F. BIGI, Ambassadeur, Représentant permanent, Genève

**SENEGAL**

M. O. CAMARA, Ambassadeur, Représentant permanent, Genève

M. D.M. SENE, Ministre Conseiller, Mission permanente, Genève

M. A. BASSE, Premier Secrétaire, Mission permanente, Genève

**SLOVAKIA**

Mrs J. BARTOSIEWICZOVÁ, Counsellor, Permanent Mission, Geneva

**SOUTH AFRICA**

Ms D. MAFUBELU, Counsellor, Permanent Mission, Geneva

**SWEDEN**

Ms P. STAVÅS, Counsellor, Permanent Mission, Geneva

Ms D. ALOPAEUS-STÅHL, Director, Ministry of Foreign Affairs, Stockholm

**SWITZERLAND**

M. G. SILBERSCHMIDT, Chef, Division des Affaires internationales, Office fédéral de la Santé publique, Berne

M. A. VON KESSEL, Division des Affaires internationales, Office fédéral de la Santé publique, Berne

Dr M. BERGER, Adjoint scientifique, Direction du Développement et de la Coopération, Département fédéral des Affaires étrangères, Berne

M. J. MARTIN, Section Affaires multilatérales, Direction du Développement et de la Coopération, Département fédéral des Affaires étrangères, Berne

M. F. DEL PONTE, Direction du Développement et de la Coopération, Département fédéral des Affaires étrangères, Berne

**TUNISIA**

M. M.H. MANSOUR, Ambassadeur, Représentant permanent, Genève

M. H. LANDOULSI, Conseiller, Mission permanente, Genève

**TURKEY**

Mr H. ERGANI, Second Secretary, Permanent Mission, Geneva

**UNITED KINGDOM OF GREAT BRITAIN AND NORTHERN IRELAND**

Dr C. PRESERN, First Secretary, Permanent Mission, Geneva

Dr W. THORNE, Senior Medical Adviser, Department of Health, London

Ms H. NELLTHORP, First Secretary, Permanent Mission, Geneva

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Sra. B. PORTOCARRERO, Embajadora, Representante Permanente, Ginebra

Dra. A. ABREU CATALÁ, Directora de Cooperación Técnica y Relaciones Internacionales, Ministerio de la Salud, Caracas

Sra. M. HERNÁNDEZ, Ministro Consejero, Misión Permanente, Ginebra

Dra. K. GUZMÁN PORTOCARRERO, Representante del Ministerio de la Salud para el Programa de Inmonutrición, Caracas

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Mr M. BURCHARD, Chief, Liaison Office,  
Geneva

Ms R. AL-HADDAD, Liaison Office, Geneva

#### **World Food Programme**

Mr D. BELGASMI, Director, WFP Liaison  
Office, Geneva

#### **United Nations Population Fund**

Dr V. FAUVEAU, Senior Adviser, Maternal  
Health, UNFPA Office, Geneva

Mr E. PALSTRA, Senior External Relations  
Officer, UNFPA Office, Geneva

#### **International Narcotics Control Board**

Dr P.O. EMAFO, President

Ms E. BAYER, Drug Control Officer,  
Narcotics Control and Estimates Section

### **SPECIALIZED AGENCIES**

#### **International Labour Organization**

Mr A. BONILLA-GARCIA, Social Protection  
Sector

Dr I. HERRELL, Social Protection Sector

#### **Food and Agriculture Organization of the United Nations**

Mr T.N. MASUKU, Director, FAO Liaison  
Office, Geneva

#### **World Meteorological Organization**

Dr B. NYENZI, Chief, World Climate  
Applications and CLIPS Division, World  
Climate Programme

#### **World Intellectual Property Organization**

Mrs K. LEE RATA, Senior Counsellor,  
External Relations

#### **International Atomic Energy Agency**

Mr P. ANDREO, Division of Human Health,  
IAEA Office, Geneva

Ms J. RISSANEN, External Relations Officer,  
IAEA Office, Geneva

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Dr F. BERLINGIERI, International Trade  
Department

#### **African Union**

Mrs S.A. KALINDE, Ambassador, Permanent  
Observer, Geneva

Mr V. WEGE NZOMWITA, Counsellor,  
Permanent Delegation, Geneva

**European Commission**

Mrs M.-A. CONINSX, Minister Counsellor,  
Permanent Delegation, Geneva  
Mrs I. DE LA MATA, Directorate General for  
Health and Consumer Protection, Brussels  
Mrs P. DUARTE GASPAR, Administrator,  
Directorate General for Health and  
Consumer Protection, Luxembourg  
Mrs A. AJOUR, Administrator, Directorate  
General for Health and Consumer  
Protection, Brussels  
Mr C. DUFOUR, Attaché, Permanent  
Delegation, Geneva

**International Organization for Migration**

Dr D. GRONDIN, Director, Migration Health  
Services  
Ms J. WEEKERS, Senior Migration Health  
Adviser

### **REPRESENTATIVES OF NONGOVERNMENTAL ORGANIZATIONS IN OFFICIAL RELATIONS WITH WHO**

**Association of the Institutes and Schools of  
Tropical Medicine in Europe**

Dr D. VAN DER ROOST

**Council on Health Research for  
Development**

Professor C. IJSSELMUIDEN

**Council for International Organizations of  
Medical Sciences**

Dr J.E. IDÄNPÄÄN-HEIKKILÄ  
Dr J. VENULET  
Mr S. FLUSS

**Cystic Fibrosis Worldwide**

Mrs C. NOKE  
Mrs G. STEENKAMER

**FDI World Dental Federation**

Dr J.T. BARNARD  
Dr H. BENZIAN  
Ms C. NACKSTAD

**German Pharma Health Fund e.v.**

Dr C. FINK-ANTHE

**Global Forum for Health Research**

Mr A. DE FRANCISCO  
Mr A. GHAFAR  
Ms M.A. BURKE  
Ms S. OLIFSON  
Ms S. AL-TUWAIJRI

**Global Health Council**

Ms S. DE HAAN

**Inter-American Association of Sanitary and  
Environmental Engineering**

Mr O. SPERANDIO

**International Alliance of Women**

Mrs H. SACKSTEIN  
Mrs M. PAL

**International Association for Maternal and  
Neonatal Health**

Dr R. KULIER

**International Association for the Study of  
Obesity**

Mr N. RIGBY  
Professor P. JAMES

**International Association of Cancer Registries**

Dr R. ZANETTI

**International Catholic Committee of Nurses and Medico-social Assistants**Mme A. VERLINDE  
Mme D. ROSIER**International College of Surgeons**Professor P. HAHNLOSER  
Dr R. DIETER  
Professor C.-J. LEE  
Professor N. HAKIM  
Mr M. DOWNHAM**International Council of Nurses**Dr J.A. OULTON  
Dr T. GHEBREHIWET  
Dr M. KINGMA  
Ms P. HUGHES  
Dr S. FERGUSON  
Mrs L. CARRIER-WALKER**International Council of Women**

Mrs P. HERZOG

**International Federation of Business and Professional Women**Ms M. GERBER  
Ms G. GONZENBACH**International Federation of Pharmaceutical Manufacturers Associations**Dr H.E. BALE  
Mr B. AZAIS  
Dr E. NOEHRENBURG  
Dr O. MORIN  
Mr M. GAJEWSKI  
Dr R. KRAUSE  
Mr T. SANOMr A. MURDOCH  
Ms A.-L. BOFFI  
Ms S. CROWLEY**International Federation of Surgical Colleges**

Dr S.W.A. GUNN

**International Life Sciences Institute**

Dr N. VAN BELZEN

**International Organisation of Consumers Unions (Consumers International)**Dr L. LHOTSKA  
Ms A. LINNECAR**International Organization for Standardization**

Mr T.J. HANCOX

**International Society of Andrology**

Dr M. MBIZVO

**International Society of Physical and Rehabilitation Medicine**Professor G. STUCKI  
Dr J. MELVIN**International Union against Cancer**

Mrs I. MORTARA

**Rotary International**

Mr G. COUTAU

**World Heart Federation**Ms J. VOÛTE  
Ms H. ALDERSON  
Ms D. GRIZEAU-CLEMENS

## COMMITTEES AND WORKING GROUPS<sup>1</sup>

### 1. Programme Development Committee

Dr J. Boshell (Colombia), Dr M. Camara (Guinea), Dr M.A. Al-Jarallah (Kuwait, member ex officio), Dr H.N. Acharya (Nepal), Mr M.N. Khan (Pakistan), Dr M.M. Dayrit (Philippines), Professor Y.L. Shevchenko (Russian Federation)

### 2. Administration, Budget and Finance Committee

Mr Liu Peilong (China), Dr C. Modeste-Curwen (Grenada, member ex officio), Dr J.C. Sá Nogueira (Guinea-Bissau), Mr D.Á. Gunnarsson (Iceland), Dr A.A. Yoosuf (Maldives), Dr A.B. Osman (Sudan), Dr W.R. Steiger (United States of America)

**Twenty-first meeting, 14 May 2004:** Dr A.A. Yoosuf (Maldives, Chairman), Dr Yin Li (China), Dr J.C. Sá Nogueira (Guinea-Bissau), Ms A. Knútsdóttir (Iceland, alternate to Mr D.Á Gunnarsson), Mr D.E. Hohman (United States of America, alternate to Dr W.R. Steiger)

### 3. Audit Committee

Mr D. MacPhee (alternate to Dr J. Larivière, Canada), Mr Liu Peilong (China, member ex officio), Professor B. Fišer (Czech Republic), Professor M.N. El-Tayeb (Egypt, alternate to Dr M.A.A. Tag-El-Din), Dr J.-B. Ndong (Gabon), Mr M.A. Didi (Maldives, alternate to Dr A.A. Yoosuf), Dr Y.-J. Om (Republic of Korea)

**Tenth meeting, 13 May 2004:** Professor M.N. El-Tayeb (Egypt, alternate to Dr M.A.A. Tag-El-Din, Chairman), Mr D. MacPhee (Canada, alternate to Mr I. Shugart), Dr Yin Li (China, member ex officio), Professor B. Fišer (Czech Republic), Dr J.-B. Ndong (Gabon), Mr M.A. Didi (Maldives, alternate to Dr A.A. Yoosuf), Dr Y.-J. Om (Republic of Korea)

### 4. Standing Committee on Nongovernmental Organizations

Dr F. Huerta Montalvo (Ecuador), Dr A.A. Yoosuf (Maldives), Dr F. Lamata Cotanda (Spain), Dr A.B. Osman (Sudan), Mrs Le Thi Thu Ha (Viet Nam)

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<sup>1</sup> Showing their current membership and listing the names of those members of the Executive Board who attended meetings held since the previous session of the Board.

## **5. Léon Bernard Foundation Committee**

Dr D. Hansen-Koenig (Luxembourg), together with the Chairman and Vice-Chairmen of the Board,  
members ex officio

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## **SUMMARY RECORDS FIRST MEETING**

**Monday, 24 May 2004, at 09:35**

**Chairman:** Dr A.K. AFRIYIE (Ghana)  
**later:** Mr D.Á. GUNNARSSON (Iceland)

### **1. TRIBUTE TO THE MEMORY OF PROFESSOR DANG DUC TRACH, MEMBER FOR VIET NAM ON THE EXECUTIVE BOARD**

The CHAIRMAN announced that it was his sad duty to inform the Board that Professor Dang Duc Trach had died on 10 April 2004. His work on the Board as the member for his country had been exemplary and members would doubtless wish to pay tribute to his memory.

**The Board stood in silence for one minute.**

### **2. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional Agenda (Document EB114/1)

The CHAIRMAN, declaring the 114th session of the Executive Board open, invited the Board to consider the provisional agenda (document EB114/1). He proposed the deletion of agenda item 5.2, Confirmation of amendments to the Staff Rules [if any], since no amendments were being submitted at the present session.

**The agenda, as amended, was adopted.<sup>1</sup>**

### **3. ELECTION OF CHAIRMAN, VICE-CHAIRMEN AND RAPPORTEURS:** Item 2 of the Agenda

The CHAIRMAN invited nominations for the office of Chairman.

Dr LAMATA COTANDA (Spain) nominated Mr D.Á. Gunnarsson (Iceland), the nomination being seconded by Dr YIN Li (China) and Dr STEIGER (United States of America).

**Mr D.Á. Gunnarsson (Iceland) was elected Chairman.**

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<sup>1</sup> See page ix.

The DIRECTOR-GENERAL thanked Dr Afriyie, outgoing Chairman, for all his hard work during the past year.

**The Director-General presented Dr Afriyie with a gavel.**

Dr AFRIYIE (Ghana) said that serving as Chairman of the Executive Board had been both an honour and an enriching experience. He felt particularly privileged to have worked with Dr Lee and his team as they faced the challenge of advancing the Organization's work. He looked forward to the coming discussion under item 6.2 on the terms of reference, composition and membership of the proposed new Committee of the Board. He thanked all the Board members for their support and guidance over the past 12 months and looked forward to working with them in the year ahead.

**Mr Gunnarsson took the Chair.**

The CHAIRMAN thanked Board members for electing him. Coming as he did from a relatively rich country, his first-hand knowledge of the diseases that were the Organization's major preoccupation did not compare with that of Dr Afriyie. It had been an education for him to travel to Ghana for the Board's retreat and experience life there at first hand, and he thanked Dr Afriyie for having invited him.

He highlighted the positive influence that families could and should have in shaping global values, and pledged that his actions as Chairman would be guided by compassion.

He invited nominations for the four posts of Vice-Chairman.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) nominated Dr Osman (Sudan).

Dr ZEPEDA BERMUDEZ (Brazil) nominated Dr Huerta Montalvo (Ecuador).

Ms HALTON (Australia) nominated Dr Yin Li (China).

Dr ACHARYA (Nepal) nominated Dr Yoosuf (Maldives).

**Dr Osman (Sudan), Dr Huerta Montalvo (Ecuador), Dr Yin Li (China) and Dr Yoosuf (Maldives) were elected Vice-Chairmen.**

The CHAIRMAN noted that, under Rule 15 of the Rules of Procedure of the Executive Board, if the Chairman were unable to act between sessions, one of the Vice-Chairmen should act in his place, and that the order in which the Vice-Chairmen would be requested to serve should be determined by lot at the session at which the election had taken place.

**It was determined by lot that the Vice-Chairmen should serve in the following order: Dr Osman (Sudan), Dr Yin Li (China), Dr Yoosuf (Maldives) and Dr Huerta Montalvo (Ecuador).**

The CHAIRMAN invited nominations for the office of Rapporteur.

Dr KASSAMA (Gambia) nominated Dr Nyikal (Kenya).

**Dr Nyikal (Kenya) was elected Rapporteur.**

#### 4. **OUTCOME OF THE FIFTY-SEVENTH WORLD HEALTH ASSEMBLY:** Item 3 of the Agenda (Document EB114/2)

The CHAIRMAN reminded the Board that Dr Yin Li (China), Dr Afriyie (Ghana), Dr Modeste-Curwen (Grenada) and Dr Al-Jarallah (Kuwait) had represented the Board at the Fifty-seventh World Health Assembly.

Dr AFRIYIE (Ghana) introduced document EB114/2, which summarized the work done during the Health Assembly.

Mr FURGAL (Russian Federation) said that he had noted with satisfaction the outcome of the Fifty-seventh World Health Assembly. The key theme had been HIV/AIDS and the “3 by 5” initiative. Although it was of great concern to all countries, consideration should not be limited to one positive assessment of the work of the Health Assembly. On the one hand, all the topics considered had been timely and relevant; on the other, the working arrangements adopted had been questionable. First, the lengthy discussions on agenda items at the outset of the session had not only caused undue delay but set the wrong tone. A more rational approach should be taken in future. Secondly, while the importance of holding round tables was acknowledged, how could the outcome of such meetings be put to practical use? Some thought should be given to that matter. Thirdly, an overburdened agenda had made it difficult for many delegations to make a contribution to all subjects; his delegation had indeed felt compelled to refrain from taking the floor on some topics, solely to save time. Fourthly, not only had the opening of the Committees’ work been delayed, but the meetings themselves had often been late in starting for want of a quorum. Fifthly, delegations should have been given more timely and precise information on such matters as the transfer of agenda items and the General Committee’s decisions. Sixthly, statements could be improved and made shorter – he suggested a maximum of three minutes – and focused on an evaluation of the Organization’s activities and how to improve them. Lastly, given the complexity of some topics, interpretation difficulties could be alleviated if speakers submitted texts beforehand; it would likewise help if interpretation was made available in all languages at all meetings.

Dr STEIGER (United States of America) said that the report failed to mention the work leading to the adoption of resolution WHA57.18 on human organ and tissue transplantation, regarding which he expressed his appreciation of the Spanish Government’s leadership on the issue. He agreed with the previous speaker that, although the outcome of the Health Assembly had been generally good, the efforts to achieve that result had been painful. He endorsed the Russian Federation’s proposals to make the work of Health Assemblies more expeditious, and had three further observations. First, the Board had a responsibility to restructure the Health Assemblies to ensure an improved flow in consideration of agenda items, plus adequate time for invited speakers, without undue interruption. Secondly, there was a need for changes to the Rules of Procedure to enable the President of the Health Assembly and the Chairman of the Board to expedite the work. He suggested that the Board should establish a working group to consider the implications, with a view to adopting suitable proposals at the Board’s 115th session in January 2005. Thirdly, ministerial round tables had perhaps outlived their usefulness; it might be more helpful if facilities could instead be made available for bilateral discussions, so as to take advantage of the presence of ministers at the Health Assembly.

Mr RAZZOOQI (Kuwait) said that the Health Assembly had been productive, all delegations having had an opportunity to express their views. He observed that the chairmen of the committees and the various groups had endeavoured to start all meetings on time. More attention should perhaps be given in future to allocation of the various topics for consideration and the order of priority. He supported the previous speaker in questioning the usefulness of ministerial round tables.

Dr YOOSUF (Maldives) said that he shared the previous speakers' concerns about how the Health Assembly had functioned. General discussions might in future be improved through recourse to more regional or country-bloc reports in order to reduce the number of speakers and make better use of the time. There was surely a better way of conducting ministerial round tables than just having a minister present what amounted to a country report and then leave.

Mrs LE THI THU HA (Viet Nam) commented that the Health Assembly had completed all the items on its agenda and adopted several important resolutions, including one on a global strategy on diet, physical activity and health, which, like the WHO Framework Convention on Tobacco Control, spelt major progress. Adoption of the global strategy was only a first step, however, and needed to be followed by the adoption of national strategies, for which purpose WHO's leadership and technical assistance would be most important. The proceedings of the Health Assembly had indeed been hampered by lengthy discussion at the outset over the adoption of the agenda, and she agreed with the member for the Russian Federation that a more rational approach should be taken to such issues in the future.

Ms HALTON (Australia) agreed with the previous speakers that a more streamlined approach to adopting the agenda of Health Assemblies would be welcome. Her country's Minister of Health had been unable to attend the Health Assembly but, had he done so, he would certainly not have been favourably impressed by the proceedings. The Board could surely find ways, for future Health Assemblies, of both letting views be stated and managing the business on the agenda. She endorsed previous speakers' views in that regard. In particular, the round tables either needed review or might have outlived their usefulness. Those that she had attended in other bodies, such as OECD, involved genuine dialogue, not just a succession of statements. Changes must be made if a genuine exchange of ministerial views was wanted.

Dr YIN Li (China) said that the Health Assembly had been tense but fruitful, with discussion of highly important topics, such as HIV/AIDS and the "3 by 5" initiative. The work could not have been done without the valuable assistance of the Secretariat and the collaboration of all Member States. While largely agreeing with previous speakers, he made three points. First, the agenda had been very long and Committee A's workload particularly heavy, with the result that some items had had to be transferred to Committee B. In future, agenda items should be more clearly identified and priorities reviewed. Secondly, it had been an inspiration to hear invited speakers with actual experience of problems such as persons living with HIV/AIDS, and the practice should be continued. Thirdly, it was a pity that the beginning of the Health Assembly had again been marred by political rancour. China remained opposed to the continued tabling of the question of Taiwan, China. His delegation had made helpful suggestions in the General Committee on the relevant proposal; but a few countries had insisted on tabling the topic, despite the views of the vast majority of Member States, and were thus to blame for delaying the Health Assembly's work. The subject should not, he suggested, be brought up at future Health Assemblies.

Dr TANGI (Tonga) endorsed the concerns of previous speakers. The first afternoon of the Health Assembly in particular had been unproductive. The ministerial round tables provided an opportunity to hear about other countries, and in that sense, since interpretation had always been provided, they had been particularly useful. Should the round-table format be felt to have outlived its purpose, it was to be hoped that some suitable alternative would be instituted.

The Health Assembly had adopted an important strategy on diet, physical activity and health. However, the final wording had been watered down by undue concern for commercial and other nonmedical interests. He noted that similar considerations had prolonged work on and diluted the text of the WHO Framework Convention on Tobacco Control. Preparations for similar major texts could perhaps in future be handled in the regional committees.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that the work of the Health Assembly had been intensive, constructive and marked by a commitment to seek solutions to the many health problems faced by Member States in general and the developing countries in particular. Strategies had been identified on which the Member States had shown a large measure of agreement in discussing priorities and guidelines, such as the “3 by 5” initiative, which had been welcomed as an appropriate strategy. The commitment of partners in mobilizing the resources needed to reach the Millennium Development Goals was all-important. The connection between chronic ailments such as diabetes and arterial hypertension and certain risk factors such as tobacco use led to much hope being placed on preventive measures such as the WHO Framework Convention on Tobacco Control. He endorsed the comments by the member for Maldives regarding group reports.

Mr JUNOR (Jamaica) shared the concern expressed by previous speakers about the need to use time efficiently during the Health Assembly. Nevertheless, given the great diversity of systems and experiences in the Member States, some very satisfactory results had been achieved during the Health Assembly. The ministerial round tables might be more productive if they included presentations by experts on specific aspects of the chosen theme. For example, on the subject of HIV/AIDS, it would have been interesting to enquire how different countries had legislated against stigmatization and discrimination, or what other means had been used to tackle them; what treatment protocols they had developed; how they provided access to medication, and how they experienced the impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights. Countries could then have responded on those specific areas, rather than simply giving a country report. Greater specificity within the agenda and in directing contributions to the various topics, including at the Committee level, would also be useful.

Mr KHAN (Pakistan) expressed regret that, in spite of its heavy agenda, the Health Assembly had lost an entire day of its proceedings discussing an item that was not really of concern to WHO. Efforts had been made to create an atmosphere of consensus, but a spirit of confrontation had developed and had been exacerbated by some unseemly behaviour in the public gallery. It had been a sad day for the Organization, and it was to be hoped that such scenes would not be repeated. The events of the first day had also placed extreme pressure on Member States in working to complete the agenda.

He agreed with the member for Australia that the attendance of health ministers, for two or three days at least, was critical to the success of the Health Assembly. Their presence influenced the pace and impact of decision-making.

The DIRECTOR-GENERAL thanked the member for the Russian Federation for opening up a candid exchange of views. He would review the Fifty-seventh World Health Assembly and work with the Board, the President of the Health Assembly and the chairmen of the committees to see how best to reform the Health Assembly’s working methods. There were good reasons for establishing certain procedures, but WHO should not become a prisoner of tradition. The round tables, for example, had been introduced five years earlier because many Member States had felt that a five-minute presentation at the Health Assembly was not productive. However, the round-table discussions had become a repetition on a smaller scale of those in the Health Assembly itself, and it was clearly time to look at them again. Cooperation from all countries would be needed to ensure that the events of the first day would not be repeated. However, it was essential to ensure that, when Member States did have differences, they were discussed openly. He understood the concern expressed by the member for Tonga regarding the input of health professionals to strategy formulation, but it was important not to exclude contributions from others, such as economists, social scientists and anthropologists, where their expertise was relevant. He would strive to make the Fifty-eighth World Health Assembly more efficient and effective.

The CHAIRMAN proposed that the Director-General should be requested to review the working methods of the Health Assembly, in consultation with Board members and taking into account the discussion in the Board, and to report back to the Board at its 115th session in January 2005.

**It was so agreed.**

## **5. MANAGEMENT AND FINANCIAL MATTERS: Item 6 of the Agenda**

### **Committees of the Executive Board: Item 6.2 of the Agenda**

- **Filling of vacancies on committees** (Document EB114/11 and EB114/11 Add.1)

The CHAIRMAN drew attention to paragraph 4 of document EB114/11, on the Standing Committee on Nongovernmental Organizations, on which there were two vacancies to be filled. He pointed out that the Board member designated by Spain had changed since the previous meeting of the Standing Committee.

**Decision:** The Executive Board appointed Dr A.A. Yoosuf (Maldives) and Mrs Le Thi Thu Ha (Viet Nam) as members of the Standing Committee on Nongovernmental Organizations for the duration of their term of office on the Executive Board, in addition to Dr F. Huerta Montalvo (Ecuador), Dr F. Lamata Cotanda (Spain) and Dr A.B. Osman (Sudan), already members of the Committee. It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.<sup>1</sup>

(For continuation of the discussion, see summary record of the sixth meeting, section 2, page 122.)

## **6. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda**

### **Cancer control: Item 4.1 of the Agenda (Documents EB114/3 and EB114/18)**

The CHAIRMAN said that the item had been included on the agenda at the request of a Member State. He drew attention to the draft resolution set out in document EB114/3. Document EB114/18 conveyed a request from a Member State that the Executive Board should review the possibility of establishing an international fund to support cancer control in developing countries.

Mr SHUGART (Canada) said that in Canada, as in many Member States, there was some tension between chronic and infectious disease control. The social and economic consequences of premature deaths from cancer prevented many countries from making public health gains. As the report pointed out, knowledge about cancer risks, and cancer prevention and control measures, was not always sufficiently put into practice. Better dissemination of information and techniques would

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<sup>1</sup> Decision EB114(1).

improve access to prevention and control measures and technologies. A recent report had indicated that, if current trends in Canada continued, cancer would be the leading cause of death by 2010. Canada was developing a national strategy, in line with the approach recommended by WHO, involving government agencies, professional communities and nongovernmental organizations in a broad partnership. That strategy would be reinforced by resolution WHA57.17 on diet, physical activity and health. Some useful publications on cancer control had been produced by WHO and IARC, in particular the handbook on national cancer control programmes,<sup>1</sup> the *World cancer report*<sup>2</sup> and documents dealing with the benefits of dietary intake of fruits and vegetables. Canada's national institute on cancer had established the ambitious goal of eliminating the suffering and death caused by cancer by 2015. He supported the draft resolution, but wished to include a reference to the 40th anniversary of the establishment of IARC, in recognition of that Agency's enormous contribution in providing the evidence base on which productive cancer control strategies depended.

Mr FURGAL (Russian Federation) observed that a positive decision by the Board would enable the Health Assembly, for the first time, to consider cancer control as a separate agenda item in 2005. That in turn would facilitate the emergence of a long-term WHO strategy on cancer control in both developing and developed countries, a significant step at a time of demographic ageing. The Russian Federation was going through a complex phase of demographic transition, with political and economic factors resulting in both depopulation and ageing. Over two million people had been diagnosed with malignant tumours, and an average of 52 new cases were recorded every day. The need for cancer care would grow in the coming decade, as the population continued to age. As paragraph 3 of the report indicated, there was gap between current knowledge about cancer and actual practice in preventing and controlling the disease. The reasons for that gap should be taken into account in developing a "road map" for cancer control in countries at different income levels and with different health systems. Some guidance had been provided in previous Health Assembly resolutions on noncommunicable diseases, but more information specific to cancer control was needed. Cancers varied considerably and often entailed long and expensive forms of treatment. He therefore supported the draft resolution, with the suggested addition of "rehabilitation" after "treatment" in paragraph 1(1).

Dr NDONG (Gabon), referring to paragraphs 5 and 7 of document EB114/3, said that prevention and early detection of cancers were the most cost-effective strategies for controlling the disease. That called for appropriate hospital facilities to confirm diagnosis and provide treatment. In the developing countries, however, for socioeconomic reasons, many laudable initiatives by health administrations and other organizations, including nongovernmental organizations, to raise public awareness and to improve early detection rates had failed to live up to expectations.

Some of the risk factors for primary liver cancer, which was widespread in young men in African countries, for example hepatitis B virus infection and alcohol abuse, were avoidable, and he would like to have seen a mention in the report of liver cancer as an avoidable form of the disease.

He proposed that the draft resolution should be amended by the insertion, before the existing paragraph 1(3), of a new subparagraph that would read, "to encourage and formulate policies for the strengthening and maintenance of technical equipment for early detection and treatment of cancer in designated hospitals".

Professor FIŠER (Czech Republic) said that cancer control should receive adequate attention, alongside the prevention and control of HIV/AIDS, tuberculosis and malaria. In paragraph 2(1) of the draft resolution, WHO should use clear scientific language for its cancer control strategy, rather than

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<sup>1</sup> *National cancer control programmes: policies and managerial guidelines*, Geneva. World Health Organization, 2002, 2nd edition.

<sup>2</sup> Stewart BW, Kleihues P (Eds). *World cancer report*, Lyon, France, IARC Press, 2003.

the diplomatic phraseology used for the global strategy on noncommunicable diseases. Cancer control programmes were mainly supported by the research undertaken in high-income countries, and relied on expensive forms of diagnosis and treatment, including cytostatic drugs. The initiatives mentioned in paragraphs 2(3) and 2(5) would therefore be vital in supporting cancer control programmes in low-income countries.

Dr CAMARA (Guinea) said that, despite remarkable progress in recent years, including by developing countries, in reducing levels of infant and maternal mortality, cancer remained one of the leading causes of morbidity and mortality. Yet there were effective strategies for relieving suffering, providing palliative care and preventing certain forms of the disease, such as cancers of the colon and cervix. He therefore endorsed the approaches proposed in document EB114/3, and supported the establishment of an international fund to support cancer control in developing countries.

Dr AL-SAIF (Kuwait), drawing attention to the references in document EB114/3 to the need for screening and early detection of cancer, said that he looked forward to greater attention being given to cancer control in the future, especially in the developing countries. More resources were needed, including more professional staff in that area within WHO. Greater emphasis should be placed on certain types of cancer, such as leukaemia.

Paragraph 1(8) of the draft resolution referred to the WHO Framework Convention on Tobacco Control. Ratification of the Convention should be a priority for the Director-General.

Dr STEIGER (United States of America) said that in his country hardly a family was untouched by cancer. As in Canada, it was the second cause of death and well on the way to becoming the first; more than 560 000 people were expected to die of it in 2004. The United States was emphasizing cancer prevention, and had found that the number of new cases could be substantially reduced by healthier lifestyles. The Government spent about US\$ 400 million a year on promoting tobacco control, increased physical activity, achievement of optimal weight, improved nutrition and avoidance of sun exposure, and had set an ambitious goal of eliminating the suffering and death caused by cancer by the year 2015. It was investing heavily in research through its National Cancer Institute, and was working with other countries to find new methods of cancer prevention, control, treatment and cure. The Secretary of State for Health had discussed cancer control with the health ministers of many of the countries he had visited. Interested visitors from abroad were invited to visit the National Cancer Institute in the United States, with a view to establishing partnerships. He expressed the hope that WHO would help sustain the partnership momentum so as to reduce cancer-related mortality and morbidity. One such partnership was the Alliance for Global Cancer Control, launched by WHO in 2003; in addition, a major initiative on radiation therapy for cancer, not mentioned in document EB114/3, to which the United States had pledged an extrabudgetary contribution, was sponsored by IAEA. Mention should also have been made of the Global Alliance for Vaccines and Immunization, especially in view of the growing importance of liver cancer, which could be prevented by hepatitis B vaccination; and of ongoing clinical trials to find a vaccine against human papillomavirus infection, which caused cervical cancer. The document should also have called for policy changes to facilitate improvements in palliative care and in support mechanisms for the families of cancer patients, and included a mention of prostate cancer.

In the light of all those initiatives, the establishment of an international fund was premature: serious dialogue on making the benefits of research available to developing countries did not necessarily require such a mechanism. He would submit some amendments to strengthen and clarify the text of the draft resolution.

Professor DAB (France) said that cancer was a serious problem in its own right, but an integrated cancer control strategy could serve as a model for numerous other diseases. France supported the draft resolution in document EB114/3, which was in line with its own national cancer control plan, launched in 2002. The situation in France was paradoxical, because in spite of having

one of the best prognoses for cancer patients, it had one of the worst rates of premature mortality from cancer owing to inadequate prevention; that was the problem that the national programme aimed to resolve. He supported the proposals by the members for Canada and the Russian Federation. As for international research, IARC had made great strides in that area. France had made a special contribution of €1.7 million for 2003 to fund research, especially into behavioural patterns, such as those that made it possible to understand the determinants of tobacco consumption among young people, a subject which called for a multidisciplinary approach. In that connection WHO offered excellent tools for primary prevention, particularly in respect of diet and tobacco. In the case of tobacco, in a single year France had reduced the number of smokers by 12%, and by 18% among young people. As for nutrition, two years of the national nutrition and health plan had halted the decline in the consumption of fruit and vegetables for the first time in 10 years. In other words, the situation could be improved.

The draft resolution should include a mention of occupational exposure as a source of cancer and stress the part played by exposure to the sun in causing skin cancer, whose incidence had doubled in frequency in France and other countries over the previous decade. It should also mention the role of ionizing radiation and call on the medical professions to optimize the use of radiography. He endorsed the points made in respect of secondary prevention, but pointed out that, to be effective, screening programmes must cover at least 60% of the target population. Indeed, France hoped to achieve 80% coverage for breast-cancer screening, in a programme reaching every part of the country. Another screening programme, for colon and rectal cancer, covered 22 administrative regions. It was vital to reach the target populations, and much could be learned from international exchanges about how to “sell” prevention. Lastly, to back up its fight against cancer, France had decided to establish a national cancer institute by the end of 2004, on the model of that of the United States of America. In cooperation with WHO, the institute would conduct research, make recommendations for health professionals and organize public information campaigns.

Dr LAMATA COTANDA (Spain) said that in Spain cancer was the second cause of death in absolute figures, but the leading cause of premature deaths, up to 30% of which were preventable. Spain had a national strategy for cancer prevention and treatment, based on the principles set out in document EB114/3. He agreed with the analysis in that report and supported the draft resolution. Spain followed an integral approach to prevention, treatment and early diagnosis and had established a national cancer research institute, the work of which was available to colleagues and to WHO. The draft resolution might also include a form of words to ensure that appropriate clinical information was provided to help patients take decisions and thus exercise their right to informed consent, which was especially important in cases of complex treatment. Patients should be able to choose whether or not to undergo radiotherapy, surgery, chemotherapy, or any other procedure. Emphasis should also be placed on the role of primary care in early diagnosis, and in the promotion of healthier lifestyles.

Dr ACHARYA (Nepal) said that many people in Nepal were exposed to cancer risk factors. As a result of the prevalence of smoking, lung cancer was a real problem, but statistics were incomplete. Three hospitals in Nepal provided cancer treatment but there were few preventive programmes, although the Government was emphasizing the preventive aspects of cancer control. He expressed deep concern about the radiation hazards faced by health workers, including radiologists. Many private and public X-ray departments lacked the necessary radiation detectors, thus placing health workers at risk. The draft resolution should therefore draw attention to radiation hazards and their harmful effects.

Dr HANSEN-KOENIG (Luxembourg) welcomed document EB114/3, and especially the emphasis, in paragraph 8, on the need to establish treatment guidelines and standards in order to prevent the misuse of resources and to provide treatment tailored to the stage of the cancer. WHO should help countries to establish treatment guidelines and standards of practical use to patients. Much money was spent on research. As the member for France had pointed out, research into behavioural

patterns was also important. Efforts were also needed in the area of palliative care. Luxembourg had recently organized training for general practitioners in palliative care, and 40% of its general practitioners had volunteered to take the course. The draft resolution should also mention skin cancer, which was becoming frequent but was avoidable. She fully supported the draft resolution and the work of WHO in cancer control.

Mrs LE THI THU HA (Viet Nam) said that, in developing countries, the incidence of cancer was often underestimated, owing partly to poor statistics and a limited strategic view on the part of policy-makers. In many cases prevention existed only on paper, and palliative care was limited. Viet Nam faced several problems, including the lack of appropriate training in cancer control for general practitioners. Cancer control was heavily treatment-oriented with little funding for screening activities. The Government had recently adopted a national programme for the prevention and control of noncommunicable diseases for the period 2002-2010 to include cancer control and cancer prevention. With technical support from WHO, the cancer registry had been strengthened and a high-quality epidemiological study had been conducted. A pilot screening programme for cervical cancer had been carried out, but the cost made expansion difficult. Lung cancer was the leading cancer among men, and tobacco-control activities had been stepped up. Another major problem was liver cancer. With support from the Global Alliance for Vaccines and Immunization, Viet Nam was vaccinating all neonates against hepatitis B, and a vaccine production facility was being built to ensure self-sufficiency in vaccines. She supported the draft resolution, although funding to implement it would be difficult for poor countries. WHO and other partners should continue to help developing countries in cancer control and especially in the training of health workers, including doctors and nurses.

Dr HUERTA MONTALVO (Ecuador) supported the draft resolution, but suggested including a paragraph on the carcinogenic effects of depletion of the ozone layer. It was also necessary to emphasize the financial aspects of cancer control, which would require a concerted worldwide effort. That effort was still weak in many countries, including Ecuador, and depended on private initiatives, which had plenty of goodwill but limited resources. He supported the idea of establishing an international fund. The success achieved in controlling tobacco use was an encouraging example for action in cancer control.

Dr YIN Li (China) said that cancer was the second commonest cause of death in China. Prevention and control must be improved. He agreed with the analysis presented in document EB114/3, and supported efforts to devise more effective policies for cancer control. Unfortunately there was already a serious shortfall in bilateral and multilateral donations for the control of noncommunicable diseases, and China was concerned that most cancer funds were used for basic research in developed countries and that not all the knowledge gained about effective cancer prevention and control was translated into action to reduce morbidity and mortality in developing countries. Sophisticated technology was available for cancer control and for palliative care, but many developing countries lacked the resources to buy them. To reverse the situation, Member States should increase their investment in prevention and control; the international community should pay more attention to cancer-related activities and mobilize more resources to assist developing countries in cancer control. The Chinese Government commended the work of IARC and the Alliance for Global Cancer Control, and hoped to set up a relationship with them. It supported the proposal in document EB114/18 to establish an international fund to support cancer control in developing countries.

**The meeting rose at 12:35.**

## **SECOND MEETING**

**Monday, 24 May 2004, at 14:05**

**Chairman:** Mr D.Á. GUNNARSSON (Iceland)

**TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

**Cancer control:** Item 4.1 of the Agenda (Documents EB114/3 and EB114/18) (continued)

Dr TANGI (Tonga) welcomed the report contained in document EB114/3, as WHO had had too low a profile on cancer for too long. Endorsing the comments by the member for the United States of America at the previous meeting, he said that a global strategy should be devised to support developing countries in setting up systems for cancer prevention, early detection, management and follow-up and to encourage the rich countries to carry out research into affordable screening options for the world's smaller and developing countries. An Internet search had suggested that WHO's involvement in cancer research was minimal. Small developing countries lacked even basic tools like cancer registration, and he had requested assistance from IARC in setting up a good cancer registry. He thanked the New Zealand Government for enabling patients from Tonga to travel to New Zealand for radiotherapy and chemotherapy.

Ms HALTON (Australia) said that Australia was fortunate to have a well-developed system of cancer prevention, control and care, and similar systems should be available globally. The positive outcomes achieved in Australia had largely been the result of implementing the type of measures that were recommended in document EB114/3. She concurred with the member for the United States of America that the document should also have mentioned prostate cancer.

Since 1996, when Australia had declared cancer a national priority, significant improvements had been made. A strategy was being considered to ensure best-practice interventions and care in all parts of the country, irrespective of socioeconomic circumstances. The strategy would be based on some of the aspects already mentioned in the discussion, including evidence-based clinical guidelines for cancer detection and management; psychosocial care; a robust programme of research; breast cancer and cervical cancer screening programmes and a pilot project on screening for bowel cancer; multidisciplinary care; and cancer registries. Australia also had a good track record of effective tobacco-control strategies, and expected to be able to ratify the WHO Framework Convention on Tobacco Control in August 2004.

The priority accorded to cancer was a function of its demographic impact. In Australia, one in three men and one in four women would be directly affected by cancer before the age of 75. Cancer was diagnosed in more than 50 000 Australians each year, and the disease accounted for 30% of male and 25% of female deaths. In view of the global increase in the burden of the disease, the low priority given to it and the imbalance between resources for treatment and those allocated for research, prevention and control strategies, a global resolution to be adopted by the Fifty-eighth World Health Assembly would be both appropriate and highly desirable. It would also be timely, as 2005 would be the 40th anniversary of IARC, which had led international cancer research efforts with great distinction. She therefore proposed the inclusion of a new preambular paragraph in the draft resolution, that would read: "Recognizing the contribution of IARC over 40 years in research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the causes of cancer and mechanisms of carcinogenesis and effective strategies for cancer prevention and early detection;"

Despite the need for increased efforts to support cancer control in developing countries, a separate international fund was not necessarily the best approach. Separate administrative structures could be expensive, and there was room for only so many global fund arrangements. A better approach would be to channel support through WHO structures. The draft resolution made a significant statement about the need to increase the priority of cancer prevention and control and would go some way towards ensuring recognition.

Dr CISNEROS (Bolivia) said that in Bolivia cervical and breast cancers were the commonest forms of the disease, affecting poor women in particular. Prevention and early diagnosis would enable low-cost treatment, obviating the need for sophisticated methods, which were prohibitively expensive for developing countries such as his own. Cervical cancer was associated with poverty, low coverage of health services and other known risk indicators such as early sexual initiation, sexual promiscuity, repeated abortions and infections with viruses such as human papillomavirus. A PAHO-supported study conducted in the principal cities of Bolivia had shown an incidence of 151 cases per 100 000 inhabitants. The draft resolution would help in bringing about implementation of integrated cancer control programmes. He endorsed the proposal by the member for Spain with regard to patients' right to information on their health status and probable treatment.

Mr JUNOR (Jamaica) said that the report captured the essential problems and indicated laudable solutions and approaches. Prostate cancer was a major disease in the Caribbean region – in Jamaica it was the leading cause of death among men, and its prevalence was increasing as the population aged. It should have been listed among the other diseases in paragraph 7 of the report. If there was insufficient evidence for recommending routine screening for cancer of the prostate, WHO should conduct more research to find effective preventive strategies and to prepare guidelines for screening and treatment. Some success had been reported recently with cryotherapy, which was cheaper and less invasive than the treatment methods currently in use. He therefore proposed that the words “and prostatic” should be inserted after the word “cervical” in paragraph 1(4) of the draft resolution.

Dr ZEPEDA BERMUDEZ (Brazil) said that many of the goals and strategies listed in document EB114/3 had already been adopted by the Brazilian National Cancer Institute, which had built up a great deal of experience and established a network of partnerships throughout the country. Some primary prevention activities, such as tobacco control and early detection of cervical cancer, were already well structured. Planning for breast cancer control was under way, and control activities against oral cancer would begin in the second half of the year. Efforts were being made to improve care for children with cancer. One of the Institute's priorities was to expand palliative care to the whole of the Brazilian health system. The contacts built up with professional associations and social services also needed to be strengthened to enable them to support and take part in the cancer control network. Brazil seemed to be on the right road, but much remained to be done. He supported the draft resolution and endorsed the proposal by the member for Spain on patients' rights.

Dr AFRIYIE (Ghana) said that the cancer burden in Ghana, although high, was overshadowed by the burden of infectious diseases. In the West African subregion in general, the most prevalent cancers were Burkitt's lymphoma and leukaemias in children, liver cancer in young males and genital tract cancer in women. Ghana had embarked on various measures, including prevention, education and immunization, and had been one of the first countries to include routine hepatitis B immunization in its national programmes. Screening for cervical cancer had been introduced, and clinics were being set up for the early detection of breast cancer. Two radiotherapy units had been installed, with the collaboration of IAEA. Nevertheless, palliative care needed to be made available, and problems encountered in setting up a cancer registry and national cancer control programme needed to be solved; he called on WHO to provide technical support in those areas. Many patients in Ghana relied on traditional and herbal medicine. He therefore proposed two amendments to the draft resolution: in paragraph 1(3), insertion of the words “including traditional and herbal medicine” after the word

“research”; and the introduction of a new subparagraph after paragraph 1(10), to read “to ensure the availability of traditional and herbal medicine;”.

Mr KHAN (Pakistan) said that his country, like many other developing countries, was facing a double burden of disease. Although accurate statistics for cancers were not available, estimates showed that the global picture of the disease burden due to cancer applied equally to Pakistan. He supported the creation of an international fund to support cancer control in developing countries, although he agreed with the member for Australia that separate administrative structures would not necessarily be required.

He endorsed the draft resolution and proposed the addition of two subparagraphs to paragraph 2, that would read: “to develop an ethical, cost-benefit-based treatment regime for terminal cases of cancer where generalized secondaries have limited the treatment outcome and chemotherapy is being indiscriminately used;” and “to advise the Member States, especially the developing countries, to maintain and develop a national cancer registry containing the type and location of the cancer and its geographical and topographic distribution;”.

In the 1960s, there were few cases of cancer. People in Pakistan ate a natural diet consisting of organic foods, fresh vegetables, fruit and fresh milk – tinned foods were unheard of; animal feed was natural, pesticide use was limited, natural manure was used on crops, there were few vehicles on the road, more people walked, air pollution was unheard of and nobody mentioned the ozone layer. The 1990s saw a real increase in the number of cases. By that time smoking had increased tremendously, especially in countries where cigarette manufacturers applied aggressive marketing techniques; tinned foods were widely available, and stronger preservatives were being used to increase shelf-life. The assistance of the United States of America could be critical in examining the latter aspect. Consumption of fast foods increased dramatically from the mid-1990s, and aggressive marketing techniques targeted children and adolescents. There was massive use of pesticides, of new varieties of seeds with cross-pollination and of chemical fertilizers. It was imperative to conduct more studies into genetically modified foods and their effects. Steroids were given to livestock to accelerate growth. The increase in alcohol consumption in some countries had been enormous and exposure to radiation had increased. The use of depleted uranium in conflicts and its possible effect of increasing the incidence of cancer, especially of the haematological system, could not be ignored. There was something seriously wrong with the way in which humankind was treating nature, and the time had come to conduct a serious study based solely on demographic and medical facts, untainted by lobbying, marketing tactics and influence. Again, the support of the United States of America would be critical in that regard, although WHO should take the lead.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that in Guinea-Bissau the health systems were facing financial, material and human resource problems, so that most cancer patients had to be referred for treatment to Portugal, within the framework of cooperative agreements. That was a heavy burden for both countries and for the patients themselves.

Referring to paragraph 6 of document EB114/18, he suggested that the experience acquired under existing initiatives could be used to mobilize funds to finance specific programmes or those integrated within a global partnership. It was also important to make use of initiatives at the country level such as policies to combat tobacco use and alcohol abuse. He supported the draft resolution contained in document EB114/3 and looked forward to consultations on the setting up of an international fund to support cancer control.

Dr KASSAMA (Gambia) said that in his country hepatocellular carcinoma was the commonest cancer in males and cervical cancer the commonest in females. All children were therefore immunized against hepatitis B, and Papanicolaou (Pap) smear tests for cervical cancer were performed through national screening programmes. He therefore questioned the emphasis in paragraph 7 of document EB114/3 on “awareness of early signs and symptoms” and a better first sentence would have been “Early detection is key in the management and control of cancers”. Population screening should be

advocated even for low-resource settings to detect precancerous lesions and identify high-risk sections of the population to whom targeted interventions could be applied. Screening in low-resource settings should be integrated into existing health structures using available resources, both human and material, in order appropriately to deal with detected risk factors. So-called low-cost interventions, such as visual inspection for cervical cancer after application of acetic acid, which was less accurate than the Pap smear, should be introduced with caution so as not to compromise quality, not only in risk-factor detection but in the management and care of detected cases. Use of that method, however, would require wide coverage of the population, the availability of appropriate treatment and good quality-control standards; it could not be cheaper than the classic Pap smear. He fully endorsed the draft resolution and supported the creation of a fund to support cancer control in developing countries, in the context suggested by the member for Australia.

Dr NYIKAL (Kenya) said that in developing countries the burden of infectious diseases drew attention and resources away from cancer, which was just as great a problem, especially childhood cancer. Kenya had introduced programmes for breast and cervical cancer screening and tobacco control, and all children were immunized against hepatitis B. Although those preventive measures were clearly cost-effective, chemotherapy, radiotherapy and palliative treatment should not be dismissed on the ground of cost. The first two were being introduced in Kenya. The cost of such programmes was high, however, and he welcomed the emphasis on prevention, research and international partnerships. He supported the proposal to create an international fund to support cancer control in developing countries, and called on other Board members to do likewise. He proposed that a new subparagraph should be added after paragraph 2(4) of the draft resolution, reading: "to review the possibility of establishing an international fund to support cancer control in developing countries".

Dr SUWIT WIBULPOLPRASERT (adviser to Dr Vallop Thaineua, Thailand) said that WHO should act to correct the popular misconception that cancer was just a noncommunicable disease; viral hepatitis and liver fluke infections were major causes of liver cancer, human papillomavirus was the major cause of cervical cancer and Kaposi's sarcoma was associated with HIV/AIDS. Increasingly, cancer caused illness, disability and death in all countries, and the total burden of disease attributable to cancer was perhaps not much smaller than that due to HIV/AIDS. Just as the "3 by 5" initiative had been set up for HIV/AIDS, there could be a "5 by 3" initiative to prevent cancer, consisting of five "do's" – eating more fruit and vegetables, taking more exercise, practising meditation and relaxation, practising safer sex, and regular self-examination of breasts – and three "don'ts" – eating raw or smoked meats and drinking alcohol, smoking tobacco, and excessive sunbathing.

Thailand supported the establishment of an international fund to support cancer control in developing countries, although there was clearly no prospect of its happening soon. There had been enormous community support and political commitment for the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, which simply did not exist at present in the case of cancer.

He supported the draft resolution contained in document EB114/3 but had several amendments to suggest: he would gladly participate in the work of a drafting group. Cancer control should be integrated into health care at the primary level in an intersectoral manner, particularly in relation to issues such as behavioural modification and primary prevention, including breast self-examination, promotion of physical activity and early detection of cervical cancer. Thailand was introducing visual inspection after application of acetic acid for the detection of cervical cancer to replace the Pap smear in remote rural areas where the latter could not easily be organized.

Cancer control programmes should include strengthening of public health infrastructure, including human resources for health. He was pleased to note that the Health Assembly had chosen human resources for health as the theme of World Health Day 2006, and that human resources were to be given priority in WHO's General Programme of Work 2006-2015. Human resources were the mainstay of any solution to health problems.

He called for the rapid ratification and implementation of the WHO Framework Convention on Tobacco Control, since tobacco had been proved to be the main cause of several types of cancer. Any

move to expand the use of opioid drugs in palliative care of cancer patients should be made cautiously. Increases in cancer incidence were closely linked to the increased use of chemicals: WHO must work closely with ILO, FAO, UNEP and other organizations in the field of chemical safety.

The transfer of technology relating to cancer prevention and control, including surveillance, screening and research, was vital for developing countries. Progress in implementing the draft resolution should be reported regularly to the Health Assembly.

Mr CONSTANTINIU (Romania) said that he concurred with other members that the report should place more emphasis on prostate cancer, which occurred in all countries and was expected to increase in incidence and prevalence as the male population aged. In his own country, in 80% of cases, the cancer was not diagnosed until an advanced stage, when the patient already had systemic disease. The treatment protocols for late-stage cancer were expensive and complex, and mortality was high. Simple diagnostic tools were available, including digital rectal examination, serological testing for prostate-specific antigen and ultrasound techniques, for screening men at high risk of prostate cancer. He proposed that prostate cancer should be added to the list of cancers amenable to early detection and treatment in the Annex to the draft resolution, which he otherwise supported.

Dr YOOSUF (Maldives) said that cancer treatments, such as chemotherapy and radiotherapy, were expensive. Prevention and screening had been proved to be effective, but some of those procedures were also expensive. He agreed with the member for Thailand that it was more cost-effective to promote healthy lifestyles, increase political commitment and improve legislation and regulation in order to reduce to a minimum the environmental causes of cancer.

He was concerned that an international fund for cancer control would be costly to administer. Some countries that had received funding from the Global Fund to Fight AIDS, Tuberculosis and Malaria had been obliged to spend a large part of it on administration. There was also a danger of donor fatigue.

The CHAIRMAN, speaking as the member for Iceland, said that cancer was the second most common cause of death in his country among both men and women. Evidence-based cancer control programmes were essential in order to reduce cancer incidence and mortality and improve the quality of life of patients and their families. Member States should collaborate closely with WHO and IARC to plan and evaluate effective, efficient programmes. The incidence of cervical cancer in Iceland had fallen by 60% since the introduction of a screening programme, and Iceland was participating in a trial of a vaccine against cervical cancer. Genetic research in Iceland had yielded the hope that some forms of cancer would one day be treatable. Iceland's comprehensive cancer registry went back over 50 years, and all cases recorded in it were classified according to the *International classification of diseases*. In that context, it would be valuable for all Member States to have cheap, direct access to the electronic version of that classification. He supported the draft resolution with the proposed amendments.

Mr ERGANI (Turkey)<sup>1</sup> recalled that it had been his Government that had suggested the establishment of an international fund to support cancer control. Cancer was the second most common cause of death throughout the world. It was a destructive disease, with social and economic impacts. During the second half of the twentieth century, researchers had identified many risk factors for cancer. One third of new cancer cases could be prevented by banning tobacco smoking and another third, in theory, by changing people's eating habits. Early detection of some cancers and the establishment of standards for cancer treatment had reduced the number of deaths.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Over the next 20 years, the number of new cancer cases was expected to triple, with 70% of the increase in developing countries. Cancer would thus assume the status of a public health problem. The first task was to determine the magnitude of that problem. Primary prevention strategies must then be worked out to protect people from carcinogens; tobacco-control strategies were particularly important, since cancers associated with tobacco use (e.g. of the lung, larynx, oral cavity and bladder) were among those that occurred most frequently in some countries. Effective strategies were available for the early detection of some cancers, such as breast and cervical cancer.

If the information that had been obtained was to be put to good use, collaboration between governments and civil society would be needed at both national and international level. National cancer institutes worldwide must work together; however, most developing countries lacked the capacity to do so effectively. WHO might consider supporting the establishment of national cancer institutes, particularly in less developed countries, at the financial, technical and scientific levels. Turkey had proposed the establishment of an international fund in order to mobilize international resources and collaboration for national cancer institutes in developing countries and to ease the suffering of cancer patients. Such a move was consistent with the country-based approach adopted by WHO: it would facilitate exchanges of information and experience at international level and implementation of best practices at national level. He thanked those Board members who had supported the proposal.

Mr SHARMA (India)<sup>1</sup> expressed his support for the draft resolution. In a large developing country like India, with a population of 1000 million and a health system facing resource constraints, it would be more feasible to screen the at-risk population for cancer than to try and screen everybody. In a pilot screening project for cancer detection, however, people had been reluctant to undergo screening because of the fear that cancer evoked. Screening was likely to be more successful as part of a comprehensive check for noncommunicable diseases, including simple tests for cardiovascular disease and diabetes.

His country was concerned about the provision of morphine for oral use in palliative care. He was pleased to note that WHO's guidelines for national cancer control programmes<sup>2</sup> referred to the need for appropriate policies and legislation, which were already in place in India at federal level and in a number of states.

The Indian National Cancer Control Programme had been launched in 1975 and revised in 2004. Its new strategy involved the nongovernmental sector much more widely in both prevention and care. India had ratified the WHO Framework Convention on Tobacco Control in February 2004. A comprehensive anti-smoking act had been adopted, which banned tobacco advertising, the sale of tobacco to minors and smoking in public places. More effort would be needed to achieve the requisite 40 ratifications of the Framework Convention that would allow it to enter into force.

Dr KASAI (Japan)<sup>1</sup> welcomed the discussion on cancer and the draft resolution. Cancer was a major public health challenge in Japan, with its rapidly ageing society. Before the issue came before the Health Assembly, more information should be provided about the respective roles of WHO and IARC, the activities to be undertaken at the various levels of WHO, and the transfer of funds from headquarters to the country level. His Government concurred with the members for Australia and the United States of America that the proposal to establish an international fund to support cancer control was premature.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> *National cancer control programmes: policies and managerial guidelines*. Geneva, World Health Organization, 2002, 2nd edition.

Ms ALOPAEUS-STÅHL (Sweden)<sup>1</sup> noted that document EB114/3 dealt with prevention as well as control. In her country, considerable attention was paid to prevention, which involved lifestyle and behavioural factors, food safety, the environment and education – all issues that went beyond the medical sphere. She, too, would welcome a reference to prostate cancer in the draft resolution, since the incidence of the disease was on the increase in Sweden. She would submit a number of other amendments to the members of the Board who would revise the draft resolution.

Dr VIOLAKI-PARASKEVA (Greece)<sup>1</sup> suggested that paragraph 1(2) of the draft resolution should emphasize the important role of general practitioners as the first point of contact with the health system, and the need to give them appropriate cancer training. The draft resolution should also urge Member States to strengthen programmes of immunization against hepatitis B virus in view of its association with liver cancer.

Dr EMAFO (International Narcotics Control Board) noted that international drug control treaties required a reduction in illicit drug supply and demand while allowing a supply of drugs for those who genuinely needed them for medical purposes. Ensuring freedom from pain was one of the main challenges for public health authorities; however, medicines to relieve pain were not always available in sufficient quantities, particularly in developing countries. As a result, patient care was affected. In the developed countries, expertise in pain management had not always been sufficiently developed, but there was better access to narcotic analgesics. Several factors had contributed to the low availability of narcotic analgesics. In some countries, drug regulations were considered to hinder access to controlled drugs; negative attitudes towards controlled drugs and cultural attitudes to pain management had limited the rational use of narcotic analgesics; irrational procurement procedures had encouraged purchase of more expensive but less effective drugs for pain management; training for medical personnel in the use of pain-relieving drugs was inadequate; and resources to procure sufficient narcotic drugs for medical use were lacking.

The Control Board organizations had cooperated with WHO on several initiatives, including the production of a set of guidelines for pain management.<sup>2</sup> Those guidelines should be distributed and recommended to governments, national drug regulatory authorities and medical schools as part of an awareness programme. Governments should also be encouraged to make funds available for the procurement of narcotic drugs in sufficient quantities and should foster an environment that would encourage patient access to narcotic drugs for medical purposes. National drug regulatory authorities should be made aware that the laws controlling distribution were intended not to prevent access but to promote the rational use of drugs for medical purposes only. Medical personnel involved in pain management should receive appropriate training in the rational use of narcotic drugs. Such sensitization programmes fell within the purview of WHO, but the Control Board would be willing to lend its support whenever necessary. As far as funding was concerned, with the right “packaging”, sponsors for the programmes could be found among governments and the pharmaceutical industry. He encouraged action. WHO should work towards making effective and affordable pain management available to patients throughout the world.

Dr LE GALÈS-CAMUS (Assistant Director-General) acknowledged the constructive suggestions. To be effective, a cancer control strategy had to combine all the primary prevention elements of a public health policy. The many cancers caused by infection, particularly in the developing countries, were preventable at the primary level. A real public health policy also involved early detection, effective treatment, integrated readjustment and rehabilitation and palliative care. It

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> *Narcotic and psychotropic drugs: achieving balance in national opioids control policy – guidelines for assessment*. Geneva, World Health Organization, 2000

had also been pointed out that the scientific knowledge that had been built up should be put into practice, and that to be sustainable, programmes should be adapted to suit national situations. WHO would provide technical support to enable each country to build such programmes. It would also strengthen its international partnerships; its collaboration with IARC was being intensified and extended to include other organizations. It was working to make better use of existing financial mechanisms.

Dr BOYLE (IARC) said that he had noted the references to the importance of cancer registration. IARC was currently running a course on cancer registration and epidemiology in Tonga, with participants from various countries in that large geographical region. The Agency had worked closely with more than 200 cancer registries, mainly in low- and medium-resource countries, to develop methods and improve the quality of the data collected. Software developed at IARC for that purpose was used in more than 100 cancer registries around the world.

Several members had also referred to cancer screening – an important way forward for cancer control – and he noted the efficacy of screening programmes for breast cancer (with mammography), and cervical cancer (with Pap smears). Such programmes were expensive, however, and could be justified only in certain settings. With those constraints in mind, the Agency had planned a series of meetings to pool all knowledge on the etiology of cervical cancer and the efficacy of various screening techniques, and to create menus for use in countries with different levels of available resources.

Other members had mentioned prostate cancer, the incidence of which was growing rapidly, although the median age of death from prostate cancer in developed countries remained 80 years. The current problem was to evaluate the effectiveness and efficacy of screening for prostate cancer, and a consensus meeting on that issue had been planned for late 2005, to be followed by a global summit on prostate cancer screening and early detection in mid-2006.

The importance of national cancer institutes had been mentioned. IARC was initiating a series of meetings to harness the capacities of all the national cancer institutes in the world in order to tackle the most urgent problems in cancer control, ranging from tobacco control to transnational research and the use of proteomics in identifying patients at high risk of developing the disease, for whom screening could be most effective.

Reference had also been made to chemical carcinogenesis and the environment. In its series *IARC monographs on the evaluation of carcinogenic risks to humans*, IARC had published more than 90 volumes containing evaluations of more than 900 chemicals, processes and lifestyle factors. Those evaluations formed the basis of legislation in many countries. The monographs were increasingly important in view of the growing industrialization of low- and medium-resource countries, many of which did not have access to the expertise necessary to make their own evaluations. The monographs could thus be used to set standards and reduce exposure of the workforce to carcinogens. The latest monograph – on tobacco – had provided a body of overwhelming scientific evidence that tobacco smoking was the direct cause of a large number of common cancers. It also provided evidence that passive smoking was a significant, proven cancer hazard.

Dr NYIKAL (Kenya) asked for more specific information about the kind of preparation and timeframe needed to establish an international fund to support cancer control in developing countries.

The CHAIRMAN said that he took it that members considered that the proposal for an international cancer-control fund was premature and that they would prefer to deal with it at a later occasion after further preparation. He therefore proposed that the item be left open and that an amended draft resolution should be considered at a later meeting. In the meantime some thought could be given to the question of a timeframe.

**It was so agreed.**

(For continuation of the discussion, see summary record of the fourth meeting.)

**Disability, including management and rehabilitation:** Item 4.2 of the Agenda (Document EBI14/4)

The CHAIRMAN, speaking in his capacity as the member for Iceland, suggested that, after the report had been discussed, the item should be left open until the next day when a draft resolution that he and other sponsors were preparing could be considered. Once members returned to their respective countries, they could submit further comments in time for a finished document to be prepared for consideration by the Board at its next session.

Dr HUERTA MONTALVO (Ecuador) said that States should aim to prevent disabilities as well as provide care for disability. A better title of the report would have been: "Disabilities, including prevention, management and rehabilitation".

Mr ASLAM (alternate to Mr Khan, Pakistan) said that the report covered most relevant issues, particularly rehabilitative services. However, initiatives should also target congenital disabilities, especially mental handicap. In Pakistan a national institute for handicapped children had been set up with satellites in each province, and an artificial limb centre was being established. The report made no mention of mentally handicapped children, who posed a challenge to poor societies in view of the modern treatments that were increasing their lifespan. Pakistan therefore requested inclusion of such disabilities in the policy document and consideration of a strategy to support developing countries in rehabilitating "special" children.

Mr FURGAL (Russian Federation) said that substantial long-term savings could potentially be made through investment in the prevention and early detection of disabling illnesses and through rehabilitation. It was therefore right to place great emphasis on screening for chronic conditions in primary health care provision. For that reason, reference should be made to the preparation at the international level of educational and training material on diagnosis, treatment and rehabilitation of the most widespread disabling diseases. After suitable adaptation, the health indicators within the International classification of impairments, disabilities and handicaps, adopted by WHO in 2001, could possibly be used by Member States for diagnosing such diseases in adults and children. The drafting and adoption of a United Nations convention on the protection and promotion of the rights and dignity of persons with disabilities would represent an important step forward in the rehabilitation of those people and in helping them to secure equal opportunities in society and equal access to medical and social assistance.

Dr LAMATA COTANDA (Spain) said that Spain had four million handicapped people. In view of the magnitude of the problem, the Prime Minister had committed himself to putting a bill on disability before Parliament, which should lead to a series of initiatives on prevention, management and rehabilitation of disability. He agreed with the member for Pakistan that the report should have mentioned mental disability as it was one of the factors leading to loss of function. Its consideration would also be in line with WHO's definition of health as a state of physical, mental and social well-being. Mental rehabilitation was particularly important, enabling people to be reintegrated into society. Ageing also resulted in disability, causing loss of physical and mental capacity and thus contributing to a loss of autonomy. The plan of action of the Second World Assembly on Ageing (Madrid, 2002) was being evaluated. It would be interesting to know what impact ageing had on health systems.

Dr CISNEROS (Bolivia) emphasized the close links between poverty and disease, and poverty and disability. In Bolivia a major cause of disability was the lack of health care given to women during pregnancy and childbirth. Problems during childbirth could cause neonates to be starved of oxygen, leading to mental handicap later in life.

Mr RAMOTSOARI (Lesotho) said that disabled people had been marginalized in society for a long time. WHO should continue to develop and implement programmes to assist disabled people

particularly in developing countries. Their rights should be protected and they should be allowed to participate and express their point of view in different forums; for example, reports on centres for disabled people could be presented by the disabled people themselves.

Professor FIŠER (Czech Republic) agreed with the views expressed by the member for Pakistan; he preferred to talk about “people with physical and mental disabilities” because the rehabilitation of those with mental disabilities was very important. That term was used in the resolution being drafted, of which the Czech Republic was a sponsor. In view of the importance of rehabilitation, for both groups of disabled people, the proposed resolution should be submitted to the next Health Assembly.

Dr ZEPEDA BERMUDEZ (Brazil) agreed with the member for Spain that ageing was the driving force behind the increasing prevalence of disability. The extremely high proportion of elderly people living in the developing world, some 400 million people, two thirds of the global figure, represented a huge challenge for struggling health systems. Policies were urgently required and he requested that a progress report on the implementation of the International Plan of Action on Ageing 2002 should be submitted to the Fifty-eighth World Health Assembly, in relation to the subject of disability.

Ms HALTON (Australia) noted that disability was a consequence of many factors, from congenital defects to violence. The report offered a useful summary of high-level issues, but did not provide sufficient detail to enable the governing bodies to determine where best to direct their attention. Should the approach of encouraging integration of rehabilitation into the mainstream of health services be continued? Should specific disabilities, for example, preventable blindness, continue to be identified for priority attention? Should attention be focused on population groups through, for example, strategies to mitigate or avoid the disabilities associated with ageing, an issue in which Australia, like other Member States, had a particular interest; with an ageing population there was a need to ensure continued, productive participation of all citizens in society. The important global strategy on diet, physical activity and health that had just been adopted by the Health Assembly in resolution WHA57.17 might have the potential to prevent disabilities caused by noncommunicable diseases. As disability intersected with many different aspects of the health system, in particular population health, it was important to determine where Member States could best apply their efforts. She had intended to suggest the referral of the item to a working group in order to consider an appropriate strategy on identification and management of disability, with particular attention to intersectoral cooperation between partners. However, she would wait for the draft resolution, in the hope that it would address the issues she had mentioned.

Professor DAB (France) expressed support for the proposal to draft a resolution and the process suggested by the Chairman. A bill on equal rights and opportunities for disabled persons was under consideration by the French Parliament, aspects of which might be useful at the international level. For his country, the main difficulty lay in establishing a coherent link between various public policies (in particular, those on transport, the workplace and education) affecting persons with disabilities, who were living longer thanks to medical, technological and social advances. If programmes were more closely coordinated, they might be more effective. In the French version of the report, it would have been more respectful to refer to “personnes handicapées” rather than to “handicapés”.

Dr AL-SAIF (alternate to Mr Razzooqi, Kuwait) drew attention to the fact that road traffic injuries were a major cause of disability, especially among the young. While it was right to emphasize prevention and care, it was also vital that health ministries, nongovernmental organizations and youth organizations should jointly seek ways of preventing such accidents and injuries. He agreed that mental disabilities should also have been included in the document.

Dr OSMAN (Sudan) agreed with the previous speaker that it should also have mentioned road traffic injuries. Diabetes should also be included among the reasons for disability. Partnerships between WHO, governments, nongovernmental organizations and all interested parties might hold the key to combating many causes of disability and should be mentioned in the proposed draft resolution. In that regard, he felt that more time was required for discussion.

Dr ACHARYA (Nepal) said that the incidence of physical disability was so high in his country that even the substantial amount of community-based rehabilitation work being done by a number of nongovernmental organizations was insufficient to meet demand. Rehabilitation ought to be part of basic or primary health care, but the Government did not have sufficient resources to offer such treatment and international attention was therefore much needed.

Dr YIN Li (China) said that the rehabilitation of persons with disabilities was an important medical service and making such care accessible was a vital mission for health institutions and health workers. The number of people with disabilities was rising worldwide and 80% of those people lived in the developing countries, where they had no access to basic health services. As the world's population was ageing, the international community and the governments of all countries would have to make an effort to provide medical care, rehabilitation and support services not only to persons with disabilities, but also to the elderly. His Government greatly appreciated WHO's technical support for rehabilitation and hoped that the Organization would expand its guidance and support to Member States for the formulation and implementation of rehabilitation strategies. It should also strengthen exchanges and cooperation among institutions and communities in the sphere of rehabilitation management and technology.

Dr SUWIT WIBULPOLPRASERT (adviser to Dr Vallop Thaineua, Thailand) said that it was difficult to reach and to collect information on persons with disabilities as they were a highly marginalized group and therefore did not receive adequate rehabilitation. A more accurate definition of disability, improved survey methods and a more reliable manner of registering the disabled were required because, in his country, the statistics for disabled persons varied according to their source. Persons with disabilities were stigmatized and suffered from low self-esteem, particularly those living in rural areas. Furthermore, the cost of the social welfare they received was regarded as an undesirable expense by budgetary officials and politicians alike. For that reason, a persuasive campaign was needed in order to change the image of persons with disabilities and to show that they were potential human resources. With the help of proper rehabilitation services and support from the people close to them they could become productive, valuable members of society; rehabilitation would then be seen as an investment rather than as a cost.

There were many ways of preventing disability and often they were linked. An interdepartmental and intersectoral approach was therefore imperative. For example, more should be done to prevent mental disability and the diseases causing it. The burden of disease caused by mental disability was increasing. A new strategy on mental agility along the lines of that promoting physical activity might be useful in that connection. Could WHO also look into ways of stretching minds and boosting mental stamina?

One of the main difficulties encountered in providing treatment for persons with disabilities was locating them and helping them to gain access to rehabilitation services. His country was testing a new model in which a "disabled persons manager" would be given incentives to provide support for such persons in obtaining comprehensive rehabilitation services, including medicine, health education and occupational therapy. A completely new approach to the whole issue was called for.

Dr STEIGER (United States of America) endorsed most of the comments of the preceding speaker. President Bush had launched the New Freedom Initiative designed to remove the barriers faced by persons with disabilities in obtaining housing, employment and services. Another initiative was aimed at imparting the message that such persons should be viewed as resources rather than

burdens. He agreed with the member for Sudan that diabetes was indeed a potential cause of disability that affected millions of people worldwide and that it should therefore be mentioned in the draft resolution. A progress report evaluating the International Plan of Action on Ageing 2002 was expected to be published in the next six months and such an assessment would be valuable.

Mrs LE THI THU HA (Viet Nam) said that developing countries bore the brunt of the burden of disability. In her country, it was estimated that 5% to 7% of the population lived with disabilities and 20% to 30% of those were children. Motor disability accounted for 30% to 40% of handicaps. Most disabled persons were poor and lived in remote rural areas where there were no adequate health or rehabilitation services. Experience had shown that community-based rehabilitation was the best approach, with priority going to early diagnosis in the primary health care system. Such rehabilitation should be combined with education for disabled children, and job creation and income-generating activities for adults. It would also be necessary to provide devices to assist the disabled, and to train rehabilitation workers and members of the disabled person's family, although developing countries would be unable to do so without the financial assistance of partners and donor countries. She supported the comments on ageing made by previous speakers.

Dr AHMED (alternate to Dr Afriyie, Ghana) said that his Government had submitted a bill designed to deal with the problems arising from the increasing number of disabilities caused by accidents in the home and a veritable epidemic of road traffic injuries. Something should be done to alter the traditional perception of disability because, in some countries, children who were born with disabilities were not expected to live and were sometimes made to "disappear". Another issue that had to be dealt with was the frequent lack of access to public buildings for persons with disabilities. It was also important that the disabled should be rehabilitated and retrained so that they could be self-sufficient and productive. To that end, appropriately equipped rehabilitation centres should be built, especially in rural areas. If a strategy on the management and rehabilitation of disability were drawn up, it might help to quantify the size of the problem in his part of the world.

Dr NYIKAL (Kenya) stated that, especially in developing countries, the question of ageing was becoming acute because young parents were dying from HIV/AIDS and the elderly had to look after the orphans. The well-being and good health of senior citizens was therefore crucial for the survival of orphans. In Africa, social structures were changing, with some elderly being looked after in commercially-run homes. He would have liked to see more about the prevention of road traffic injuries in the report, as they were the chief cause of disability among adults in some countries.

The CHAIRMAN, speaking in his capacity as the member for Iceland, said that, without appropriate health services and rehabilitation, many people with disabilities would have limited opportunities to avail themselves of their right to education, work or social life. Disability was therefore a public health issue that was creating a huge demand for health and rehabilitation services in all Member States. Through its expertise WHO could provide support to Member States to promote equal access to health, medical care and rehabilitation.

Mr BHUSHAN (India)<sup>1</sup> suggested that WHO might consider urging Member States to draw up country-specific legislation on persons with disabilities, focusing on prevention of discrimination, provision of equal opportunities and rehabilitation, along the lines of three acts which had been passed in his country. WHO might also support the establishment of first referral units for the prevention of disability and for rehabilitation, and the setting up of centres to train human resources for that purpose. He supported the comments on the need to consider mental disabilities. Referring to WHO's follow-up

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

to United Nations General Assembly resolution 56/168, he wondered what issues would be covered by the proposed United Nations convention, in view of the fact that the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities already covered medical care, rehabilitation and support.

Ms ALOPAEUS-STÅHL (Sweden)<sup>1</sup> pointed out that not all disabling conditions were preventable, nor should they be seen as a liability to society. People with disabilities contributed to society and could enjoy life equally provided that they were not excluded from society. In all walks of life greater efforts were needed to ensure that everyone fully enjoyed their human rights, including the right to health. As populations grew, so did the number of persons with disabilities, but that increase was not matched by a corresponding expansion of health and rehabilitation services. Yet without the appropriate services, many people with disabilities would suffer multiple exclusion, the costs of which would be high for individuals and society.

WHO should play an important role in the sphere of preventive measures, early identification of disabilities, medical care and rehabilitation services, which were accessible and affordable to all, and should ensure that the topic of disability was kept in sight in all its work. WHO should also strengthen its collaboration with other parts of the United Nations system and other international organizations, in particular associations formed by persons with disabilities. It should support the process of drawing up a comprehensive and integral United Nations convention to promote and protect the rights and dignity of persons with disabilities. Her Government would therefore welcome a Health Assembly resolution on disability, including management and rehabilitation.

Professor STUCKI (International Society of Physical and Rehabilitation Medicine), speaking at the invitation of the CHAIRMAN, emphasized the public health importance of disability and rehabilitation. The medical, rehabilitation and support services should be adjusted to the needs of persons with disabilities to prevent a worsening of their condition. Rehabilitation and support services were often required for people with acute and chronic conditions, including ageing. Many people whose functions were impaired might not consider themselves to be persons with disabilities, yet for them rehabilitation could be a highly effective means of preventing greater disability and could thus save health care costs. He urged WHO to be more proactive in the area of disability and rehabilitation.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that, although for the authors of the report there had been no doubt that the word “disability” referred to all disabilities, whatever their origin, and included mental disability, the point would be made more explicit in future. Whatever the cause of disability, efforts should first be made to prevent it and then to provide the necessary responses. Some actions had already been taken but work remained to be done, and would need to take account of the different population groups, including children and the elderly. The progress report on the implementation of the International Plan of Action on Ageing would be presented to the Executive Board at its 115th session in 2005 and subsequently to the Fifty-eighth World Health Assembly. The Organization would continue to work tirelessly to protect the rights and dignity of people with disabilities.

**The Board noted the report and agreed to keep the item open pending consideration of a draft resolution at a later meeting.**

(For continuation of the discussion, see summary record of the fourth meeting.)

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

**Recruitment of health workers from the developing world:** Item 4.3 of the Agenda (Resolution WHA57.19; Document EB114/5)

The CHAIRMAN reminded participants that the Health Assembly had adopted resolution WHA57.19 at the conclusion of its deliberations on the topic.

Mr JUNOR (Jamaica) said that, although the report focused on Africa, the problem beset all developing countries. It threatened the stability of the gains they had made and was a clear threat to the future. The English-speaking Caribbean countries provided training to a high standard, which made their health personnel readily acceptable to other English-speaking countries, and resulted in the loss, to their countries of origin, of their experience and the significant investment made in training. There was a clear need for many countries to improve their retention strategies. Greater emphasis should also be placed on ways of training more people through technical cooperation. If that were done, “managed migration” could be considered, with health workers rotating their services through bilateral agreements. He challenged fellow members of the Board and the Organization to examine systems that ensured equity in that matter and to see how the resolution could best be implemented.

Dr YIN Li (China) considered that the brain drain from developing countries was a widespread problem that had aggravated the shortage of medical personnel and seriously affected the capacity of systems to provide health care. The international community should take steps to alleviate and solve the problem. He agreed with the policy options and recommended actions contained in the report. The developing countries’ medical training systems needed continuous improvement; by the adoption of Western standards in training, the developing countries could adapt to domestic needs in the medical professions, but they needed to find ways to make medical graduates serve their own countries. The developed countries for their part must acknowledge their responsibilities in the matter, making strict rules of entry to mitigate the inflow of medical personnel from the developing countries.

Dr SUWIT WIBULPOLPRASERT (adviser to Dr Vallop Thaineua, Thailand) said that, during the drafting of resolution WHA57.19, a positive approach had been agreed whereby no blame should be attached to anyone for the recruitment described in the report. Until the migration of human resources was resolved, however, the “3 by 5” initiative was doomed to failure and the Global Fund to Fight AIDS, Tuberculosis and Malaria would be ineffective because of the lack of trained people to carry out the work. Resolution WHA57.19 was therefore important and timely and would need the best efforts of all concerned to be implemented. In Thailand, because of the good working environment and salaries, and the fact that nurses were not proficient in English, few had been recruited to work in other countries recently. During the 1970s, Thailand used to lose one quarter of its doctors to Western countries. A concerted approach to retention measures was needed. Despite all efforts, there was still a brain drain from rural to urban areas, especially when foreign patients were encouraged to seek health services in Thailand. In 2003, about one million had done so. The resolution gave a broad mandate to WHO to view migration of human resources for health as a serious issue.

Professor FIŠER (Czech Republic) said that his country was both a recipient and a source country: some health personnel came to it from the developing world and others left it for its German-speaking neighbours, showing that remuneration of health personnel was relative. Resolution WHA57.19 was extremely important.

Mr FURGAL (Russian Federation) said that the report was another necessary and important step in the preparation of a general, worldwide policy on the movement of health workers. As the information in the report was based mainly on figures provided by OECD, as such statistics did not apparently exist for developing countries, he wondered how WHO intended to implement the mechanism referred to in paragraph 23, and how it would monitor migration trends, collate statistics

and give feedback. Would the format for collection of OECD statistics be used or would a broader dialogue with countries be undertaken? If so, how would that be put into effect?

Professor DAB (France), endorsing the views of previous speakers, said that resolution WHA57.19 was a welcome step in the right direction. The topic should be considered frankly in view of the looming worldwide shortage of qualified health professionals in all countries. Without international solidarity, the situation could not be resolved. The member for Thailand had been most eloquent on that point. The medical training system in France, with its 40 medical schools, was well developed and his country was willing to share its experience in the matter. It could help to provide on-the-job training, the lack of which was often a reason for health workers moving to other countries. The use of the Internet in dealing with the situation should also be examined for training and for the use of telemedicine.

Dr AFRIYIE (Ghana) expressed satisfaction at the adoption of resolution WHA57.19. Migration of health workers from the developing to the developed world was a crucial moral dilemma. Over the past two decades, the countries that carried the heaviest disease burden had witnessed the departure of their most experienced health personnel to countries where life expectancy was high. That loss caused serious situations in the health services of the countries they left. Measures were being undertaken to stem the outflow, but they were insufficient. He suggested that, where a doctor/patient ratio was demonstrated by agreed criteria to be low, recruitment for migration should be actively discouraged. Without active implementation of the resolution in the near future, the good intentions of the Millennium Development Goals and other such initiatives would all come to nought.

Dr HUERTA MONTALVO (Ecuador) said that the issue had many facets. Free movement of professionals was advocated, but caused concern; quality of training was emphasized, and yet careers were not always open after training; there was a dichotomy between the concept of medicine as a public service and as a commercial product, open to market forces. He did not believe that retention measures should be applied, or that fair competition could be invoked without defining unfair competition. Many political, economic and social factors were involved in the issue. The subject should not be viewed completely negatively: while it was regrettable that money invested in training did not benefit the source countries, qualified professionals should be free to move. Each country must find its own solution to the problem and he advocated that the possibility be considered of holding a world day that focused attention on human resources in health development. He urged that broadly-based discussions on the subject should continue and that a further report be submitted to the Fifty-eighth World Health Assembly.

Dr YOOSUF (Maldives) drew attention to the problem of the imbalance in provision of health services between urban and rural areas, with the latter suffering most from loss of trained professionals. The developing countries needed to ensure that health professionals were given the necessary recognition and incentives to serve their own populations. As expertise gained abroad greatly improved national health services, any restrictions on the external brain drain must be given due thought. Maldives imported a large number of medical staff as it did not have its own medical school – only about 20% of doctors and 30% of nurses were Maldivian. However, the country had, generally speaking one doctor per 1000 population and a high ratio of nurses to patients. He requested that, while the topic was under discussion, the situation of countries such as his own that had to import many medical personnel should be borne in mind.

Mr ASLAM (alternate to Mr Khan, Pakistan) said that the report outlined all the issues faced by the developing countries. Pakistan suffered from a high rate of loss of skilled personnel who had spent many years in study, heavily subsidized by their own country, while the countries that benefited from that investment contributed very little towards it. He endorsed the suggestions for compensation set

out in paragraphs 10 and 11 and requested that those aspects be incorporated in a draft resolution on the subject.

Dr ZEPEDA BERMUDEZ (Brazil) associated himself with the speakers who had voiced concern at the serious problems in human resources for health facing developing countries. He supported the formulation of a code of practice on the recruitment of such staff, in consultation with Member States, to provide support to the developing world in strengthening their health services. He also supported the suggestion in paragraph 2(8) of resolution WHA57.19 that a year, or even a decade, of “Human Resources for Health Development” should be declared. Brazil had established intensive cooperation, through its national network of training institutions, with developing countries and especially lusophone African countries, in training of health personnel. He endorsed the views of the member for Ecuador on the complexity of the problem.

Dr TANGI (Tonga) said that it would be more appropriate to use the word “migration” instead of “recruitment” in the title of the report. He appreciated the analysis of the problem made by the member for France. The problem was not new but had been discussed by the international community since the 1960s. It had become more acute over the years, with many qualified health workers leaving Tonga after working there for only a few years. Governments could make policy, but the commercial realities of the salaries paid abroad meant that those policies could not be effective. The matter should be viewed as a global problem affecting everyone and the goodwill of the recipient countries should be relied on to help resolve it.

Dr NYIKAL (Kenya) observed that health systems in developing countries would not improve unless action was taken to stem the brain drain. He was not optimistic about the ability of those countries to change the situation, for instance by reducing the differential in salaries and improving working conditions. At considerable cost, developing countries trained health workers who then migrated: Kenya trained about 150 doctors a year, of whom at least 50 left the country; almost all of the registered nurses, trained to international levels, emigrated. The recipient countries, knowing the need to strengthen health systems in developing countries, had a moral responsibility to find a way to remedy the situation. They might, for example, share in the financial costs of training for health staff in developing countries. He urged WHO to help to find solutions.

Dr VIOLAKI-PARASKEVA (Greece)<sup>1</sup> affirmed the importance of human resources in strengthening the health system. Each country, however, would have to plan to cope with the brain drain, by, for example, providing better training, research facilities or financial incentives. The implementation of resolution WHA57.19 would be crucial, especially with regard to paragraph 2(10) requesting the Director-General to include human resources for health development as a top-priority area in WHO’s General Programme of Work for 2006-2015.

Ms MAFUBELU (South Africa)<sup>1</sup> said that the migration of health workers from developing countries had reached such critical levels as to constitute an emergency; steps needed to be taken to prevent a collapse of health systems. During the consultations on the draft resolution, South Africa had consistently pointed out that it was not aware of any work done by WHO on the migration of health personnel, and she therefore congratulated the Organization on the report under consideration. She was confident that WHO was in a position to report on progress to the Fifty-eighth World Health Assembly, as requested in resolution WHA57.19.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr RUIZ (Mexico)<sup>1</sup> supported the views of the members for Ecuador and Jamaica. He reiterated the request he had made during the Health Assembly, that in the Spanish text of paragraph 1(2) of resolution WHA57.19 the word “*permanencia*” should replace “*retención*”, as the latter implied holding a person against their will.

Mr SHARMA (India)<sup>1</sup> acknowledged that the emigration of health professionals created temporary setbacks for the source country, but he maintained that borders should be open for trade in services, in line with the General Agreement on Trade in Services. The recommendations aired in recent discussion to increase salaries and incentives in order to retain health professionals might not serve much purpose. The gap between salaries in developing and developed countries was so wide that any increase in the former would have a negligible impact. There was also a limit to which salaries could be raised – professional salaries had to remain in balance between the different sectors. Inevitably health professionals would move across borders.

He suggested that the health needs of source countries would be satisfied if recipient countries were to convey their requirements to the source countries in advance so that they would be taken into account in the latter’s overall planning, and if health professionals were recruited only on short-term and non-renewable contracts, with mandatory subsequent return to their country of origin. That measure would help with the transfer of technology and provide incentives for other professionals to work abroad. A means should also be devised for recipient countries to participate in upgrading the training systems of source countries.

Dr EVANS (Assistant Director-General) said that he recognized that implementation of resolution WHA57.19 would be challenging but noted that many of the issues linked more generally with those to be debated under agenda item 4.4 on human resources in health. Beyond the academic question of whether the flow of workers was a net gain or drain was the real-life experience of the human cost when loss of health workers beyond a certain threshold resulted in closure of services and loss of human life. Attainment of the health-related targets of the Millennium Development Goals would be compromised without sensitivity to countries that fell below those thresholds for human resources in health.

Workforce shortages were not specific to any part of the world and solutions would require some degree of coordination. The fact that populations were ageing meant that needs in the health professions would increase. Globally, it was necessary to start preparing to meet that increase in demand in an interdependent way. However, as members had made clear, there were no easy solutions. WHO would work with Member States to generate creative options for tackling aspects that were remediable and which would do most to improve public health.

The DIRECTOR-GENERAL said that in the 1960s the Republic of Korea had been producing about 700 doctors a year whereas that figure currently stood at 4000. In the meantime the gross national product had increased 200-fold, and the starting salary for a doctor beginning work in a government hospital was about US\$ 3000 a month. Economic progress had staunched the flow of health workers from the country; he recalled that about 80% of his contemporaries at the university where he had taken his medical degree had gone overseas but that was no longer the case for medical graduates. Migration of health workers was a matter of development, compounded by globalization. Expectations were rising, too, with patients experiencing better care in their own countries, through hospitals which, for instance, had links overseas. Migration flows were currently two-way, involving training or short stays. He recognized the complexity of the matter and would look at it carefully.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN, speaking as the member for Iceland, said that his country's experience was similar in many respects to what the Director-General had described. Although doctors had consistently travelled abroad for specialist education, 40 to 50 years ago they had tended to migrate to jobs. Since the 1980s the situation had changed completely; all those who had gone abroad wanted to return, and the difficulty was to find positions for them. Those emigrants who had returned had enriched the country through their experience.

The CHAIRMAN urged members to act on resolution WHA57.19, and invited the Board to take note of the report.

**The Board took note of the report.**

**The meeting rose at 18:15.**

### **THIRD MEETING**

**Tuesday, 25 May 2004, at 09:10**

**Chairman:** Mr D.Á. GUNNARSSON (Iceland)

#### **TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

##### **Human resources in health:** Item 4.4 of the Agenda (Document EB114/17)

The CHAIRMAN said that the topic had been included in the agenda at the request of a Member State. He referred to related discussions at the Fifty-seventh World Health Assembly.

Mr FURGAL (Russian Federation) said that the report rightly noted the connection between the health workforce and the health status of a population, and brought out the need to strengthen that workforce in accordance with the highest standards of quality. Of particular significance was the need to provide proper training of health managers, especially at the senior level. In that regard, the Director-General's Health Leadership Service with its well-focused two-year training programme for health managers deserved support, especially since new health systems in developing countries needed sound leadership.

The ideas set out in paragraph 12 of the report should nevertheless be approached with caution, since the use of "generic" workers had been tried in the past and found unproductive. He had doubts, too, about the contents of paragraph 14 because, in the past, the use of private medical schools had, as a rule, led to a decline in the quality of training, for well-known reasons such as poor curricula, lack of qualified instructors and inadequate material and technical facilities. In general, therefore, WHO should make more focused efforts to promote health-management potential. Measures taken should be as specific as possible, with emphasis on postgraduate management training in health.

Dr SUWIT WIBULPOLPRASERT (adviser to Dr Vallop Thaineua, Thailand) emphasized the need to invest in human resources for health development and, in that regard, to implement resolution WHA57.19. Of the four main resources for health systems – knowledge, facilities and equipment, pharmaceuticals and personnel – human resources accounted for more than half the health costs in most countries, yet most countries did not even have a department to manage those resources. He therefore strongly commended the Director-General's leadership in upgrading WHO's human resources unit to a department. He recalled, however, that, as a unit, human resources had only had a budget of some US\$ 20 million per biennium, compared with the US\$ 100 million allocated to the Health technology and pharmaceuticals cluster, and he expressed the hope that human resources and its budget would be upgraded further and set a precedent for the health ministries of all countries.

In most countries, including Thailand, discussion of health-worker incentives tended to focus on financial and material matters almost to the exclusion of professional ethics. If equal emphasis were placed on professional dedication and commitment, and international and national networks, such as Thailand's rural doctor network, were set up, the ethical solidarity thus created would contribute in no small way to solving the problem of health resources development. WHO should work with other international organizations to that end.

The CHAIRMAN observed that only in the health industry were human resources more important than machinery.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) agreed that development of human resources was the most important issue for health services. For some time his Region had been conducting a leadership-development programme. Originally that had involved collaboration with leading universities but, on account of the cost, it had become an independent programme. As such it had been so well received that, after a few years, it had been decentralized, and was currently established in three centres: at Alexandria, Egypt (for Arabic speakers), in Pakistan (for English) and in Morocco (for French).

There had been general agreement that private training schools were inferior to government establishments. They had proliferated to such an extent, however, that concern for standards had led to the development, with the help of the World Federation for Medical Education, of a core curriculum and accreditation system, applicable to private and public medical schools alike. On-the-job training was also important. It was the practice of some large enterprises to put new graduates through a three-to four-day course and pick out potential leaders for more advanced training.

Another important aspect of the development of human resources in health was information-sharing, one example of which was through the network of "rural surgeons" in India that enabled surgeons in scattered rural areas to exchange information on surgical techniques that could be used with the minimum level of equipment usually available in remote areas.

Dr YOOSUF (Maldives) supported the concept of "new" health workers. In Maldives, the infant mortality rate, which had stood at more than 120 per 100 000 live births some 20 years previously, was currently 17; maternal mortality had fallen from over 350 to 120; and immunization programmes covered 95% of the population. All those achievements were due to paramedic health workers. In a nation consisting of some 200 inhabited islands, it was hardly possible to have a doctor on each; trained health professionals and local midwives were therefore essential and, indeed, had managed to bring most infectious diseases under control.

In expanding health services, however, management needed attention. He therefore supported the Director-General's initiative to train public health leaders as an approach to ensure that funds were not wasted. More effort was required, however, to persuade governments to allocate sufficient funds to the health sector; in his country the allocation currently amounted to some 8.5% of the country's gross domestic product, equivalent to 12% of the national budget. Without further financial commitment, progress would be difficult.

Dr NYIKAL (Kenya) said that the concept of "new" workers implied shorter training and the performance of specific jobs, probably under supervision. In Kenya such workers were employed mostly in public institutions and therefore easy to supervise. With the growth of the private sector, however, many small clinics had been set up, creating a problem of lack of supervision, heightened by the fact that many such bodies were in remoter areas, making it difficult to regulate their activity. The problem of regulation likewise arose with regard to private medical schools, which had been set up for profit and which attracted the less able students, and the private medical institutions that tended to employ less-qualified workers in order to maintain their profit levels. Therefore, the suggestions outlined in paragraph 12 might be suitable for public institutions but risky in the private sector if regulation was lacking.

Dr AHMED (alternate to Dr Afriyie, Ghana) said that the development of health capacity had become increasingly important because of the increase in the migration of health workers. For the past 30 years his country had operated training schools for medical assistants. Applicants were normally required to have at least five years' work experience. After a year's training, they were sent to rural centres which lacked doctors. To complement their services, there were schools for community nurses and dispensary assistants, which provided two years of training that enabled them to carry out minor professional medical tasks. A dental assistants' training school had also been established. Ghana encouraged private institutions and currently had two private nursing schools that supplied staff largely to the private clinics.

Dr CAMARA (Guinea) said that lack of human resources might hinder or even set back progress in the health sector; certain epidemics and diseases currently under control might well resurface. The international community should therefore act as a catalyst, assisting developing countries to formulate integrated disease-control programmes, train health workers in the various medical fields, foster cooperation and allocate financial resources. The various problems outlined in the report called for specific action on a regional basis. WHO should provide technical support on request, ensuring that requests were in line with a country's real health needs. In any event, his country, where human resources in health were a problem, greatly appreciated the approach envisaged in the report.

Dr HUERTA MONTALVO (Ecuador) said that the suggestion in paragraph 12 of the report that between 25% and 75% of doctors' tasks, most often those of generalists, could be carried out by other health professionals was clearly linked to the statement in paragraph 14 that, in many countries, the quality of educators was less than desirable. Reports on quality of care, including concerns about poor medical practice – a widespread problem giving rise to growing disquiet in many fields – should not be ignored. It was essential that the training of new health workers conformed to the levels of competence and ethical standards associated with public health services. The rise in the number of medical faculties, which often had no proper link with hospitals and were simply set up for profit, was a cause of some concern in Ecuador. WHO could perhaps consider, together with the problem of migration of human resources in health, that of adequate regulation of medical training, with a view to avoiding risks that stemmed from lack of competence and professional rigour.

Dr ACHARYA (Nepal) said that a particular problem in Nepal was the shortage of medical specialists, particularly anaesthetists and radiologists, the chief reason being a lack of incentive for doctors to take up those specialities. Health programmes and the smooth running of hospitals could be adversely affected unless attention was paid to that problem.

Dr SÁ NOGUEIRA (Guinea-Bissau), referring to paragraphs 6 and 7 of the report, said that human resources were indeed the catalyst of all health systems, and that attention must be paid to their development through appropriate national policies and a progressive career programme involving proper performance assessment. Those measures called for a strengthening of the human resources development capacities of health ministries and a partnership involving the countries that hosted migrant health workers. A nationally administered training scheme should also be established, with the collaboration of training establishments at the local, regional and intercountry levels. All career facilities and incentives must be focused on health, and sustained by a strong partnership with government backing.

Dr RUIZ (Mexico)<sup>1</sup> said that a recent meeting of the Mexican Society of Public Health had indicated that health-service training was not producing the required human resources, because of misconceptions by students as to what the future held. Faced with the reality of everyday public health work, without the facilities and equipment they had expected, many became disillusioned and left the service. What was needed therefore, was a multidisciplinary approach to training, in which health workers were given to understand the importance of their role in the health service, regardless of their level. Community participation was also important; the paramount requirement, in that regard, was for health services to work closely with communities and to foster a sense of mutual responsibility.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr EVANS (Assistant Director-General) said that, in the context of the United Nations Millennium Development Goals, it had been realized that the state of a country's health workforce was directly linked to its health achievements. Deteriorating or poorly mobilized human resources had led to reversals in health gains in some countries and to unacceptably poor health outcomes and unrealized expectations in others. Human resources for health should be regarded as a vital asset that required active management at all levels rather than, as in recent decades, a recurrent cost that had to be minimized. The role of home-based care, including care provided by family members, should also be taken into account.

The private sector was playing an increasing role in the training and management of the health workforce, and it was necessary to develop standards and regulations accordingly. The preferences of consumers must also be taken into account; they did not always wish to be seen by health workers of the type emerging from more orthodox medical institutions. For example, in Bangladesh, 30% to 40% of primary health consultations were with so-called allopaths, most of whom had no formal medical training and were not listed among the country's official health providers.

There was a need to examine the value of in-service training, in particular the phenomenon of "hotel training", in which health workers were taken to a hotel for a seven-day training course in specific skills. In some cases workers undertook such training frequently and no cover was provided in their absence, leaving services understaffed. An evaluation undertaken by the Regional Office for Africa had shown that WHO invested some US\$ 10 million annually in such training. It was not clear whether that was the best use of those resources.

Several members had commented on management competences and health leadership. WHO's new Health Leadership Service would provide the opportunity to revitalize the culture of leadership and service, and to learn from the Organization's rich history in that regard. It would be important to work with WHO's priority programmes to provide common solutions to human resource management. WHO would also need to collaborate with international financial institutions to ensure that national fiscal frameworks were reformed to allow increases in the health sector wage bill. Some countries would need to double or triple the size of their health workforces if the health-related Millennium Development Goals were to be attained.

**The Board took note of the report.**

**Avian influenza and human health:** Item 4.5 of the Agenda (Document EB114/6)

Ms HALTON (Australia) commended WHO's leadership from both headquarters and the Regional Office for the Western Pacific during the recent avian influenza outbreak, as in the outbreak of severe acute respiratory syndrome (SARS) in 2003. The two outbreaks had highlighted the importance of all countries working together to bring emerging communicable diseases under control, especially in a world in which borders and level of development provided no protection. She endorsed the approaches to averting a global influenza pandemic outlined by WHO: prevention and control measures combined with increased preparedness and a more effective response to outbreaks. Emphasizing the need for increased preparedness, she said that Australia had worked closely with WHO to strengthen its surveillance and laboratory diagnostic capacities, and had adopted new infection-control guidelines. It had established a national system for control of communicable diseases that could respond rapidly to emerging diseases, such as pandemic influenza. The system was underpinned by collaboration between health authorities at national, state, territory and local levels. The Australian Action Plan for Pandemic Influenza provided guidance to health service providers and other groups on what to do during an influenza pandemic, and the Government had recently announced increased funding over five years to protect the population from such a pandemic.

Australia welcomed the research undertaken by WHO to improve understanding of disease risk and transmission of pathogens. It had participated actively in the WHO technical consultation on preparedness for an influenza pandemic (Geneva, 16-18 March 2004), which had provided valuable information on the feasibility and effectiveness of measures to slow the national and international

spread of influenza, reduce morbidity, and minimize social and economic disruption. Countries with direct experience of the SARS outbreak had been well aware of the social and economic consequences of such episodes.

Effective communication between countries and regions would be crucial in the future, especially as more resources were devolved to regional and country levels. The cooperation between the Regional Offices for the Western Pacific and South-East Asia exemplified the approach that would be needed. Australia would work with its neighbours and WHO to enhance surveillance and reporting, increase collaboration between the public health and agricultural sectors and improve laboratory capacity. The new Strategic Health Information Centre at headquarters would be a central component in global cooperation. What were WHO's intentions in respect of scenario planning, an invaluable tool for identifying potential weaknesses in preparedness systems?

Mrs LE THI THU HA (Viet Nam) said that, coming from one of the two countries where human cases of avian influenza had been reported earlier in the year, she welcomed the inclusion of the item on the Board's agenda. Viet Nam had experienced great difficulties initially in managing the outbreak. The timely visit of the Regional Director for the Western Pacific had provided the Government with well-documented facts and technical information on the link between the avian influenza outbreak in Asia and the possibility of a global influenza pandemic, and proposals for prevention and control measures at country, regional and international levels. As a result, Viet Nam had established a national steering committee for avian influenza control and a comprehensive multisectoral strategy to control the outbreak. She paid tribute to WHO for its valuable technical support and its efforts to mobilize resources during the outbreak, a true indication of the Organization's global leadership in health and political sensitivity. She also thanked the European Union, the Governments of Italy and Japan and the United States Centers for Disease Control and Prevention for their support.

She commended the timely production by WHO of the various guidelines and recommendations. The implementation of guidelines on the global surveillance of the H5N1 strain of *Influenzavirus A* depended on the performance of national surveillance systems. Moreover, WHO's current human case definition relied on laboratory diagnosis for confirmation, so that the quality and efficiency of national laboratory networks was crucial for accurate and rapid diagnosis. Greater technical and financial support would be needed to strengthen national capacities in those areas in developing countries, in particular given the draft revision of the International Health Regulations, which required States Parties to develop the capacity to respond promptly and effectively to public health threats and public health emergencies of international concern.

Developing countries in South-East Asia were at high risk of emergence of a new strain of *Influenzavirus A* that might give rise to a pandemic; equitable access to medical interventions was therefore an important issue. At the WHO technical consultation referred to by the previous speaker, it had been suggested that evolution of an influenza outbreak into a pandemic might be prevented by early targeted use of antiviral drugs and vaccines. WHO should therefore coordinate efforts to establish mechanisms for stockpiling drug and vaccine supplies and rapidly distributing them to developing countries. Asian countries needed to draw up comprehensive influenza preparedness plans; a model plan that could be adapted for use in developing countries would be invaluable.

Viet Nam was collaborating with WHO and other parties on research, and had provided biological samples from which the H5N1 viral genome sequence had been determined and the vaccine virus prototype strain developed by the laboratories participating in the WHO Global Influenza Surveillance Network. There was a need to clarify arrangements so that Member States felt comfortable in approving such transfers of specimens.

Experience during the recent outbreak had signalled the need for better collaboration between organizations within the United Nations system and other partners giving emergency support, in order to maximize benefits and avoid disruption. The presence of numerous organizations and donors during an emergency could add to the size and complexity of a government's task. She welcomed the interest being shown by the World Bank in a two-year avian influenza emergency recovery project proposed

jointly by FAO and Viet Nam, which covered stakeholder recovery, strengthening of veterinary services, and public awareness and information. Strengthening of the surveillance system for human cases was not included in the project, however, and it was to be hoped that WHO would continue to provide technical support and mobilize financial support to Viet Nam and other countries in Asia.

Mr JUNOR (Jamaica) said that, although the Caribbean countries had so far been spared from avian influenza, there were lessons they could learn from the experiences of others. Early recognition of the problem was a key to preventing the establishment of emerging diseases and demanded a sensitive surveillance system. Close collaboration with the agricultural sector, in particular the veterinary services, was also crucial given the zoonotic source or reservoir of many emerging and re-emerging diseases. Information on the geographical distribution of pathogen-carrying animals and febrile illness in human beings would need to be shared to identify any correlation.

Economic losses arising from disease outbreaks were a serious concern. WHO could help to minimize such losses by working closely with countries in the early stages of an outbreak and improving their capacity to undertake risk analysis. A more scientific calculation of the risks of morbidity, mortality and spread of diseases would help to allay unfounded fears in the population, which occurred even in countries that were not affected directly, and resulted mainly from media reports. Jamaica had had to channel considerable resources into SARS surveillance in response to public pressure, and it was not clear whether that expenditure had been justified.

Mr SHUGART (Canada) said that the outbreaks of SARS and avian influenza had provided sufficient warnings for all countries of the need for emergency preparedness. Canada had had to face a direct challenge, as a result of which it had improved its public health and infectious disease-control capacity and was better prepared to respond to future outbreaks of such diseases. Preparedness required advanced planning related to the role of surveillance and laboratory networks, emergency responses and links between public health and civil preparedness institutions. Moreover, many of the responses required related to the general need to improve health system capacity. It was also essential to link human and animal health. The significance of zoonoses was one of the main lessons from the outbreaks of SARS and avian influenza, and gave an indication of potential future vulnerability.

He endorsed WHO's recommendations for preventing the emergence and spread of infectious diseases, particularly on the need for surveillance efforts to focus on early detection and reporting, and the need for rapid, extensive and transparent communication of information internationally and between countries and WHO. Research in the laboratories participating in the WHO Global Influenza Surveillance Network should continue. He too commended the WHO technical consultation on preparedness for an influenza pandemic, and would welcome further opportunities for discussion of the establishment of an international stockpile of antiviral drugs and vaccine supplies. At a meeting of the Asia-Pacific Economic Cooperation Health Task Force held in Taiwan, China in April 2004, consideration had been given to collaboration in table-top exercises to strengthen preparedness for an influenza pandemic. WHO should become involved in such exercises. In respect of risk communication, mechanisms to exchange best practices should be instituted, so that the experiences of countries such as Canada, which had had to acquire expertise very rapidly, could be of benefit to others.

Dr YIN Li (China) said that, at the end of 2003 and the start of 2004, eight Asian countries had experienced outbreaks of highly pathogenic avian influenza and two countries had reported confirmed human cases of the disease. Up to 27 January 2004, 16 mainland provinces of China had reported 49 outbreaks. Up to 29 February 2004, a cumulative total of 4962 human contacts with infected poultry had been identified, from whom 3069 samples had been collected; 8146 persons had received prophylactic drugs. No suspected or confirmed human case had been reported. His Government attached great importance to prevention and control of avian influenza and, following the initial outbreak, had implemented various measures, which had quickly contained the disease. A national command centre had been established to coordinate control efforts, and local governments had also set

up command centres; a scientific prevention and control strategy had been adopted; government agencies were collaborating closely; and the population had been mobilized to join in those efforts. The Ministries of Health and Agriculture had established mechanisms for sharing information and coordinating activities. The health departments in affected areas had placed persons in close contact with infected poultry under quarantine, collected samples, and reported information on a daily basis. The Ministry of Health had released surveillance information on human avian influenza to the public every week. He thanked WHO and FAO for the technical support they had provided for prevention and control activities. The various emergency responses had played an indispensable role in containing the disease.

The recent avian influenza outbreak had sounded a warning of the potential for an influenza pandemic. It was imperative that all Member States took immediate action to enhance their ability to respond to such an emergency. The capacities of countries, and their resources to build such capacities, varied greatly. Poorer countries, which were much more likely to be the source of an outbreak and to experience more serious outbreaks, were therefore in greater need of financial support and technology transfer. WHO should do more to coordinate such support in order to enable developing countries to fulfil their international obligations. Concerted action by all Member States should help to avert or at least defer an influenza pandemic.

In the report, he would have liked to see a reference to immunization as a biosecurity measure, since FAO, the *Office International des Epizooties* and WHO had confirmed the role of immunization in containing the disease. Referring to paragraph 13, he said that it was impossible to eliminate the animal reservoir of the virus by culling, and the first step should therefore be elimination of animals infected with the virus.

Dr STEIGER (United States of America) said that influenza pandemic preparedness was of prime importance for the Board. In terms of saving lives it was also, with the possible exception of action to combat HIV/AIDS, the most important activity for the Director-General during his term of office and should remain a priority for the coming years. The report described what had been in effect a very close call that had alarmed even the most sanguine of experts and should scare everyone. The 24-hour news media coverage in the United States had heightened public panic both during the SARS outbreak and even in response to slightly increased mortality in children during a recent normal influenza outbreak. It was impossible to calculate the impact on the public of the transformation of avian influenza into a disease with human-to-human transmission. Realistic WHO assessments of risk were very important. The United States Secretary of Health and Human Services had arranged a meeting of health ministers during the Fifty-seventh World Health Assembly to discuss preparedness for an influenza pandemic. Key points arising from that meeting had included the need for rapid sharing of samples from human beings and animals, the revitalization of relations between ministries of health and agriculture and the strengthening of collaboration between WHO, FAO and the *Office International des Epizooties*.

The Director-General should look at the organizational structure of WHO with a view to bringing together the various activities related to influenza pandemic preparedness within existing programmes on zoonoses, food safety, infectious disease outbreak response, and emergency preparedness and response. He requested further information on recent collaboration between WHO, FAO and the *Office International des Epizooties* to coordinate activities at international and country levels, and to channel the generous offers of support made by many governments. Although he respected the WHO practice of sharing its resources equitably among Member States, the budget allocation process for the next biennium, which would devolve more resources to the regions, should take into account the geographical reality that influenza virus strains usually emerged in South-East Asia. Resource allocations for influenza pandemic preparedness should therefore be targeted at that area. PAHO provided some useful models; it had dedicated animal health and food safety institutes and arranged a biennial meeting of health and agriculture ministers. The United States had learned much from Canada, which probably had the best influenza pandemic preparedness plan in the world.

He urged others to study that plan, which was available on the Internet, and provided a valuable model for national planning.

Dr KRIT PONGPIRUL (adviser to Dr Vallop Thaineua, Thailand) said that avian influenza was one of the increasingly complex threats to human health that called for more knowledge and more flexible management. In Thailand, the culling of 30 million chickens had had a severe economic impact, and had also raised issues of public relations and psychosocial approaches to disease control. National capacity for surveillance, outbreak investigation and disease control was essential, and especially so in developing countries lacking sophisticated laboratories. Thailand was grateful to WHO and the United States Centers for Disease Control and Prevention for helping to establish and strengthen its Field Epidemiology Training Programme, whose staff had worked actively and successfully during the recent outbreak. The Programme had been upgraded to an international training programme to benefit neighbouring countries. The Rockefeller Foundation supported the Mekong Basin Disease Surveillance System, thereby strengthening a subregional network. Cooperation between institutions was also needed. Despite the success of a Thai scientist in sequencing the genome of the H5N1 virus, details of which had been fed into the International Nucleotide Sequence Database Collaboration and would help in developing a vaccine, it was unfortunate that academic institutions with the relevant knowledge, technology and human resources did not have the authority to deal with the epidemic.

More attention should be paid in the disease-control system to non-scientific issues, such as public relations and psychosocial approaches. He expressed the hope that WHO, the United States Centers for Disease Control and Prevention and other developed country partners would increase their support for capacity-strengthening in developing countries, to facilitate the rapid control of emerging diseases. Experience with emerging diseases such as Nipah virus infection, SARS and avian influenza should be used as case studies for the training of health professionals.

Professor DAB (France) concurred with the member for Canada that strong leadership by WHO and international solidarity were especially needed in epidemics of the type experienced in early 2004. Unlike SARS, avian influenza was contagious even in the absence of symptoms and thus created even more pressure for transparency and a speedy reaction, the two conditions on which successful control of an epidemic would depend. He paid tribute to the courage and sense of responsibility of the countries of the South-East Asia Region which had been affected. Clearly, avian influenza was one of the greatest threats to human beings, and WHO had been right to sound the alarm. France had developed a comprehensive plan of action for both the pre-pandemic and the pandemic phase, largely inspired by that of Canada. Such plans were not only a matter for health ministries, although they should provide leadership. In France, a special government department had been set up to deal with health emergencies. The principles underlying such arrangements should be shared internationally, under the auspices of WHO; health administrations were not really designed for emergencies, and had to be adapted to cope with them. Another urgent need was to update the International Health Regulations. Had WHO yet revised the timetable for doing so? He also asked about progress in producing an anti-H5N1 vaccine, and whether WHO had identified the vaccine strain and laboratories that were ready to manufacture it. Paragraph 19 of the report rightly drew attention to the possibility of an international stockpile of antiviral agents; what proposals could WHO make on that? He strongly agreed with the member for Canada about the need for collective training, exercises and simulations; in that area the leadership of WHO was essential.

Mr ASLAM (alternate to Mr Khan, Pakistan) said that the avian influenza and SARS epidemics had drawn attention to the need for global health security in the face of new threats from infectious diseases and from the deliberate use of agents for bioterrorism. Such threats were augmented by the growth in international travel and trade, which facilitated the spread of infectious diseases. The International Health Regulations were an important instrument to control the cross-border spread of communicable diseases, and Pakistan had supported the resolutions on that subject at the Fifty-sixth

World Health Assembly. It shared the international concern that current conditions in parts of Asia might trigger an influenza pandemic, which had in the past caused great loss of life, social disruption and economic loss. He welcomed the revision of the International Health Regulations, with the involvement of all stakeholders, including regional associations and international organizations.

No human case of avian influenza had been reported in Pakistan, but the country had immediately stepped up surveillance and case-detection measures. However, in February 2004, the BBC had reported an outbreak of avian influenza among poultry in Karachi and interior Sindh. Although birds had died in large numbers, the virus found in Pakistan was the H7N7 strain and not the H5N1 strain affecting poultry in South-East Asia. However, millions of birds had had to be destroyed as a precaution, and, despite an intensive information campaign, people stopped eating poultry and the financial loss to the poultry industry in one month had a serious impact on the economy. Measures should be put in place, through FAO, to immunize poultry against common diseases, especially avian influenza; that would also contribute to the protection of human beings.

Dr YOOSUF (Maldives) said that improved surveillance was essential in order to prevent outbreaks, but the process of sending samples for diagnosis to national and international laboratories had run into problems: many couriers and airlines had refused to carry the samples or, when they did carry them, the recipient country had sometimes refused entry. One batch of samples had remained in customs for three days before being sent to a European laboratory, by which time its quality had deteriorated. He urged WHO to tackle such problems so that outbreaks could be diagnosed earlier.

Dr ACHARYA (Nepal) said that, although Nepal had had no case of SARS or avian influenza so far, avian influenza might be introduced through the seasonal migration of birds. Because the disease surveillance system in Nepal was weak, the development of a vaccine was especially important for his country. WHO should place more emphasis on such work.

Dr HANSEN-KOENIG (Luxemburg) said that the management of epidemics was the most important item on the Board's agenda, and the one in which the role of WHO was most crucial. Recent epidemics of SARS and avian influenza had revealed the vulnerability and interdependence of all countries; the anxiety that such epidemics caused among the public proved the need for clear guidelines from a recognized authority. Plans to ensure preparedness were being developed in all countries and the time had come to organize international exercises to evaluate their effectiveness in crisis situations. Coordination during the SARS outbreak had proved very effective. WHO should help to coordinate research leading to the development and manufacture of vaccines. Attention should also be paid to establishing international stockpiles of antiviral agents. She commended the responsible and courageous response of the countries affected by avian influenza to the epidemic.

Mr SHARMA (India)<sup>1</sup> said that it could only be a matter of time before the H5N1 virus became capable of human-to-human transmission, and the lack of a vaccine or an effective antiviral agent made matters worse. The first priority was to produce a vaccine. Like the member for France, he would welcome information on the state of research at country level, and the likely timeframe for the production of a vaccine. With regard to surveillance, the revised International Health Regulations, after adoption, should be put in place in all countries as soon as possible, because it was impossible to say where the next outbreak would occur. Their implementation required considerable capacity-building, and would need substantial technical and financial assistance to developing and least developed countries. India was setting up a computer-based surveillance system that would include avian influenza. In 2003 it had organized a meeting among the seven countries of the South-East Asia

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Region to discuss preventive measures against avian influenza, resulting in a recommendation for collaborative effort on their part.

Dr KASAI (Japan)<sup>1</sup> said that Japan was firmly committed to combating avian influenza and would continue its efforts, while at the same time expecting strong leadership from WHO.

Dr OMI (Regional Director for the Western Pacific) said that his Region's response to the outbreak of avian influenza in late 2003 had been coordinated with headquarters and other regions. Experts, including epidemiologists, virologists, public health experts, animal experts and communications officers had been sent to the affected countries. Technical guidelines had been developed in areas such as clinical management, infection control, human surveillance protection and the health monitoring of persons engaged in culling. Donor funds had been used to buy personal protective equipment, influenza vaccines and antiviral drugs for distribution in the affected countries, especially among health-care workers and people involved in culling operations. Specimens had been sent to WHO reference laboratories for virological analysis. WHO had coordinated its efforts with FAO to ensure that the risks of avian influenza were given high priority in the affected countries.

He agreed that more collaboration was needed among regions and countries, and that the zoonotic element of the problem should be discussed, as should its impact on human health. His Region was developing a bi-regional strategy with the South-East Asia Region and headquarters to improve the response to emerging diseases. The strategy would be an operational one, not merely a statement of principles, and would include zoonotic elements such as the management of husbandry practices, which would become increasingly important in years to come. On the subject of pandemic preparedness, the South-East Asia and Western Pacific Regions were organizing a bi-regional workshop in June 2004 to help countries develop national pandemic preparedness plans. The Western Pacific Region, which had been the epicentre of the two outbreaks, was doing its utmost to find a better response to future emergencies.

Dr ASAMOA-BAAH (Assistant Director-General), agreeing that a new era was beginning for infectious diseases, said that, over the past 30 years, many human infections had been caused by pathogens originating in animals or animal products. That situation called for close collaboration between people working in human health and those concerned with animal health and the livestock industry. He therefore welcomed the Health Assembly's approval of the agreement between WHO and the *Office International des Epizooties*.<sup>2</sup> With regard to relations with FAO, cooperation had greatly improved since early 2004. Three meetings had been held in recent months, and FAO's budget for work in that area had been increased by US\$ 5 million.

Avian influenza was not a new disease. What was new was that, for the first time in many decades, there existed a serious risk of a pandemic which the world was ill-prepared to face. As a result, recent activities had focused on pandemic preparedness. The disease would indeed be difficult to eliminate because migrating birds acted as a reservoir. The best strategy lay in aggressive action against outbreaks in domestic birds. Unfortunately, that was not easy because the birds were found not only in commercial farms, but also in smallholdings and free-range areas. It was a logistical nightmare. The mass slaughter of chickens was also a nutritional and economic disaster; moreover, it tempted some countries to declare the outbreak over when that was not true, partly for the sake of public relations or for psychosocial reasons. As long as the virus continued to circulate in domestic birds, the risk to human beings remained. The cooperation of Member States and the agricultural sector was essential, but not always easy to obtain, because of the belief that neither animals nor human beings should die from the disease.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> Resolution WHA57.7.

The best way of reducing human morbidity and mortality in the case of a pandemic was to use vaccines. To be effective, they must offer protection against the pandemic strain of the virus; but that virus could not be known until the pandemic occurred, with the result that vaccines could only be produced after the start of a pandemic. Discussions with vaccine manufacturers had shown that at least four to six months were needed to produce a vaccine, and that was long enough for the virus to spread throughout the world. WHO was therefore exploring how to delay that spread or to buy time, since the disease was contagious even in asymptomatic patients. Hence the importance of investigating antiviral agents, despite the limited production capacity and the expense. The danger was that countries needing antiviral agents to delay the spread of the disease might not receive them at the right time or in the quantities needed. That made it important to consider the idea of an international stockpile, the purpose of which would be to buy time. The practical modalities of doing so were under discussion.

Surveillance was particularly important in the case of avian influenza, which affected both human beings and animals. It was not easy to work with the agricultural sector to monitor the evolution of the disease and target interventions at the right time. No country had a perfect surveillance system but the poorer ones had the weakest systems, and in a pandemic a weak surveillance system constituted a weakness for all countries. He therefore applauded the foresight of the Governments of Australia, Canada, France, Japan and the United States of America, and the European Union, in supporting countries with limited resources.

WHO was working on the revision of the International Health Regulations and, when the revised Regulations came into force, would be expected to play a more active role during disease outbreaks. The Organization therefore needed to improve its capacity in disease verification, risk assessment and mounting a response. For that purpose it was planning more simulation exercises and drills, for which the WHO situation room or strategic information centre would be a useful asset.

As for the timeframe for the production of vaccines against H5N1 virus, a prototype had been developed and tested in February and March 2004 and made available to manufacturers in April. There had been some problems, because companies were unresponsive while they were not sure of a market. Most of the manufacturers were located in Europe, so the members from European Union countries could help by putting pressure on them.

Dr STEIGER (United States of America) enquired about the possibility of targeting budget funds to specific geographical areas, and about possible changes in the organizational structure of WHO so as to respond better to a pandemic.

Dr ASAMOA-BAAH (Assistant Director-General) said that the second of those issues had arisen during a recent consultation on zoonoses. The Director-General was working on the matter. More work on zoonoses was taking place, but with the increased recognition of their importance WHO was keen to step up its work in that area.

The DIRECTOR-GENERAL said that, as in the case of poliomyelitis, considerable resources were being directed to the African and South-East Asia Regions because that was where the problems were. In the case of SARS and avian influenza, it was clearly sensible to focus on the countries concerned, and he would look into the matter.

The CHAIRMAN said that he took it that the Board wished to note the report.

**The Board noted the report.**

**Meeting of Interested Parties, 2003:** Item 4.6 of the Agenda (Document EB114/INF.DOC./1)

Dr STEIGER (United States of America) suggested that, while he recognized the value of interaction between different levels of the Organization and other bodies, it might be more useful to

hold such meetings biennially in nonbudget years, given the amount of organizational work they involved.

Professor CHURNRURTHAI KARNCHANACHITRA (adviser to Dr Vallop Thaineua, Thailand), stressing the importance of the Meetings of Interested Parties in mobilizing extrabudgetary funding, commended the amalgamation of the regular-budget and extrabudgetary resources, which would help WHO's priority programmes. To that end, the themes selected for discussion at the Meetings of Interested Parties should reflect the resolutions adopted by the Health Assembly. It was unfortunate that some resolutions could not be fully implemented for want of financial resources. He supported the suggestion of the member for the United States of America.

Mrs IORDACHE (alternate to Dr Brînzan, Romania) said that the Meetings of Interested Parties provided an excellent forum for discussing the numerous complex issues confronting countries, and should continue to be an annual event.

Ms MIDDELHOFF (Netherlands)<sup>1</sup> noted the recent improvements in the organization of the Meetings of Interested Parties, including greater involvement of all levels of the Organization and increased participation of other partners. Whereas in the past the main function of the meetings had been resource mobilization, WHO's precise role had become less clear in the discussions and panels. Nor was it clear how lessons learnt from the meetings were applied; ideally, they should focus on areas where WHO had an advantage over other organizations. Although the participation of developing countries, the main beneficiaries of much of WHO's work, had considerably increased in recent years, there was still room for improvement. At present, the programme was too full and the number and length of the statements precluded more fruitful interaction. She suggested that all levels of the Organization should decide the agenda items, in consultation with Member States, taking into account the full spectrum of WHO's work and with careful selection of priorities.

Dr BEHBEHANI (Assistant Director-General) said that the Meeting of Interested Parties in 2003 had been based on the experience gleaned from the two previous meetings and the themes had focused on a wider range of activities, in addition to WHO's goals, including the Millennium Development Goals. Whether it should continue to be held annually or biennially would have to be decided. The Meeting of Interested Parties in 2003 had cost about US\$ 300 000. He welcomed the suggestion by the representative of the Netherlands on the selection of agenda items, but observed that every attempt was made to ensure that the priorities decided on genuinely reflected the Organization's goals.

The DIRECTOR-GENERAL said that, in principle, the proposal to hold the Meeting of Interested Parties biennially in nonbudget years was good and would be duly considered. There were comparatively few participants at the meetings, probably because of all the other meetings of governing bodies that representatives were required to attend in Geneva. Experience had also shown that it was virtually impossible to decide on an organizational strategy that was satisfactory to all concerned.

The CHAIRMAN, concluding the item, said that the views expressed by Board members would be taken into account in the planning of future sessions of the Meeting of Interested Parties.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

**Dependence-producing psychoactive substances: supplementary guidelines:** Item 4.7 of the Agenda (Document EB114/7)

The CHAIRMAN drew the Board's attention, in particular, to the draft decision in the report.

Mr FURGAL (Russian Federation) said that the report reflected the provisions contained in the three relevant conventions on procedures to include new substances in schedules. The WHO Expert Committee on Drug Dependence had to be able to provide information in accordance with the conventions on dependence-producing psychoactive substances. Parties to the conventions that identified new substances not already controlled, but which led to dependency, should make such substances subject to national control and inform the United Nations of such action, if control of a particular substance was of interest to the international community. To that end, he proposed the addition of the following sentence to paragraph 2 of the annex to document EB114/7: "It is also necessary to take into account the officially generated information from the Parties on new specific substances causing dependence which have a social impact or a social dimension".

Dr STEIGER (United States of America) stressed the importance of the subject to all governments because of the potential impact of the supplementary guidelines, particularly in connection with the classification of substances used to enable people addicted to specific drugs to receive treatment. As drafted, the supplementary guidelines could result in an arbitrary system of classification, leaving out of account relevant scientific and medical evidence about a particular drug or other factors, including social factors, as the previous speaker had stressed, that were important in determining the drug's potential for abuse. There was also the possibility that certain unscheduled substances, or ones that were scheduled under the Convention on Psychotropic Substances, such as buprenorphine, which was prescribed directly by doctors for heroin addiction rather than more restrictively, might have an impact on the availability of the medical product. He suggested that the supplementary guidelines be amended to make them consistent with the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971 and the commentaries and guidelines thereon. He proposed, in paragraph 2, the replacement of "a qualitative" by "an", and of "and profiles of its liability to abuse and dependence" by "its abuse liability and its dependence-producing characteristics" in the third sentence. He further proposed deletion of the fourth sentence in the interests of clarity: a substance like buprenorphine, which might be pharmacologically similar to morphine because it bound to a common receptor, could be an immediate candidate for a Single Convention control. Buprenorphine had much less abuse potential and fewer ill effects than morphine. He also proposed replacement of the existing paragraph 5 with: "If a substance is under control of either the 1961 or the 1971 Convention, any proposal for change in the existing status of the substance should be made only if specific new control measures are necessary in order to decrease the extent or likelihood of abuse of the substance and only if such changes will not unduly limit its availability for legitimate medical and scientific purposes."

Ms HALTON (Australia) endorsed the remarks of the previous two speakers. Australia was a signatory to the relevant conventions, but was concerned that any attempt to make their application clearer could inadvertently hinder countries' efforts to tackle substance abuse and provide proper therapy in the right context.

Mr SHUGART (Canada) said that, although he supported the comments of the member for the United States of America, it might be advisable to defer a decision until the 115th session of the Executive Board.

Mr BRUNET (alternate to Professor Dab, France) said that he shared the concerns of previous speakers. Despite its complexity, the issue under consideration was of fundamental importance as it related to the availability of products used for legitimate medical purposes: in substitution treatment

and pain management. The data gathered by the International Narcotics Control Board showed great cultural variation in the medical use of opiates, particularly in pain management. Ten countries consumed 80% of the total amount of morphine used for painkilling purposes. WHO must ensure that any measures it adopted did not affect availability in either case. He would need to study the amendments proposed by the United States, but supported them in principle.

Dr KRIT PONGPIRUL (adviser to Dr Vallop Thaineua, Thailand) commended WHO's prompt response to the Expert Committee's request and supported the draft decision. He highlighted the need to maintain a balance between the medical and legal aspects in the supplementary guidelines when considering the amendments proposed by the members for the Russian Federation and the United States of America.

Dr LEWIS-FULLER (alternate to Mr Junor, Jamaica) advised a cautious approach to making changes that could restrict the use of certain drugs for medical purposes and recommended that the decision be deferred to allow Member States to seek expert advice.

Dr YOOSUF (Maldives) pointed out the difficulties many countries had in delivering effective pain-management treatment. In Maldives, increased use of morphine as an oral painkiller had caused a shortage of injectable morphine. WHO could play a valuable role in helping countries to develop their pain management strategies.

Mr KHAN (Pakistan) said that Pakistan took drug abuse seriously, primarily because it was bounded by major drug-producing countries. Pakistan appreciated WHO's efforts to resolve the conflicts over international health issues in a way that ensured maximum transparency and consistency, as exemplified by the amicable resolution of difficulties over control of psychoactive substances in applying the Guidelines to the Single Convention on Narcotic Drugs, 1961 and the Convention on Psychotropic Substances, 1971. Similarly, the difficulty of choosing between the Single Convention on Narcotic Drugs, 1961 and the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 when deciding whether to control a substance convertible to a narcotic drug had finally been settled by discussion among the parties concerned. Pakistan supported the supplementary guidelines. On the amendment to paragraph 5 proposed by the member for the United States of America, he pointed out the danger of substances being abused when available for legitimate medical and scientific purposes. Furthermore, the current imbalance in penalties needed redressing, since those producing and selling drugs were punished with the utmost severity, while users were offered therapy. Yet the fact remained that supply kept pace with demand.

Dr NYIKAL (Kenya) observed that there was a tenuous line between the use of narcotic drugs for pain control and for unlawful purposes. Kenya currently had strict laws governing the use of drugs, but pressure was building to make them more readily available for pain management. He agreed that a decision should be deferred until the 115th session of the Board to allow time for further consultation.

Dr EMAFO (International Narcotics Control Board) said that the supplementary guidelines would provide the necessary guidance to the Expert Committee on Drug Dependence to enable it to make appropriate recommendations to the Director-General. They would also help the Expert Committee to decide whether drugs were suitable for control under the Single Convention on Narcotic Drugs, 1961, the Convention on Psychotropic Substances, 1971 or the 1988 Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. Drugs that could not be controlled under the Single Convention or the Convention on Psychotropic Substances were referred to the Control Board, which assessed their suitability for control under the 1988 Convention. The supplementary guidelines would not affect the present control regime, as they would not lead to a transfer of drugs from control under the Single Convention to control under the Convention on Psychotropic Substances or vice versa, except where additional relevant medical and scientific evidence required a drug to be

rescheduled. Nor would they affect the availability of drugs for medical purposes. Rather, they would refine the Expert Committee's review process. The guidelines for the WHO review of dependence-producing psychoactive substances for international control had always been reviewed as and when required, and the reviews had never prevented access to drugs for medical purposes. The supplementary guidelines would not affect lawful access to psychoactive drugs under international control.

The Control Board was greatly concerned about the aversion of some members of the pharmaceutical industry to any form of drugs control and the unethical promotion of drugs that encouraged their illicit use. Additionally, the presentation of some drugs as having minimal abuse liability had often resulted in market advantages for the industry and, subsequently, in their abuse. The Control Board had participated in the discussions on the supplementary guidelines and supported the recommendations. The amendments tabled by the member for the United States of America improved their language and comprehensibility and should be supported.

Dr LEPAKHIN (Assistant Director-General), responding to the comments and concerns expressed, said that the proposed supplementary guidelines had been drafted by the Expert Working Group in February 2003 in response to a request from the Expert Committee on Drug Dependence, to give specific guidance on the choice between the 1961 Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances, since the control of psychoactive substances was similar to that of narcotic substances, narcotic drugs and psychotropic substances. The Expert Working Group had included experts from France, India, Japan, Poland, the United States of America, CIOMS, the International Narcotics Control Board and the United Nations Office on Drugs and Crime. The supplementary guidelines were intended not to influence the professional opinions and decision-making of the Expert Committee, but rather to provide it with procedural clarification to streamline the review process; in fact the Expert Committee had requested the guidelines because its members were having difficulty in reviewing some newly developed substances similar to narcotic drugs and psychotropic substances. The criteria for control under the conventions and the distinction between the 1961 and 1971 Conventions would not be affected by the supplementary guidelines. Nor would the guidelines lead to all substances with qualitative similarities to narcotic drugs being placed under the 1961 Convention. He acknowledged the proposed amendments which would remove any ambiguities.

Dr STEIGER (United States of America) said that, since the Expert Committee would be meeting in November 2004, he assumed that it would be doing so under the existing guidelines.

The CHAIRMAN confirmed that such would be the case. He invited the Board to agree that the decision on dependence-producing psychoactive substances: supplementary guidelines should be deferred to the 115th session of the Executive Board in January 2005.

**It was so agreed.**

**The meeting rose at 12:40.**

## **FOURTH MEETING**

**Tuesday, 25 May 2004, at 15:10**

**Chairman:** Mr D.Á. GUNNARSSON (Iceland)

**TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

**Cancer control:** Item 4.1 of the Agenda (Document EB114/3) (continued from the second meeting)

The CHAIRMAN invited the Board to resume consideration of the draft resolution on cancer prevention and control.

Ms HALTON (Australia) said that as the revised version of the draft resolution was difficult to follow in view of its numerous amendments and alternatives, her delegation, together with a number of others, had prepared a second revision, which was currently available only in English. She suggested that the Board postpone its consideration of that text until the following morning, when it would be available in all working languages.

Dr YIN Li (China) proposed that, in the second preambular paragraph, reference should be made to resolution WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, rather than to resolution WHA55.23.

The CHAIRMAN said that he took it that the Board wished to defer consideration of the draft resolution until the following day.

**It was so agreed.**

(For adoption of the resolution, see summary record of the fifth meeting, page 107.)

**Disability, including management and rehabilitation:** Item 4.2 of the Agenda (Document EB114/4) (continued from the second meeting)

The CHAIRMAN invited the Board to consider a draft resolution proposed by China, Czech Republic, Iceland and the Russian Federation, which read:

The Executive Board,  
Having considered the report on disability, including management and rehabilitation,<sup>1</sup>

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

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<sup>1</sup> Document EB114/4.

Noting that about six hundred million people live with physical and mental disabilities of various types;

Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, ageing, chronic conditions, malnutrition, war, violence, road-traffic injuries and other causes often related to poverty;

Stressing that 80% of people with disabilities live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure good quality of life regardless of disability;

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;<sup>1</sup>

Recalling also the United Nations World Programme of Action concerning Disabled Persons,<sup>2</sup> indicating inter alia that the sphere of responsibility of WHO includes prevention of disability and medical rehabilitation;

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012) and the European Year of People with Disabilities (2003);

Recalling the United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

Mindful that the United Nations Millennium Development Goals would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities,

1. URGES Member States:

- (1) to strengthen national programmes, policies and strategies for the implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (2) to develop their knowledge base with a view to promoting the rights and dignity of women, men, girls and boys with disabilities and ensure their full inclusion in society;
- (3) to promote early intervention and identification of disability, especially for children, and full physical, informational, and economic accessibility in all spheres of life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;
- (4) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;
- (5) to promote the development of assistive technology and other means which facilitate the inclusion of persons with disabilities in society;
- (6) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;

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<sup>1</sup> Adopted by United Nations General Assembly resolution 48/96.

<sup>2</sup> United Nations General Assembly resolution 37/52.

- (7) to ensure gender equality in all measures with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;
- (8) to participate actively in the preparatory work for a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities;<sup>1</sup>

2. REQUESTS the Director-General:

- (1) to intensify collaboration within WHO in order to work towards enhancing quality of life and promoting the rights and dignity of women, men, girls and boys with disabilities inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;
- (2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (3) to support Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;
- (4) to further strengthen collaborative work within the United Nations system and with governmental entities, academia, private sector, and nongovernmental organizations, including disabled peoples' organizations;
- (5) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;
- (6) to produce a world report on disability and rehabilitation based on the best available scientific evidence;
- (7) to provide a progress report on implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board.

The CHAIRMAN, speaking as the member for Iceland, pointed out that in paragraph 2(4), the phrase "governmental entities" should be replaced by "Member States". He drew particular attention to paragraph 1(8), which referred to the planned United Nations convention to promote and protect the rights and dignity of persons with disabilities; paragraph 2(1), which called for intensified collaboration within WHO in order to enhance the quality of life and promote the rights and dignity of people with disabilities; and paragraph 2(3) which requested support for Member States in collecting more reliable data on aspects such as cost-effectiveness of interventions for disability prevention, rehabilitation and care.

Dr HUERTA MONTALVO (Ecuador) said that the draft resolution should include a reference to the prevention of disability. Naturally, most attention was paid to the management and rehabilitation of disabilities that had already occurred, but prevention was possible, and it was a major aspect of WHO's work. The word "prevention" could simply be included in the title of the draft resolution, which would then read "disability, including prevention, management and rehabilitation".

Dr STEIGER (United States of America) asked for his country to be included as a sponsor of the draft resolution. He had a number of minor amendments to suggest; perhaps the text should be revised by a drafting group and resubmitted to the Board the following morning.

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<sup>1</sup> United Nations General Assembly resolution 56/168.

Dr AHMED (alternate to Dr Afriyie, Ghana) asked for Ghana to be included as a sponsor of the draft resolution.

Ms HALTON (Australia) suggested that paragraph 1(5) should be amended to read: “to facilitate access to and promote ...”.

Dr SUWIT WIBULPOLPRASERT (adviser to Dr Vallop Thaineua, Thailand) said that the text should refer to the need to overcome the misconception that people with disabilities were a burden on society, rather than a valuable human resource.

Dr RUIZ (Mexico)<sup>1</sup> suggested that a reference to accidents in the workplace should also be included, since accidents were a major cause of disability in developing countries.

The CHAIRMAN suggested that the draft resolution should be entrusted to a drafting group and that the Board should consider the revised version the following morning.

**It was so agreed.**

(For adoption of the resolution, see summary record of the fifth meeting, page 111.)

**Manufacture of antiretrovirals in developing countries and challenges for the future:** Item 4.8 of the Agenda (Document EB114/15)

Dr ZEPEDA BERMUDEZ (Brazil), speaking on behalf of the Latin American and Caribbean Group, emphasized that the comments he was about to make did not apply to his own country, which had manufactured antiretroviral drugs for the past decade. Countries with considerable socioeconomic disparities, very impoverished populations and a growing prevalence of HIV/AIDS, as was the case for most countries in the Region of the Americas, had to focus on producing essential medicines of high quality and making them available to those who needed them as a public health priority. Local production might entail considerable costs, particularly bearing in mind that currently some antiretroviral drugs could be bought on the international market at greatly reduced prices, but it could guarantee a reliable supply; sustainability of treatment was an important aspect of the fight against HIV/AIDS. Local production could also be a useful tool for negotiating price reductions with private suppliers, since if reductions were not achieved the drugs could always be manufactured locally to avoid any interruption in the supply. Such an approach was consistent with the relevant trade agreements signed by the Member States of WTO.

If good-quality medicines were to be efficiently produced, the manufacturing infrastructure must include an effective quality control system. Countries which already exported generic antiretroviral agents to other developing countries must apply international controls, perhaps endorsed by WHO, to ensure that the drugs were of the same quality and that their generic characteristics were interchangeable with those of patented drugs, in respect of both their contents and their packaging. The manufacturing country must also be able to remedy any shortcomings in respect of the quality of the product or of storage or delivery deadlines.

Prequalification was a good approach for companies which manufactured generic antiretroviral drugs at low cost in order to sell them to developing countries. However, WHO should establish a mechanism for claiming damages from pharmaceutical companies if it was proved that harm had been caused by poor-quality products.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The report did not refer in enough detail to the Agreement on Trade-related Aspects of Intellectual Property Rights (TRIPS) or the Doha Declaration on the TRIPS Agreement and Public Health, and did not mention the recent compulsory licences that had been issued by Cameroon, Malaysia, Mozambique and the Philippines. He called for a more detailed report to be produced for the next session of the Board, providing, with the collaboration of the regional offices, an analysis of the various regional initiatives, such as the manufacture of antiretroviral agents in Brazil, China and Thailand, and the results of price negotiations in the Andean region, in which Argentina and Mexico had also participated.

Paragraph 2(6) of resolution WHA57.14 on scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS, urged Member States to encourage that bilateral trade agreements take into account the flexibilities contained in the TRIPS agreement and the Doha Declaration. Current multilateral, regional and bilateral agreements, which might jeopardize access to medicinal drugs in developing countries, should therefore be reviewed with a view to determining the best course of action.

Dr STEIGER (United States of America) supported WHO's activities related to the manufacture of antiretroviral agents, particularly those to strengthen drug regulatory authorities described in paragraph 12 of the report. Drug regulation was essential, whether or not a country manufactured its own medicinal drugs. His country strongly endorsed WHO's standard-setting activities, notably training in good manufacturing practices, information exchange with national drug regulatory authorities and support for national medicines control laboratories. However, he questioned whether it was an effective use of WHO resources to consider global prices for active pharmaceutical ingredients, as referred to in paragraph 12(e). He wanted more information about the programme in question, which he believed was jointly supported by WHO and UNCTAD, and its transparency since he had heard some reports of it that gave him cause for concern.

His country had supported the resolution on HIV/AIDS adopted by the Health Assembly the previous week,<sup>1</sup> and particularly supported the call for greater transparency in the prequalification scheme. WHO should make assessment reports publicly available, for instance by posting them on its web site. The remit of the prequalification programme should be made clearer; its limits should perhaps have been stated more clearly in the report, as was done in the disclaimer that accompanied each prequalification listing. It must be clearly recognized that WHO was not a drug regulatory authority.

He commended WHO's work on the draft principles relating to fixed-dose combination drugs. The United States Food and Drug Administration had recently announced plans to accelerate their registration under the President's Emergency Plan to combat AIDS, and he would be glad to provide more information if members wished.

He welcomed the emphasis placed by the previous speaker on drug quality in local manufacture, but wondered how WHO could administer a system of sanctions for low drug quality, as the member for Brazil had suggested. Surely that was the function of a national drug regulatory authority? Future work on the manufacture of antiretroviral drugs in developing countries should be entrusted to the Commission on Intellectual Property, Innovation and Public Health, and there was accordingly no need for a separate report to the Board.

Mr FURGAL (Russian Federation) said that every country had to decide for itself whether to import or manufacture medicinal drugs, and the report provided information to support that choice. The seriousness of the HIV/AIDS problem and the vital importance of implementing the "3 by 5" initiative meant that countries must take all measures in their power to stem the epidemic. He welcomed the WHO prequalification scheme, which included antiretroviral drugs that met

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<sup>1</sup> Resolution WHA57.14.

international quality standards, thanks to which work a list of generic drugs and their manufacturers would be available and kept up-to-date, which would help countries to increase the availability of antiretroviral therapy. Russian experts had had a great deal of experience in the development of prequalification testing at national level, and were willing to contribute to the WHO scheme.

He thanked the staff of the Regional Office for Europe, who had helped the Russian Federation to improve the work of its drug regulatory authorities related to the distribution of medicinal drugs, as part of the strategy to reduce the price of antiretroviral drugs.

Dr YIN Li (China) agreed with the recommendations concerning the local manufacture of antiretroviral agents in developing countries, which was an important factor in improving access to them. Further technical and other support from WHO in that area would be crucial. Because of the costs involved, before 2001 only about 100 patients in China had been able to benefit from antiretroviral treatment. However, by the end of 2003, about 5000 people with AIDS were being treated with antiretroviral drugs, supplied free of charge by the Government.

In order to facilitate access to antiretroviral drugs, the authorities had worked actively on several fronts. Under the auspices of the Ministry of Health, negotiations with foreign pharmaceutical companies had resulted in reductions of one third or even 50% of the cost of the products. Permission had been given for antiretroviral drugs to be imported free of customs dues and tax. Thanks to joint efforts by the public authorities and the companies concerned, certain antiretroviral drugs were being produced locally. China had 13 pharmaceutical companies capable of producing antiretroviral drugs including zidovudine and stavudine. Used in different combinations, they had given very good results. In addition, locally-manufactured drugs had led to an 80% reduction in annual therapeutic costs. The Government of China would promote the supply and use of antiretroviral drugs according to the needs of the country and the capacity of local companies for research, development and production. It would give priority to locally-produced drugs, importing certain products to meet urgent therapeutic requirements. China was encouraging patent-holders to produce antiretroviral drugs in the country, through transfer of technology or technical cooperation. That would reduce costs, improve quality and respond better to the needs of patients suffering from HIV/AIDS. National pharmaceutical manufacturers were being encouraged to provide antiretroviral drugs of good quality but at lower costs for supply to other developing countries that lacked the manufacturing capability, thus fostering technical assistance and cooperation, while respecting the provisions of the TRIPS agreement. China looked to WHO for timely provision of standards for producing and handling antiretroviral drugs, together with information on pricing, and looked forward to receiving the Organization's support in training.

Professor DAB (France) said that the manufacture of antiretroviral agents and access to them were two of the main prerequisites for success in tackling HIV/AIDS; the report had set out briefly and clearly what was at stake, particularly with regard to the quality of products available. Provision of antiretroviral drugs was a crucial issue, with important medical and epidemiological implications. Money was not the end of the matter; there must also be adequate human, technical and methodological resources. The report seemed to imply that a country's capacity to manufacture pharmaceuticals was linked to its demographic size. That was not necessarily true; for example, Switzerland, a small country, produced a large quantity of high-quality pharmaceuticals. On the other hand, the existence of a strong, well-structured health authority with tools for evaluation, inspection and monitoring was an important prerequisite. WHO had a role to play in providing technological or methodological recommendations, but could not take the place of national health authorities. For the past 10 years, France had drawn international attention to the importance of improving access to treatment for the largest possible number of patients. Its national drug safety agency, which cooperated with the other members of the European Union, was also helping a number of French-speaking African countries, and stood ready to step up its collaboration with WHO and its Member States.

Ms CHA-AIM PACHANEE (adviser to Dr Vallop Thaineua, Thailand) said that the success of the “3 by 5” initiative and attainment of the Millennium Development Goals would depend on the accessibility of affordable high-quality antiretroviral agents in the developing countries. Her country greatly appreciated the Organization’s work in that respect, particularly concerning triple therapy. Thailand was able to produce high-quality triple-therapy formulations at affordable prices and, since October 2003, the Government had been pursuing a policy of universal access to antiretroviral agents. In six months, 35 000 people had been placed on such treatment, compared with a national target of 50 000. National resources provided 80% of the necessary funds, the remaining 20% coming from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Universal access to antiretroviral agents in Thailand would definitely contribute to the success of the “3 by 5” initiative.

To promote local production, WHO’s prequalification project should be strengthened in line with paragraph 3(3) of resolution WHA57.14. WHO should proactively support countries to improve production and achieve prompt prequalification, instead of waiting for them to apply and approaching them only for evaluation purposes. Secondly, WHO should rapidly provide technical support to all countries in establishing an appropriate legal framework and adequate technical capacity to make full use of the safeguard measures available under the TRIPS agreement. It should also support countries without the capacity to manufacture antiretroviral drugs, by helping countries that did have it to amend their national legislation to allow for compulsory licensing for export under the Doha Declaration and the TRIPS agreement. Countries in the first and second categories mentioned in paragraph 6 of the report, including Thailand, had the capacity to undertake generic manufacturing, and should be given support in revising their legal framework in that light. She commended Canada on being the first country to amend its legal framework to facilitate compulsory licensing for the export of high-quality generic medicines, especially antiretroviral drugs, to developing countries. She urged WHO to support the transfer of Canada’s experience to developing countries, to enable them to make use of the TRIPS agreement in increasing production of good-quality antiretroviral drugs and access to them.

Mr ASLAM (alternate to Mr Khan, Pakistan) said that his country had a vigorous pharmaceutical manufacturing sector and was meeting 80% of its needs through generic drugs. There were 320 national and 30 multinational units, manufacturing all dosage forms. The industry was entirely in the private sector, with the exception of biologicals which were to be manufactured in the National Institute of Health. There was a well-organized drug regulatory system that licensed manufacturing units, registered drugs and ensured quality control from the point of manufacture to the retail outlet. A national control authority for biological preparations and a national control laboratory responsible for release of vaccine lots worked under the supervision of the Drug Regulatory Authority. Pakistan had only a limited market for antiretroviral drugs, but had the potential for manufacturing common antiretroviral drugs through formulation and repackaging after bulk import of ingredients. Like certain other developing countries, Pakistan did not have the resources to develop a bulk manufacturing facility. Moreover, the impact of the TRIPS agreement on the availability of raw materials and finished antiretroviral drugs would have to be carefully evaluated. Developing countries should be provided with adequate safeguards against international monopoly trends, which led to excessive prices for raw materials, and put life-saving drugs, like antiretroviral drugs, out of reach for those who desperately needed them, even in countries with manufacturing capability. Patent regulations should ensure that countries did not suffer difficulty in gaining access to basic raw materials for the drugs they needed in public health emergencies when they had the capacity for lower-cost indigenous formulation. A global strategy to tackle that problem should focus on formulating a detailed action plan for proper infrastructure and appropriate financial and technical resources, especially in the disadvantaged nations.

Dr LAMATA COTANDA (Spain) said that access to safe, effective medicines through the “3 by 5” initiative was the strategy of choice. Supplying safe life-saving drugs at the right time to all those who needed them, and stemming the advance of the epidemic, was a key objective. He welcomed the efforts made to see how that objective could be achieved by manufacturing the drugs in

the developing countries themselves, and endorsed the initiatives taken by Brazil, China, Pakistan and Thailand in that direction. He endorsed the suggestions made on behalf of the Latin American and Caribbean group of countries. The discussion could also be broadened to include the question of access to medicines generally.

Dr LEWIS-FULLER (alternate to Mr Junor, Jamaica) said that Jamaica agreed in principle with the issues raised by the member for Brazil. She emphasized the need for diversity and flexibility: countries and regions should be free to decide whether to produce antiretroviral drugs. The Caribbean countries were small and most of them lacked the capacity to produce antiretroviral drugs. They were therefore unable to take advantage of the relevant sections of the TRIPS agreement and the Doha Declaration with regard to compulsory licensing. They were also unable to afford the financial outlay in technology, infrastructure, human capital and raw materials. If such investments were made, it would take many years for a significant return to be realized. Her country was therefore grateful to WHO, the World Bank, UNICEF, UNFPA and UNAIDS for working to ensure the availability of good-quality antiretroviral drugs on the market. She called on WHO to step up its efforts to ensure a sustainable supply of low-cost, effective, good-quality antiretroviral drugs, whether produced in developing or developed countries. In the interests of public health, everyone who needed antiretroviral drugs should have access to them.

Mrs LE THI THU HA (Viet Nam) said that many developing countries were exploring ways to provide antiretroviral therapy to people living with HIV/AIDS. In March 2004, her Government had adopted a national strategy for HIV/AIDS prevention and control to 2010, along with its "Vision 2020" programme, with a view to providing adequate HIV/AIDS care and treatment for 90% of HIV-infected adults, all infected pregnant women and all infected children.

The "3 by 5" initiative had recently been incorporated into the national strategy, and the Ministry of Health had accordingly proposed a relatively high target of reaching 15 000 HIV-positive people in need of antiretroviral drugs, a target recently reviewed by the Ministry with WHO and UNAIDS. The Ford Foundation had recently completed a study on the legal aspects of access to antiretroviral drugs in Viet Nam, including local production. Various options were being considered, such as buying generic versions of antiretroviral drugs not yet patented in Viet Nam in parallel with imports from patent holders, compulsory licensing and buying the drugs under a "drug deal" brokered by the Clinton Foundation and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Viet Nam hoped for technical support from WHO to ensure that it made a good policy decision.

Dr NYIKAL (Kenya) said that, as the global initiatives already in place would increase the availability of drugs and prompt many countries to prescribe antiretroviral drugs more widely, especially if greater use were made of generic products, there was an urgent need to enable States to enforce strict regulations on drug quality. WHO's activities, as described in the report, particularly paragraphs 12(a) and (d), were extremely important. It was vital that developing countries, where mainly generic products were sold, should be supported in setting up efficient quality-control laboratories and proper regulatory systems, including market surveillance. As it would take time to establish such systems, the WHO prequalification process and its guidance for countries without drug-testing facilities would be invaluable. WHO should be more active in that respect and not wait until companies applied for assessment. The production of antiretroviral agents in developing countries also needed to be supported as their needs were likely to grow and large-scale production would make for lower costs. The TRIPS agreement set out options enabling governments to respond to the HIV/AIDS crisis by providing drugs for their citizens through compulsory licensing and parallel imports. WHO should therefore issue guidelines and provide technical support to countries wishing to use those provisions, even if, like Kenya, they had companies manufacturing antiretroviral drugs.

Dr HUERTA MONTALVO (Ecuador) said that the proposal submitted by the member for Brazil was of historic importance because it was aimed at combating a terrible scourge. The generic

antiretroviral drugs exported to developing countries should indeed comply with provisions relating to best manufacturing practices in order to guarantee their highest quality. One way of ensuring that might be to demand that the products be registered with WHO.

Dr ACHARYA (Nepal) explained that his country manufactured only 30% to 40% of the drugs it required and had no possibility of producing antiretroviral drugs. It wanted to ensure that imported drugs were of the highest possible quality. Since antiretroviral drugs should also be affordable, producers might need some support. The report was timely and commendable given the effort that would be needed to achieve the goals of the “3 by 5” initiative.

Dr PHOOKO (Lesotho) commented that companies producing antiretroviral drugs had to be persuaded to invest in developing countries where the problem of HIV/AIDS was acute, and which therefore offered a ready market. Such a step would facilitate the implementation of the “3 by 5” initiative by making access to drugs easier in poor countries unable to afford imported medicines. WHO should continue to conduct research and to update guidelines as manufacturing processes developed. Producing countries should not be threatened, but given incentives to supply high-quality goods.

Dr CAMARA (Guinea) observed that the quality of health services depended on the supply of effective drugs; yet the latter were expensive and would remain beyond the means of developing countries, unless steps were taken to promote local production in an effort to supply affordable, high-quality drugs to those who really needed them. Since cheap labour in developing countries might help to reduce the purchase price of drugs, companies should be encouraged to set up manufacturing facilities there.

The CHAIRMAN, speaking as the member for Iceland, said that, although it was understandable that most Member States wanted to produce the medicines they most urgently needed, huge disparities in the drug regulatory environment in different countries meant that his Government concurred with the World Bank’s opinion, as outlined in paragraph 7 of the report. Furthermore, local production of medicines could not be recommended in places lacking an effective regulatory system: insufficient capacity to control substandard medicinal products, whether locally manufactured or imported, could lead to increased resistance or other harmful effects. The need was for effective drug regulatory authorities to be able to evaluate all products in a transparent and professional manner. WHO could and should help Member States to establish such authorities.

Mr SHARMA (India)<sup>1</sup> noted that the report’s recommendations were in line with resolution WHA57.14. The “3 by 5” initiative could not be fully implemented unless good-quality, cost-effective generic drugs were actively promoted. To that end, all the countries concerned, particularly developing and the least developed countries, should take advantage of the flexibility allowed under the TRIPS agreement and the Doha Declaration, and WHO should play a facilitating role in that respect.

The launching of generic versions of many antiretroviral drugs by Indian pharmaceutical firms had reduced their price the world over. Those companies could make good-quality, inexpensive, effective and safe products. India was the fourth largest manufacturer of drugs worldwide and a net exporter. Four of the 10 firms producing antiretroviral drugs had been prequalified by WHO in a stringent, scientific process which should be regarded as an adequate benchmark for the supply of cost-effective antiretroviral agents.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Ms MAFUBELU (South Africa)<sup>1</sup> said that, assuming that one of the objectives of the report was to address the issue of increasing access to affordable medicines, encouragement of local manufacture of medicines might have been expected, given that the lack of such productive capacity made it harder for developing countries to avail themselves of flexible arrangements, such as the compulsory licensing provided for in the TRIPS agreement, that would make medicines more affordable. Developing countries still faced significant barriers to the local manufacture of drugs and therefore looked to organizations like WHO to help remove such barriers. She congratulated Canada on being the first country to amend its legislation so as to enable countries to make effective use of the flexibility offered under the TRIPS agreement. Referring to subparagraphs 6(a) and (b), she requested assurance that the classification into large and small countries did not imply any difference in status.

Dr ABREU CATALÁ (Venezuela)<sup>1</sup> endorsed the statement by the member for Brazil on behalf of the Latin American and Caribbean Group. In order to guarantee the quality of the packaging and storage of products and of the products themselves, quality control should be based on good manufacturing practices, as suggested by the member for Ecuador. She asked what funds were available for the activities mentioned in Health Assembly resolutions concerned with intellectual property rights and access to drugs.

Dr BALE (International Federation of Pharmaceutical Manufacturers Associations), speaking at the invitation of the CHAIRMAN, said that the questions raised in the report applied to the manufacture of all pharmaceutical products. What were the right local conditions and could local production of drugs improve access to them? Recent studies suggested that pharmaceutical production was increasingly concentrated in just a few developing countries, and even more so in the case of active-ingredient production. The report did not distinguish between production by local manufacturers in developing countries and investment by global companies in developing countries' firms and in local research and development. Multinationals were participating widely in some developing countries' production. The size of the country mattered less if the right government regulatory policies were in place. Countries promoting investment created opportunities for local manufacturing, technology transfer and the growth of domestic capacity to meet their pharmaceutical needs. Research-based companies were also cooperating with local manufacturers in some countries with a view to transferring appropriate antiretroviral technology. While local manufacturing was no panacea for improving access to medicines, in some circumstances it was an appropriate means of meeting national and regional health needs, provided that it was done in an economical fashion free of hidden subsidies, trade barriers or irrational manufacturing standards.

Dr LEPAKHIN (Assistant Director-General), responding to points raised, said that, although local production of medicines might seem to be the most logical approach to improving access to antiretroviral drugs in developing countries, it was not always the best public health option. WHO had an international mandate in public health and worked with the ministries of health; aspects connected with industrial development were best left to ministries of trade and industry and to UNIDO. WHO's objective was to ensure access to effective, safe, good-quality medicines at the lowest possible cost to society and to patients. There was evidence to suggest that, for most developing countries and certainly for smaller countries, the best way to achieve that goal was probably through large-scale or pooled procurement from reliable suppliers. That was one of the main reasons why WHO and its United Nations partners had launched the prequalification process, an approach which had just been endorsed by the Health Assembly. WHO was also engaged in other activities in support of production of antiretroviral medicines, including the formulation, dissemination and promotion of international norms and standards on efficacy, safety and quality, support to national regulatory authorities and

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

national control laboratories, training of national staff in good manufacturing practices, and issuing global market information on prices of active ingredients.

In reply to the member for Brazil, he agreed that a fuller report would be desirable, especially at a time when new initiatives and activities had just been launched. In the past year, the laws of some countries had changed and compulsory licensing had taken effect. Antiretroviral drugs had started to be produced in some developing countries prepared to use the flexibility allowed under the TRIPS agreement. WHO had begun a special project to monitor how all that commercial activity affected access to life-saving drugs. Should the Executive Board so decide, documentation on the results of that work would be prepared for 2005.

Responding to matters raised by the member for the United States of America, he emphasized the need for safety and high quality of products. If countries, especially poorer ones, procured poor-quality products, their problems would only be compounded. In that context, WHO did much to strengthen the drug regulatory authorities and quality control laboratories. In the prequalification project undertaken by WHO, UNICEF, UNFPA and UNAIDS, more than 250 HIV/AIDS products had been assessed, of which only 63, along with 11 double or triple combinations, had been prequalified. Clearly, the project was crucial in weeding out unsuitable drugs. A big effort was also made to prequalify suppliers: of the 45 participating, only 12 manufacturers of HIV/AIDS products had met the requirements. He welcomed the proposal by the Russian Federation to participate in the process and to invite other countries, particularly those with strict drug regulatory authorities, to do likewise, making their expertise available to other countries.

China had made great progress in producing antiretroviral drugs and the 80% reduction in costs was undoubtedly due to local production of those drugs. WHO could continue to provide standards, price information and training in various aspects of drugs. The member for France had underlined that the core issue was quality of drugs and the need for human resources. WHO provided training in many aspects of quality assurance. Thailand had asked WHO to strengthen local production, which was a difficult issue for WHO as an international organization to take on. WHO's role lay more in providing information, technical support and, if requested, inspection. He thanked the member for Thailand for proposing the strengthening of the prequalification process: the figures just quoted demonstrated the need to strengthen and expand that activity. He agreed that WHO should be proactive but the Organization lacked the necessary human and financial resources to deal with large numbers of applications; it would continue its work in relation to the TRIPS agreement, the Doha Declaration, legislation and compulsory licensing.

The member for Pakistan had pointed out that the pharmaceutical industry in that country was mostly in the private sector. That applied to most countries but meant that there was a need for very stringent drug regulation and legislation. WHO could help countries in that regard. Some had mentioned that that was a key issue for access to safe and effective antiretroviral drugs. Countries had asked for more technical help and support and WHO would continue to do its utmost in that regard.

Many speakers had referred to product quality but there had been no mention of counterfeiting. Of course, substandard drugs were undesirable, but counterfeiting, and increasingly counterfeiting of antiretroviral drugs, was a huge global problem. If funds permitted, WHO would step up its activity on its special project related to counterfeiting; some countries and the International Federation of Pharmaceutical Manufacturers Associations had also proposed collaboration. The member for Ecuador had mentioned prequalification and good manufacturing practices: special WHO guidelines on the matter were available. WHO would continue its work but had limited resources. There was a need for help and collaboration from countries as money was not the only factor involved in providing access to safe, effective, good-quality and low-cost drugs. That was crucial for the success of the "3 by 5" initiative.

The DIRECTOR-GENERAL said that WHO was not a global regulatory agency, nor had it the capacity to act as one. Many of its activities concerning medicines had been undertaken with a view to ensuring that the products procured by the United Nations system met the necessary stringent standards. The Organization was not ideologically against any particular group in the pharmaceutical

industry but clearly had a duty to undertake such activities and to keep its Members informed about such dangers as poor-quality drugs and counterfeiting.

The CHAIRMAN took it that the Executive Board wished to take note of the report.

**The Board noted the report.**

**Sustainable financing for tuberculosis control:** Item 4.9 of the Agenda (Documents EB114/14 and EB114/14 Corr.1)

The CHAIRMAN invited comments on the draft resolution contained in document EB114/14.

Mr SHUGART (Canada) expressed support for WHO's forward-looking recommendations, which highlighted the need for sustainable funding for tuberculosis control in order to address global tuberculosis targets, including the Millennium Development Goals. WHO played a critical role in supporting the successful Stop TB Partnership but, he stressed, commitment to the Partnership was also needed from all its Member States. Canada acknowledged the merit of regular reports on global tuberculosis efforts to the Executive Board and, more importantly, the Health Assembly, starting perhaps in 2006. That would give greater prominence to the global emergency and would allow timely review of the achievements of the global tuberculosis targets for 2005.

His country was pleased to contribute to international efforts against tuberculosis and had played a key role since 1996, providing financial support and expertise to tuberculosis programmes worldwide. Tuberculosis could be further combated globally through greater coordination of various United Nations and multilateral agencies, for which collaboration the Stop TB Partnership constituted a positive model.

Ms HALTON (Australia) supported the draft resolution and the work being undertaken in accordance with resolution WHA53.1 and the Amsterdam Declaration to Stop Tuberculosis. Australia accorded particular priority to tuberculosis as it was one of the leading causes of death and was of great significance in the Western Pacific Region. Good governance and sound economic management in recipient countries were particularly important factors for effective delivery of health services, yet the report identified a lack of high-quality staff, poor monitoring and evaluation, inadequate infrastructure, weak laboratory services, the failure of programmes to involve the full range of health providers and ineffective decentralization as critical constraints. It was therefore important that national governments tackle those infrastructure weaknesses in order to make the best use of donor contributions. She supported the previous speaker's call for regular reporting.

She was encouraged that the draft resolution called for both national governments and the international community to provide sufficient domestic and external resources to achieve the Millennium Development Goals. Developing capacity and strengthening health systems were important considerations. She supported the request to the Director-General in the draft resolution to devise a sustainable financing mechanism for tuberculosis control. Since the need for sustainable financing pervaded much of WHO's work, she urged the Director-General to consider how that issue could be pursued for the sake of sustainable gains in health across all priority areas.

Ms VALDEZ (alternate to Dr Steiger, United States of America) said that sustainable financing was the key to the accelerated progress required to meet the global tuberculosis targets by 2005. Tuberculosis patients should be ensured access to the universal standard of care within the framework of the DOTS (directly observed treatment, short course) strategy. The report and draft resolution highlighted the major issues and constraints of tuberculosis control; to make progress, Member States should give greater emphasis to the overlapping epidemics of tuberculosis and HIV, which required expanded access to tuberculosis treatment for persons with HIV infection; to the growing problem of drug-resistant tuberculosis and multidrug resistance, which required implementation of the DOTS-Plus

strategy to identify and appropriately treat affected persons with high-quality, affordable second-line drugs, and simultaneous strengthening of the basic DOTS strategy to avoid generating additional drug resistance.

She strongly supported the draft resolution, but proposed three amendments: the addition, at the end of subparagraph 2(2)(b), of the phrase “for patients with tuberculosis who are also infected with HIV”; the addition of a new subparagraph after paragraph 2(2) that would read “to implement and strengthen strategies for the effective control and management of persons with drug-resistant tuberculosis”; and the deletion from paragraph 2(3) of the words “to devise a mechanism,” so as not to limit the ways in which sustainable financing could be achieved.

Mrs LE THI THU HA (Viet Nam) said that the national tuberculosis control programme of Viet Nam, one of 22 high-burden countries, was successful and had received an award at the Second Stop TB Partners’ Forum in New Delhi in March 2004. Among the keys to its success were the high political commitment of the Government, reflected in increased funding for the programme, and a strong partnership with, *inter alia*, WHO, the World Bank, the Royal Netherlands Tuberculosis Association and the Global Fund to Fight AIDS, Tuberculosis and Malaria. However, the programme was facing new challenges including funding beyond 2005, the increase in joint tuberculosis/HIV infection, and the collaboration of the private health sector in the implementation of DOTS. The national tuberculosis programme had estimated that US\$ 30 million would be needed to finance tuberculosis control at all levels in the period 2006 to 2010. Resource mobilization was essential, as the agreements with the World Bank and the Netherlands Government would expire in 2005, and an agreement with the Global Fund for US\$ 10 million over five years would only cover part of the cost. Besides an increase in direct government spending on tuberculosis control, therefore, consideration was being given to including tuberculosis diagnosis and treatment in the health insurance package, which currently covered some 14% of the population. However, since tuberculosis mostly affected the poor, the DOTS package would continue to be provided free of charge. Viet Nam looked forward to continued support from international partners for its tuberculosis control and other programmes, and supported the draft resolution.

Mr ASLAM (alternate to Mr Khan, Pakistan) welcomed the report and supported the draft resolution, to which he proposed two amendments: insertion of a new preambular paragraph after the third preambular paragraph, that would read: “Noting the need to strengthen health systems development for the successful delivery of tuberculosis control”; and changing paragraph 2(3) to read: “to strengthen WHO’s support for national health financing policies with a mechanism to ensure adequate financing for tuberculosis:”

Dr THAKSAPHON THAMARANGSI (adviser to Dr Vallop Thaineua, Thailand) endorsed the position of the United States of America on the need to improve treatment for HIV-positive patients with tuberculosis. Some areas of the current tuberculosis control programme received comparatively little attention and should have a dedicated resource allocation. They included health education, quality control of the drug supply system and human resources. Workforce development and incentives were essential to tackling the disease in the long term. Prevention of tuberculosis worldwide was crucial. Without adequate financial resources the situation could get out of control, with the inevitable negative consequences. Resource-poor countries would need sustainable financial mechanisms to support tuberculosis control efficiently. Innovative thinking was necessary, therefore, to create new financing schemes to support the Stop TB initiative, possibly ring-fencing tobacco and alcohol excise taxes or applying the Brazilian tobacco tax model. Prevention and control of communicable diseases like tuberculosis could and should be part of the benefit package of any social health insurance scheme. Tuberculosis would not disappear in the short term and she therefore strongly supported any move towards sustainable financial support. She fully supported the draft resolution.

Dr NYIKAL (Kenya) was in favour of adding a new subparagraph on multidrug-resistant tuberculosis to paragraph 2 of the draft resolution, as proposed by the member for the United States of America. However, he did not support deletion of “devise a mechanism” in paragraph 2(3), on the grounds that it would weaken the resolution. Some mechanisms, like the Global Drug Facility, had proved extremely useful in supporting tuberculosis treatment.

Dr AFRIYIE (Ghana) expressed support for the amendments proposed by the member for Pakistan. Drawing attention to paragraph 8 of the report, which highlighted important constraints in tuberculosis control, he suggested that more emphasis should be given to the lack of qualified staff. One way of tackling the problem in developing countries was to provide incentives to health workers involved in tuberculosis programmes and it was therefore important to make budgetary provision accordingly. At the local level, Ghana was experiencing problems in coordinating the numerous partners who contributed to the tuberculosis programme. He supported the draft resolution.

Mr FURGAL (Russian Federation) said that he supported the draft resolution and most of the comments made and amendments proposed. In paragraph 1(1) of the draft resolution, Member States were encouraged to fulfil their commitments, *inter alia* under the Amsterdam Declaration. The Ministerial Conference on Tuberculosis and Sustainable Development (Amsterdam, March 2000), at which the Amsterdam Declaration had been adopted, had called for the setting up of a global fund for tuberculosis and many countries had supported the idea of a global tuberculosis drug facility to expand access to high-quality drugs at affordable prices. He asked what had become of those schemes.

Dr CISNEROS (Bolivia) said that, because of the HIV/AIDS epidemic, the incidence of tuberculosis had reached unprecedented levels in many countries. In Bolivia, tuberculosis along with Chagas disease and malaria, was one of the commonest diseases, notwithstanding the progress made in recent years. The DOTS strategy had helped to improve the rates of detection and successful treatment. He expected Bolivia's involvement in the Global Fund to help improve implementation of an integrated programme and to increase the treatment success rate.

Mr BHUSHAN (India)<sup>1</sup> expressed support for the draft resolution but was against the deletion of the words “devise a mechanism”. Since WHO had declared tuberculosis a global emergency in 1993 and advocated DOTS as the most effective strategy to control it, India had made significant progress with DOTS expansion. The country was committed to nationwide expansion of DOTS by 2005 and was on course to achieve the global targets. In the DOTS implementing areas, the case-detection rate and the treatment success rate were close to or above global targets. In order to achieve the desired epidemiological impact, a long-term tuberculosis control programme would be required, even after full coverage, and sustained efforts would have to continue far beyond 2005.

Most of the high-burden countries were implementing DOTS with technical support from WHO and financial assistance from various partners. Funding agencies had different financing mechanisms and commitment terms, thus creating uncertainties for long-term planning. Despite the strong Government commitment to long-term tuberculosis control, therefore, the uncertain funding from partner agencies was a substantial constraint on future planning at the country level. India had tried to resolve the problem by means of donor coordination meetings, but that mechanism also had its limitations. He therefore urged WHO to take the lead and work with partners in evolving a mechanism for sustainable funding with longer-term funding commitments to enable high-burden countries to achieve effective long-term planning for tuberculosis control.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr KASAI (Japan)<sup>1</sup> said that he was hopeful that the global plan to stop tuberculosis for the period 2006-2015 would play an important role in achieving the Millennium Development Goal relevant to tuberculosis and he strongly supported WHO's effort in that regard. Tuberculosis control was one of the top priorities in his country's international cooperation programme on account of Japan's strong expertise in, and experience of, tuberculosis control, especially using DOTS. Where tuberculosis programmes were integrated into the general health system, especially in health centres that functioned as an interface with the community, they had a catalytic effect on the entire health system. He commended the work of the Regional Office for the Western Pacific in setting up the special Stop TB Programme in 2000. Since then, under that programme, regional strategies and national policies of high-risk countries had been built and a budget allocated. As a result, the financial gap in the countries concerned had been reduced from 40% to around 10%. He emphasized the need to install DOTS within the general health service to secure its long-term sustainability and ensure that finance was available, mainly from the national budget. He supported the draft resolution.

Dr RUIZ (Mexico)<sup>1</sup> reaffirmed Mexico's commitment to the Stop TB Partnership. Mexico was an alternate member for Latin America and the Caribbean Group on the Board of the Global Fund to Fight AIDS, Tuberculosis and Malaria. He endorsed the report and the draft resolution, but proposed two amendments in the interests of an integrated approach: the word "prevention" should be inserted in the title of the report, so that it would read: "Sustainable financing for tuberculosis prevention and control", and, similarly, in the draft resolution, a new subparagraph should be added after paragraph 1(1) which would read: "to strengthen prevention and social mobilization against tuberculosis".

Dr HUERTA MONTALVO (Ecuador) seconded the remarks of the previous speaker. He also expressed his appreciation to Canada for the assistance provided to his country's tuberculosis control strategy.

Dr CHOW (Assistant Director-General) observed that two overarching themes had emerged from the discussion. Successful tuberculosis control depended on strengthening health systems, including elements specific to tuberculosis control needs. Secondly, achieving the Millennium Development Goal relevant to tuberculosis depended on long-term planning, including financial planning, and sustainable financing. Accomplishment of that ambitious agenda rested on key building blocks, in particular a well-trained and well-managed public health workforce with both specific expertise and broader skills applicable to health system strengthening as a whole; a sufficient physical infrastructure to conduct diagnosis, treatment and care; and surveillance, monitoring and evaluation, and reporting. Those and other building blocks applied across the range of public health needs and they all required financing for growth and sustainability.

According to the WHO report on global tuberculosis control for 2004,<sup>2</sup> the cost of control in the high-burden countries was about US\$ 1000 million in 2003 and rising. While several high-burden countries had projected budgetary increases in line with DOTS expansion needs, others needed money to jump-start and accelerate their efforts to an adequate level. About two thirds of funds dedicated to tuberculosis efforts came from the governments of high-burden countries through domestic resources, such as the private sector and individual payments, and through loans from the World Bank. About 10% came from grants from the Global Fund and bilateral agencies. The Global Fund had already approved agreements containing tuberculosis components worth nearly US\$ 600 million over the next five years, and continued growth was probable.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

<sup>2</sup> *Global tuberculosis control: surveillance, planning, financing: WHO report 2004*. Geneva, World Health Organization, 2004.

Looking ahead, the need for sustainability in tuberculosis control was particularly compelling. Funding gaps identified by the Stop TB Partnership were US\$ 300 million annually for DOTS implementation, since resources were being mobilized to cover the overall need of US\$ 1000 million for the 22 high-burden countries. However, two major areas were still largely underfunded: the world needed at least US\$ 120 million for tuberculosis/HIV and about US\$ 160 million for multidrug-resistant tuberculosis control every year.

Stable and growing tuberculosis control programmes worldwide would not only specifically counter that one disease, but would spare potentially crippling expenses by, and depletion of, health systems. In view of the expected spread of tuberculosis and HIV, it was imperative that tuberculosis efforts should be quantitatively and qualitatively adequate. The goals of 70% case-detection and 85% treatment success rates were not static. The attainment of those goals should not lead to a relaxation of efforts, as some countries had discovered to their cost. Both the public health workforce and financial investments should be maintained to relieve health systems of the burden of tuberculosis and enable their restoration.

Achieving the Millennium Development Goal relevant to tuberculosis depended on increasing funding up until 2015 in line with population growth, giving the highest priority to DOTS expansion and interventions for tuberculosis/HIV and multidrug-resistant tuberculosis.

In response to the question by the member for the Russian Federation, he said that the Amsterdam Declaration had led to the setting up of two major schemes: the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the creation and implementation of the Global Drug Facility.

Mr AITKEN (Director, Office of the Director-General) read out the amendments proposed by the member for the United States of America for an addition to subparagraph 2(2)(b) and a new subparagraph after paragraph 2(2); by Pakistan, for a new preambular paragraph; and by Mexico for a new subparagraph under paragraph 1(1).

Noting the divergence of views on the United States proposal to delete the words “to devise a mechanism” from paragraph 2(3), he suggested, to meet the concerns of all, that the paragraph should read: “to take the lead under the national health authorities in working with partners to devise a mechanism to facilitate sustainable financing of tuberculosis control”.

Ms VALDEZ (alternate to Dr Steiger, United States of America) expressed concern that the verb “devise” might suggest new mechanisms, whereas mechanisms already existed to support sustainable financing for tuberculosis control. She proposed using the words “to strengthen and support mechanisms to facilitate ...” in place of “devise”, and further proposed that the expression “Millennium Development Goals” should be replaced by the more formal “internationally agreed development goals as contained in the United Nations Millennium Declaration”.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution contained in document EB114/14, as amended.

**The resolution, as amended, was adopted.<sup>1</sup>**

**The meeting rose at 18:20.**

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<sup>1</sup> Resolution EB114.R1.

## FIFTH MEETING

Wednesday, 26 May 2004, at 09:05

**Chairman:** Mr D.Á. GUNNARSSON (Iceland)

**TECHNICAL AND HEALTH MATTERS:** Item 4 of the Agenda (continued)

**Social health insurance:** Item 4.10 of the Agenda (Document EB114/16)

The CHAIRMAN said that the item had been included on the agenda at the request of a Member State.

Dr NYIKAL (Kenya) said that inadequate health financing was the fundamental reason for the poor and, in some cases, deteriorating health status in many countries. It was perhaps even more significant than the scarcity of health personnel, already discussed by the Board. Kenya had experimented with three different financing mechanisms – services paid for at the point of delivery, services funded by taxation and free at the point of delivery, and a combination of the two – but none of them had succeeded in ensuring equity of access to health care.

In 2002, Kenya had decided to introduce social health insurance. The scheme was relatively simple, comprising a basic benefit package of professionally acceptable health care, and socially acceptable hospital facilities for inpatients for a small compulsory annual per capita payment of the equivalent of about US\$ 5, plus employer contribution where relevant; those identified as too poor to pay would be paid for by the Government. More expensive facilities would be available either by means of top-up payments or private medical insurance. High-cost specialist care would depend on a realistic professional assessment of likely outcomes. The scheme would cover both public and private hospitals and clinics and would be implemented in phases, beginning with employees and followed by those in informal employment. A bill establishing the legal framework for the scheme was currently before Parliament. The scheme would require considerable start-up expenditure and future challenges would lie in containing costs and avoiding overuse of the services provided.

He expressed deep appreciation for the technical support provided by WHO and other development partners, and urged WHO to develop further expertise in order to provide continued technical support and guidance to Member States. He expressed the hope that a draft resolution on social health insurance could be submitted to the Board at its 115th session, for transmission to the Fifty-eighth World Health Assembly.

Dr NDONG (Gabon) said that, as recognized in *The world health report 2000*,<sup>1</sup> access to basic health care at an affordable price was a matter of life and death in some countries. Obstacles to achieving universal health insurance could jeopardize the attainment of the United Nations Millennium Development Goals. Health insurance was an indispensable element of public health, and

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<sup>1</sup> *The world health report 2000: Health systems: improving performance*. Geneva, World Health Organization, 2000, ch. 5.

was among the major challenges of the 21st century, but there was no ready-made solution; every country had to decide on its own approach.

As indicated in the report, there was always a transition period when introducing a social health insurance scheme. In some countries, such as his own, such schemes needed to be preceded by a learning phase to enable a culture of accountability and responsibility to be created among the public, both health-care providers and consumers. Delays in introducing social health insurance schemes might well be the consequence of the lack of such a culture, as were abuses by prescribers and consumers who were not fully aware of the costs involved. It was essential to establish an appropriate legislative and regulatory framework for a universal insurance scheme, to ensure that funds were raised and pooled, and services purchased. He regretted the absence of a draft resolution.

Mr FURGAL (Russian Federation) endorsed WHO's approach to social health insurance at a time when many countries, including his own, were undergoing a complex process of modernization of the entire social fabric, including the health sector. For the first time in his country's history, the Minister of Health and Social Development was not a doctor by training, but a high-level manager with expertise in social insurance. The report would have been of greater benefit to Member States if it had taken into account additional factors such as differences between health systems, the impoverishment of the population, differing health system workloads, according to the health status of the population, and pressures on financing, especially in the context of the HIV/AIDS epidemic. It also contained one glaring contradiction. Paragraph 2 stated that the purpose of health financing schemes was to ensure that all individuals had access to effective public and personal health services; yet paragraph 15 suggested that advice to countries should be based on a consensus among international and bilateral agencies on how to finance social health insurance. The policies of those agencies could generally be summed up as privatization of health services, with a resultant weakening of national health systems. In the light of the present topic, he wished to know what WHO thought about the privatization of health systems.

Dr LAMATA COTANDA (Spain) pointed out that many of the issues discussed by the Board during the current session related to vertical programmes for specific diseases or for a particular emergency. However, vertical programming alone would not be sufficient to achieve the Organization's global objectives. He therefore welcomed the inclusion of social health insurance on the Board's agenda.

Health systems were constantly evolving, and each Member State must determine the best financing formula to suit its needs. As the member for Gabon had said, there was no ready-made solution suitable for all, and what worked in one country could be disastrous in another. In giving advice to countries, WHO must pay heed to their varying circumstances. The interventions of international bodies were not always appropriate; sometimes they tried to enforce the wrong kind of reforms, resulting in a deterioration in health status and health services.

Paragraph 15 of the report mentioned a consensus among agencies. As he understood it, the intended meaning was that consensus should be reached between WHO and the country concerned, not among advisers, as to the approach to be followed in that country. Obviously countries did need advice from WHO and from elsewhere. Spain had received guidance from the Regional Office for Europe. It had also collaborated with other international organizations, and had received useful information from other Member States. But countries must then take their own decisions and adopt financing schemes appropriate to their needs. The financing of health systems was a challenge everywhere, regardless of differences in levels of development, as countries sought to resolve problems relating to their diverse health systems and social demands. The role of WHO in providing guidance should be strengthened.

WHO could also play a role in strengthening information and inspection and quality-control systems, which were vital to ensure the proper functioning of health systems. A strong quality-control and inspection system was particularly important where systems were being privatized or brought into a social insurance scheme.

Mr SHUGART (Canada) endorsed the previous speaker's remarks about diversity. Canada, for example, had a federal system. A properly designed social health insurance system should facilitate the achievement of three main goals: equity of access to health services, efficiency in those services and improved health outcomes. He agreed with the analysis in the report, which provided some useful guidance. In developed and developing countries alike, services provided for the public at large, such as clean water supplies and health protection services, including immunization and the regulation of food safety, were sometimes more cost-effective than personal health services. They were also the sine qua non of good health outcomes, and could not be forgotten, even in the context of social health insurance. An important question for many countries concerned the choices of health services or products to be covered by social health insurance schemes. The choices made benefited individuals, and therefore generated strong public interest and political support. However, becoming a prisoner of those choices could hamper the evolution of health systems. A strong evidence base should be built into social health insurance, to ensure that the choices made were cost-effective and would improve both individual and collective health outcomes. The pursuit of universal objectives in social health insurance should not be an obstacle to designing special provisions for vulnerable groups in the population. Canada supported the work being done on the topic, and would be happy to contribute either through WHO or bilaterally.

Dr HUERTA MONTALVO (Ecuador) said that Ecuador had had a social security system for more than 50 years although it covered only 16% of the population, even including the new scheme for the rural population. Some 10% of the population was covered by private insurance, but even with the special schemes for the armed forces and the police, less than 30% of the population was insured. The big problem was inequity, and one principle that ought to be espoused was equity. The Regional Committee for the Americas at its Fifty-fourth session in 2002 had urged Member States of the Region of the Americas to identify potential causes of social exclusion in health, and to consider adopting policies and practices to reduce income inequality, one of the underlying causes of health disparities in the Region.<sup>1</sup> In combating that inequality, Latin American countries were hampered by the problem of external debt: where countries had to earmark more than 40% of their budgets to pay off their debts, they could not pay adequate attention to health. The report mentioned a transition period in the move towards full health insurance coverage. There should also be a transition period for doing away with inequality, and another for the problem of external debt. It was not possible to make progress in areas such as cancer control, avian influenza and disability given the current economic background. Solidarity was needed on the part of countries with firmly established health systems so that Latin American countries could make progress. The theme of extending social health insurance derived from the Declaration of Alma-Ata. In fact there were many decisions on paper from previous meetings of WHO's governing bodies that had yet to be translated into practice.

Dr STEIGER (United States of America) agreed with the member for Spain about the need to recognize the idiosyncrasies of Member States with regard to social health insurance: every country took its own path to the provision of health care. He supported the goal of the greatest possible access to affordable health care for all citizens. However, the United States had a market-based system. Its health care system for the elderly, Medicare, was based on premiums paid by individuals, employer contributions and funds from general tax revenue. It was a very expensive system, covering 41 million people at a cost of US\$ 281 000 million a year, which was rising rapidly. The United States was facing the same problems as those mentioned by other speakers, including overuse of services and the need to rationalize their delivery to an ageing population. As the member for Canada had rightly observed, discussion of social health insurance should be linked to interventions affecting the whole population, especially where prevention was concerned. The discussions on diet strategy during the Health

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<sup>1</sup> Resolution CSP26.R19.

Assembly were directly relevant, because every system was having to make serious choices about what services to cover, and without efforts at prevention to keep people healthy as long as possible, health systems would eventually become financially unsustainable, even in wealthy nations. In the United States, as part of the Medicare reforms, from 2005 every eligible citizen, on reaching 65, would have to undergo free health screening when entering the Medicare programme. It was hoped by that simple step to identify many illnesses before they became serious enough to require expensive treatment. The work of WHO on social health insurance should recognize national particularities, bearing in mind that private solutions had a role to play in health systems. He would have preferred more emphasis in the report on market-based approaches and perhaps also a reference to consumer preference. Equity could be achieved through subsidies for participating in the private market: a mixed system was more responsive, more flexible, more innovative and more efficient than government-managed systems, which tended to have problems of bureaucracy, lengthy waiting times and rationing. There should be a full discussion on the costs and benefits of private intervention as compared with purely public intervention. There were also advantages of introducing information technology at all levels: it could produce major savings even in basic health systems, and contribute to a more effective service and better patient outcomes.

Dr AL-SAIF (alternate to Mr Razzooqi, Kuwait) said that social health insurance represented a huge burden on the finances of many governments. It was important to work towards a system by which the State and employers shared the burden and by which no individual was denied the benefits of social health insurance. The State should finance health insurance for the most vulnerable. In Kuwait, all citizens were entitled to health care, and the costs were covered by the State. In view of the frequency of international travel, WHO might usefully consider the question of health insurance for travellers, and the possible cross-border implications.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that the financing of health systems was a growing problem, especially for low-income countries. His country's poverty was exacerbated by the high prevalence of diseases such as HIV/AIDS, tuberculosis and malaria. The funding of health systems had already been discussed by countries at the regional level. There was a need for more effective strategies to ensure that people were provided with essential health services at affordable prices. Guinea-Bissau followed a number of different co-funding procedures but was still facing difficulties. The system was not yet effective, and only the employees of certain private enterprises were covered by social insurance. Moreover, the State budget was insufficient to meet the cost of health insurance. He welcomed the report, and undertook that his country would play its part in the work of WHO in that area.

Ms WARANYA TEOKUL (adviser to Dr Vallop Thaineua, Thailand) commended the report. Thailand had recently introduced a health insurance scheme to cover all members of the population not already covered by a publicly-managed health insurance scheme, including the informal sector. The system was financed from general taxation, patients being required to pay the equivalent of one Swiss franc for each course of treatment. The Government had started social health insurance schemes for the poor and disadvantaged in 1975, at a time when it was spending 25% of the national budget on defence. That figure had since fallen, as had the cost of servicing the public debt. Public health spending had thus increased from 4% to 8% of the national budget in the previous 10 years, making it possible to introduce universal insurance coverage. The extension of social health insurance was the work of democratic governments, which were more responsive to popular demand. In Thailand's experience, the main factors facilitating the adoption of universal health provision were economic growth, peace and democracy.

With regard to technical advice, Member States were highly varied, with different levels of income and growth and different labour market structures. The countries in need of assistance, for either health or development, were those with limited resources. A tool to measure national expenditure on health existed, namely the national health account, which provided information on

resource flows within each system, from the funding source to the health-care function and the care provider. They showed, for example, the allocation of resources among public health programmes, the percentage spent on prevention or treatment, and the amount each household had to pay from its own pocket. Information of that sort made it easier to design social health insurance schemes, and in Thailand had revealed the size of the financial obligation arising from the new universal scheme. Such data would not only help to fine-tune the design of social health insurance systems, but could also be used to monitor their efficiency and effectiveness.

In view of the share of the global burden of disease borne by countries with limited resources, whose social health insurance systems might not generate sufficient resources to finance all their health needs, WHO might consider establishing a resource pool or a reinsurance mechanism to ensure adequate funding. Systems should be designed and managed to run efficiently, be financially sustainable and achieve equity between, as well as within, generations. The experience of Member States in managing micro-credit schemes could also be explored as a step towards community health insurance and ultimately social health insurance, and the experience of other international organizations, such as the World Bank and ILO, in system design and financial management for social protection schemes, might also be drawn upon in order to arrive at a financially sustainable model.

Dr AHMED (alternate to Dr Afriyie, Ghana) said that, although two attempts in Ghana to set up a health insurance system, in 1969 and in 1981, had been shelved, a further attempt in 1998 had resulted in a health insurance law that had been adopted in September 2003. A council set up by the Government was responsible for running the system, which was based mainly on district mutual insurance schemes covering almost all the 110 districts, or 90% of the country. Both profit-making and non-profit private insurance schemes were encouraged. The law made it compulsory for everyone to belong to at least one of the available schemes. Monies in the national health insurance fund came from four sources. Workers in the formal sector paid national social security contributions, of which the Government took 2.5%; there was a 2.5% indirect tax on goods and services; the fund drew some income from investments, interest and donations; and finally, there were insurance premiums. Previously, health insurance had been based on a "cash and carry" system of user fees, that had contributed only about 20% of the total health budget. Under the new system, everyone was covered; children under five paid no contributions, nor did those under 18 with contributing parents. The scheme was designed for people up to age 60. People employed in the formal sector received benefits until they died; those in the informal sector were covered between the ages of 60 and 70 by the Government, and thereafter were treated free. The system covered around 80% of the diseases commonly reported in Ghana. The other 20%, which included heart diseases and conditions requiring plastic surgery, were financed by the patients. Members of the scheme were entitled to benefits after an initial contribution period of six months. Recognized indigents were also covered by the fund. Ghana's social health insurance system adhered closely to almost all the points mentioned in paragraph 11 of the report. It had also had to face some of the problems described in paragraph 7. For example, it was trying to group the large number of people in the informal sector into cooperatives for the purpose of registration under the scheme. Paragraph 8 mentioned the transition towards universal coverage. In that respect, Ghana's system was very recent, and would need to be reviewed and monitored critically at a later stage to see how well it was functioning. He asked WHO to look at the traditional forms of insurance prevailing in certain countries, which might be of interest to others. One example in Ghana was social insurance for funerals or special needs.

Dr TANGI (Tonga), speaking on behalf of many small Pacific island countries, observed that a system that was already in operation should initially be accepted, and only later should changes be attempted to improve it. The report noted that some countries had taken more than 20 years to make those changes. The problem of change was not an isolated phenomenon, but part of the total picture. Most health systems in the Pacific had been set up against a background in which all health spending was financed from general taxation. That had always been the case, and it was deeply engrained in the mentality of the population that expenditure on health was the sole responsibility of governments. He

had noted the comment by the member for Canada concerning interventions for the public at large. The goal of his administration was to make the health ministry more responsive to the needs of the people to ensure that all individuals had access to effective and affordable health services, and to be accountable for the outcome. At present, people paid nothing for hospital treatment, consultations and medicines, apart from their taxes. The health indicators were close to those of Australia and New Zealand. In the past few years there had not been a single maternal death for 3500 births. But the country could not afford to continue the same way. In recent years, he had tried to change attitudes in Tonga towards the funding of health care, and had been examining therapeutic and pharmaceutical costs, and health-care finance with the Government of Australia. As the system was in crisis, he had been forced to ask the World Bank for a loan. Efforts would be made to improve the system. The issue was highly sensitive and of great importance to small island countries. There was apparently no particular model for such countries; each one had to develop its own. He was listening carefully and hoping to learn from other members of the Board.

Mr BRUNET (alternate to Professor Dab, France) said that the discussion so far had demonstrated both the topicality of the issue and the complexity of finding solutions that responded to the many different situations in countries. In France the first health insurance schemes, for the benefit of workers in the mining industry, dated back a century. By comparison, a transition period of 20 years seemed short. The United Kingdom of Great Britain and Northern Ireland had been the first country to introduce a national health system designed to improve and extend health-care coverage while reducing the burden on industry. The process had taken more than 50 years. In France, more than a century had elapsed between the emergence of the first rudimentary health insurance system and the introduction of universal health insurance on 1 January 2000. To provide universal coverage, the State shouldered a substantial proportion of the financing, as it would have been impracticable to rely too heavily on the market where such an important and sensitive issue was concerned. However, the French health budget was at present deeply in debt, owing not to the introduction of universal coverage but to rising costs, and the time had come to decide whether it was feasible to go on financing the entire range of services or whether the public as a whole should be offered a care package providing a minimum level of care. Escalating costs and their impact on financing were the biggest challenge facing all countries, but particularly developed countries.

The report emphasized the importance of meeting the needs of individuals in accordance with the Declaration of Alma-Ata and health for all, but did not mention the equally, if not more, important Millennium Development Goals. Any discussion on universal health coverage should take account not only of individual needs but also of WHO's public health development objectives. Health-care financing systems were the means of accomplishing both those ends, but a decision had to be taken on what should be publicly funded and what should be left to the market. Achieving the right mix would make it possible to meet the appropriate objectives. Health financing systems, as the paymasters, could also be highly influential in determining the precise activities to be undertaken by health care professionals.

Dr CAMARA (Guinea) said that the ongoing problem of financing in Guinea had led to reform of the health sector. However, the various financing methods tried so far had failed to provide sustainable and equitable financing; hence the need to explore other options, including universal health insurance. Given its lack of experience, the complexity of universal health insurance and the question of feasibility, Guinea had focused its health-care provision on pregnant women. With the help of some nongovernmental organizations, including The Save the Children Fund, a form of insurance covering pregnancy and childbirth had been extended to several districts and had resulted in a marked improvement in antenatal and postnatal care services and a drop in maternal deaths. It remained to move on to the next stage, for which Guinea would welcome financial and technical assistance from countries with experience in developing social health insurance.

Professor FÍŠER (Czech Republic) reported that total expenditure on health care in his country amounted to 7.5% of the gross domestic product; 91% was funded by the Government, of which compulsory health insurance accounted for 80% and taxation 11%. Gratifyingly, a number of health indicators had performed better than in some countries with higher per capita income, including the 15 countries that had composed the European Union before its enlargement. He attributed his country's success in the health sector to solidarity in the bid to improve health.

Dr YOOSUF (Maldives) said that Maldives had succeeded in controlling most of the major communicable diseases and its health indicators were good, probably owing to the quality of primary health care. However, the growing incidence of chronic noncommunicable diseases requiring expensive treatment or surgery was proving a burden. High-quality curative care could not be provided free of charge indefinitely. Cost-recovery options had been tried out in the capital island, which was the centre for most secondary and tertiary care, but provision was still free in the rural islands. Maldives was keen to pilot a workable health-care financing mechanism based on the experience of other countries, and he hoped that WHO and other international agencies with experience in health financing and insurance would provide guidance. Countries whose health ministries were unable to administer insurance schemes might also need assistance from the appropriate agency. He agreed with the member for the United States of America about the low cost of prevention and health screening compared with curative care for chronic diseases that appeared late in life. Since the State might not always be able to provide the full range of health services, both social and private health insurance should be considered. Twenty years was too long to wait for universal coverage and the issue had to be addressed as a matter of urgency. The member for Tonga had highlighted the particular difficulties of small island countries and it would be appreciated if WHO could play a key role in coordinating their activities and disseminating their experiences.

Mr ASLAM (alternate to Mr Khan, Pakistan) observed that providing universal health coverage was a major challenge for the governments of poor countries because of the very small tax base. As a country with an economy in transition, Pakistan still found it very difficult to provide its large population with essential health care. Vertical health programmes organized centrally, including those on AIDS, tuberculosis, malaria, nutrition and reproductive health, were funded by the Government with support from international partners and WHO. Pakistan had given priority to primary health care and the training of community health workers, who provided 80% of the population with preventive, health promotion and family planning services in addition to treatment for local diseases. Such a strategy had been adopted as an alternative to health insurance, to which only 25% of the population, including industrial workers and government employees, had access. Self-employed people were at a particular disadvantage as many were on very low incomes and could not afford treatment either in government hospitals, which were poorly funded, or in private hospitals. He therefore requested WHO to provide technical support to countries in assessing the feasibility of establishing health insurance schemes.

Mr CONSTANTINIU (Romania) said that financing national health services was of paramount importance to both developed and developing countries. Romania had had a compulsory social health insurance system for six years. Vulnerable social groups unable to contribute had access to free essential health-care services. The Government's share of health expenditure on national programmes for major health interventions, covering communicable and some noncommunicable diseases and immunization, amounted to 30%. In 2005 a private voluntary health insurance law would be implemented, targeted at 10% of the population. Sustainability and cost-effectiveness were prerequisites for any satisfactory social health insurance system. That presupposed a balance between the funds allocated and expenditure, given the growing cost of medical technologies and therapy. The inevitable gap in funding could be bridged by an innovative combination of medical and financial tools. WHO might usefully look into ways of reducing the cost of health services.

Dr ACHARYA (Nepal) said that, as 70% of health expenditure in Nepal was paid by patients, the Government had introduced an alternative health financing scheme in the form of a community medicines programme, under which all income groups could buy medicines at subsidized prices and very poor people receive them free of charge. Furthermore, all primary health-care services were free. The scheme was being well supported by the community and was working well. The next step would be the introduction of social health insurance, although it would be difficult to convince people of its feasibility owing to weaknesses in Nepal's health-care system, including a lack of trained health personnel and basic medical equipment.

Dr LEWIS-FULLER (alternate to Mr Junor, Jamaica) said that her country, like many others, had been battling with health financing over the years. The move towards universal health insurance coverage was incremental, as recognized in the report. Jamaica had begun with a programme on drugs for the elderly, to provide medicines for people over 60 years of age with chronic illnesses. A national health fund had then been established with a view to providing medicines for all those with chronic diseases. The fund, in fact, fitted the description of a social health insurance fund given in the report. Increased taxation on tobacco had had the double effect of contributing to the fund as well as reducing tobacco consumption. The fund also benefited from other public and private contributions. While the fund was viewed as the forerunner of a universal health insurance system, further moves towards universal coverage had hitherto been thwarted, because a number of the requisite systems and conditions had not been in place. Jamaica's experience indicated that it could be difficult for WHO to set a definite time-frame for the development, in any country, of universal health coverage, which would have to grow naturally taking into account socioeconomic and political forces.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho) said that his Government subsidized health services and public-sector health centres. As a result, a consultation which would cost, for example, US\$ 30 in the private sector cost US\$ 10 under the Government scheme. Lesotho was currently discussing measures to establish a mandatory universal health insurance scheme and would therefore welcome support from WHO, in particular the provision of information on schemes in other countries, for comparison purposes.

Dr CISNEROS (Bolivia) said that the report took into account important factors in social health insurance, such as the number of contributing employees, social security management capacity and the type and capability of health systems. The Bolivian social security system covered 25% of the population but expenditure accounted for some 50% of the national health-care budget and was confined mainly to urban areas. The system had been based initially on insurance for certain sectors of the workforce, which covered only a small portion of the population. For the remainder, public insurance schemes had been set up, particularly to provide for mothers and children under five years of age. Rises in unemployment and in self-employment, however, had made it difficult to collect the revenue needed. The need to finance external debt, which took up 30% of the national budget, was a further burden. Nevertheless, the Ministry of Health was convinced that universal health insurance was feasible; but the task would take time and require resolute political will. He therefore requested WHO to provide the necessary technical support.

The CHAIRMAN, speaking as the member for Iceland, agreed that it took time to implement universal health insurance coverage and formulate relevant legislation. Guidelines were required, and WHO's advice was important. Schemes must, of course, be based on the situation pertaining in each country as well as on evidence gathered by international organizations with the relevant expertise. For many years, Iceland's health system had been based on social insurance, but it also incorporated some features of a market economy, and was underpinned by the philosophy propounded by Bismarck, a former Chancellor of Germany, and Bevan, a former Minister of Health of the United Kingdom. He stressed the importance of a strong health insurance system and the need to define the system and other pillars of the welfare state. Icelandic employers and employees had agreed, 35 years previously,

on the financing of a pension system. As a result, the scheme was not facing the huge problems faced by those of many other nations; it had also been possible to finance the scheme mainly from tax revenue, although some services were fee-based.

Mr KRECH (Germany)<sup>1</sup> said that global health expenditure was currently US\$ 3.8 million million per year. Health insurance costs accounted for one quarter of that sum, and out-of-pocket payments accounted for a further quarter – a figure that was far too high and contributed to the escalation of poverty. WHO should continue to encourage a move away from out-of-pocket expenditure to pre-paid funding, which enhanced risk-sharing and access to health care. Universal coverage could be achieved by general taxation, health insurance schemes or a mixed system. Because of rising demand, the international community should do more to support countries in building up health insurance systems. But those systems must be technically sound, and efforts by bodies such as WHO, ILO and the World Bank, as well as bilateral donors, must be well coordinated.

There was no ideal solution. Technical support must be flexible, therefore, and based on each country's culture and broad social protection network. However, values such as equity, solidarity and universal access must remain the foundation of any truly social system. Germany appreciated efforts by WHO and ILO, and other development partners to support the social health insurance scheme being developed in Kenya. More such partnerships might be established and cooperation between the international organizations strengthened further. The subject of social health insurance should be included on the agenda of the Fifty-eighth World Health Assembly.

Mr LEÓN GONZÁLEZ (Cuba)<sup>1</sup> said that it was up to the various countries themselves to decide what health insurance system they wished to apply. WHO should nevertheless strive to foster universal access to health care; it should therefore study the world's various systems with a view to highlighting the best elements. Cuba deemed it important for all its citizens to have access to good quality health care, and for that purpose financed free-of-charge care from the State budget. As a result, infant mortality had been reduced to 6.5 per 1000 live births and life expectancy exceeded 76 years. Universal immunization was also provided against three diseases. Such advances had been achieved despite Cuba's situation as a poor country subjected to economic warfare by a neighbouring super-power. Financial resources alone, although important, must be accompanied by a health system that provided universal coverage. As a result of that approach, WHO had recognized Cuba, in 1998, as having attained basic health goals. Cuba recognized that many countries needed support in developing health services, and cooperated with a number of them for that purpose. More than 17 000 Cuban health workers were active in dozens of countries. Cuba remained ready to cooperate with WHO in the effort to broaden health insurance coverage throughout the world.

Mrs VALLE (Mexico)<sup>1</sup> said that, in giving importance to vertical programmes, WHO should not overlook horizontal programmes such as the development of health systems, especially social security. The latter had existed in Mexico since 1943, with the establishment of two major institutions, for government employees and for industrial and commercial workers. The service covered roughly 50% of the population, and the funding basis was tripartite, with contributions from workers, employers and the State. Those not covered by social security used services provided by the Ministry of Health and, to a lesser extent, the private sector. Mexico had embarked on major reforms, and the Ministry of Health was strengthening its leadership role in all its spheres of competence. The aim was to ensure the provision of health services to people without social security, chiefly in the poor states, by means of a "people's insurance" programme, with a view to avoiding health crises. It was estimated that the entire Mexican population would have social health insurance by 2010. She endorsed the comments on inequity and solidarity, and the importance of recognizing that policy implementation

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

must take into account each country's specific features. Mexico was ready to share its experience and to cooperate with interested Member States.

Dr ABREU CATALÁ (Venezuela)<sup>1</sup> said that in her country social exclusion had increased as privatization models and diversification of systems had proliferated. During the twentieth century various models had been created. The public sector had been based on a mainly preventive approach, but had gradually assumed increasing responsibility for support at all levels. From 1945, social security systems had been developed in specific fields of activity for the formal sector of the economy, with a tripartite revenue base. There had also been a growth in the private sector, which catered for the high-income groups of the population and involved a number of individually-tailored systems. The resultant trend had been towards private schemes, to the detriment of publicly-funded services.

At the end of the previous century, 60% of the population had had no access to health services covered by social security. The Government had therefore instituted radical changes over the past five years in order to bring about universal, State-financed health coverage. It was recognized that the system must be suitable for a country with a complex epidemiological profile. Based on experience, and thanks to the active solidarity of the Cuban Government, an experiment had been set up in 2003 to redesign the health system on the basis of the needs of communities as defined by themselves. As a result, doctors' services were available in all communities across the country; the services provided included nutrition, education and free access to medicines. Those activities had been accompanied by institutional changes, including the work of a presidential commission aimed at removing internal barriers between ministries and coordinating all social development activities, and their budgets. The aim was to establish a unified national public health system and to rationalize the contribution of the private sector.

As previous speakers had pointed out, the widely differing economic, social and cultural features among countries implied a diversity in health systems. Venezuela would seek to learn from the experience of other countries; for that reason, it requested that the subject should be included on the agenda of the Fifty-eighth World Health Assembly.

Dr ROSES PERIAGO (Regional Director for the Americas) said that estimates indicated that some 27% of Latin Americans (125 million people) had no regular access to basic services; almost 50% of those in Latin America and the Caribbean (some 230 million people) had no health insurance cover. In addition, 43 million people in the United States of America lacked such cover. In Latin America and the Caribbean, out-of-pocket expenses accounted for some 40% of total health costs. When catastrophic expenses were added, it could be seen that the extension of health cover, in terms of not only access to basic services but also an actual poverty-reduction strategy, was of immense importance. Unemployment and the informal labour market further reduced the scope of social health protection. Expansion of that protection, therefore, had become a matter of technical cooperation. In that light, the Organization had sought to consolidate alliances with various interested partners. Progress had been made with the assistance of the Swedish Government through a joint project, which had also involved an agreement with ILO. Bolivia, the Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Paraguay and Peru were among the collaborating countries. Some Caribbean countries had been revising their social health security systems, while other countries, such as Brazil, Chile, Colombia, Costa Rica and Cuba, which had the widest coverage, were likewise benefiting from the experience of other groups of countries. Five years previously WHO and ILO had signed an agreement and promoted an initiative to support the extension of health insurance systems in Member countries. At the 2001 International Labour Conference, the representatives of governments, trade unions, workers and employers had reached a new consensus relating to social security, which included recognition of the need to formulate policies and initiatives to extend social security cover to

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

those not yet covered. As a result, through resolution CSP26.R19 the WHO Regional Committee for the Americas at its Fifty-fourth session in 2002 had established a precise mandate for the development of strategies and activities to support countries in extending social protection to excluded peoples of the Americas. Work was being carried out accordingly to collect data and promote dialogue in order to develop and improve social security schemes. Interested parties, including ILO and other development partners, had held a meeting in November 2003 with the aim of extending social protection for mothers and children.

Dr EVANS (Assistant Director-General), responding to points raised, acknowledged the diversity of experience. The Board's consideration the previous day of sustainable financing for tuberculosis control had reflected the need to put directly observed treatment, short-course (DOTS) and related regimens in cases of multidrug resistance into some form of secure financing system to improve access and coverage. Similar ambitions existed for the funding of antiretroviral therapy, bednets for malaria and the range of "best buys" in terms of maternal and child health, noncommunicable diseases and essential drugs. Clearly there was a need to think about how to build financing systems at country level that would cater for diverse national needs. It was a mistake to imagine that a single financing system could be set up for each individual priority intervention, and countries needed to consider ways of working across such interventions efficiently and in a way that both strengthened the financing system and accelerated achievement of the objectives of those programmes.

From a broader perspective there was also an interesting trend relating to work done by WHO in the context of the Commission for Macroeconomics and Health. Economists and finance ministers, who might be expected to take a critical view of increased spending, had nonetheless agreed that a massive expansion of health systems was needed in the poorest countries. At a recent OECD meeting, a similar consensus had been reached on the likelihood of an expansion of health systems in OECD countries. Ageing populations, technological advances and demand from patients were all indicators that health systems would be expanding in the world's richest countries over the next 30 years. Globally, therefore, there would be an expansion of health systems, which represented a big opportunity for the future. The challenge was to decide what needed to be financed and achieved. What should the goals be for the health sector? There were already targets for the Millennium Development Goals, specific disease treatment objectives and sets of values related to such factors as access, safety, quality, affordability, patient preferences and patient protection. However, there was a need for much more evidence to identify the "best buys". Given the wider trends, it was important to look at how health systems were going to be financed; the report described one of the mechanisms for financing health systems: social health insurance. While social health insurance could draw on rich experience that should be exploited across the Member States, the systematic work that had been done so far to review such evidence was modest. Few key studies were available and evidence remained scarce; although illuminating, it was hard to make widespread use of such material. Some specific points on social health insurance had emerged from cases in Ghana, Kenya and Thailand to show that social health insurance was not simply a matter of payroll taxes; governments, too, had a role to play in providing cover for vulnerable groups, such as the poor and the unemployed. It was important to note that social health insurance was sensitive to country context and compatible with private provision of health care. Cost containment was also an important concern across all health insurance systems, including social health insurance, and was performed through regulation and provider payment schedules. In addition, the benefit packages, which needed to be based on evidence, were also defined as an important part of social health insurance.

What role was appropriate for WHO needed to be considered. Its leadership was deemed to be crucial. Work needed to be done on guidelines and evidence. The time had come to put research and evidence issues relating to health financing higher on research agendas. Experience and expertise needed to be pooled, and lessons learnt from mistakes. The issue was complex and presented countries with many obstacles, and creative solutions had to be found. It would also be necessary to think more creatively about WHO's priority programmes, as each represented an important opportunity to

strengthen health financing systems, and ensure that no barriers were created. WHO could not do that work alone. An intersectoral approach and greater interagency coordination were needed so that resources could be pooled more effectively in response to demand.

Dr HUERTA MONTALVO (Ecuador) supported Venezuela's request that social health insurance should be considered at the next Health Assembly. The subject was one that the Organization had to keep under consideration. At least the routes taken by other countries and the possible applications of that experience could be outlined, together with the work needed in order to make universal coverage not just a wish but a closer prospect.

Dr NYIKAL (Kenya) supported the comments of the previous speaker and proposed that WHO should be requested to work on the matter, looking into all the relevant areas, in order to provide a draft resolution in good time for consideration by the Board at its 115th session in January 2005 and subsequent submission to the Fifty-eighth World Health Assembly.

Dr NDONG (Gabon), emphasizing that the report did not go far enough, supported the proposal by the member for Kenya.

Dr STEIGER (United States of America), while not wishing to stand in the way of a resolution, expressed the hope that its intention would not be to endorse one particular system. WHO's resources were limited, and difficult choices would inevitably have to be made when Member States asked for support and prioritization. Such a resolution should concentrate on asking Member States to endorse basic principles, rather than on elaborating a large number of specific requests to the Organization.

Dr YOOSUF (Maldives) observed that there was much work to be done before a resolution could be passed. Passing resolutions was easy; what happened afterwards was less clear and, in the case of the resolution in question, the proposals would be very varied.

Mr CONSTANTINIU (Romania) fully agreed with the views expressed by the members for Maldives and the United States of America. What had to be considered was the outcome of any resolution and, since there was no panacea for the financial problems it was unclear what purpose a resolution would serve. All financial aspects should be covered, including how to collect and how to spend the money. He recommended discussing the matter further and more broadly.

The CHAIRMAN said that most Board members appeared to be in favour of having a draft resolution submitted to the Board's 115th session rather than continuing to discuss the issue by electronic mail, for example. He therefore took it that the Board in the meantime wished to take note of the report.

**It was so agreed.**

**Cancer control:** Item 4.1 of the Agenda (Document EB114/3) (continued from the fourth meeting)

The CHAIRMAN drew attention to a revised draft resolution on cancer prevention and control, which read:

The Executive Board,  
Having examined the report on the prevention and control of cancer,<sup>1</sup>

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<sup>1</sup> Document EB114/3.

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

Recalling resolutions WHA51.18 and WHA53.17 on the prevention and control of noncommunicable diseases, WHA57.17 on the Global Strategy on Diet, Physical Activity and Health, WHA56.1 on tobacco control, and WHA57.12 on reproductive health strategies, including control of cervical cancer, and WHA57.16 on health promotion and healthy lifestyles;

Recognizing the suffering of cancer patients and their families and the extent to which cancer threatens development when it affects economically active members of society;

Alarmed by the rising trends of cancer risk-factors, the number of new cancer cases, and cancer morbidity and mortality worldwide, in particular in developing countries;

Recognizing that many of these cases of cancer and deaths could be prevented, and that the provision of palliative care for all individuals in need is an urgent, humanitarian responsibility;

Recognizing that the technology for diagnosis and treatment of cancer is mature and that many cases of cancer may be cured, especially if detected earlier;

Recognizing that tobacco use is the world's most avoidable cause of cancer and that control measures, such as legislation, education, promotion of smoke-free environments, and treatment of tobacco dependence, can be effectively applied in all resource settings;

Recognizing that among all cancer sites cervical cancer, causing 11% of all cancer deaths in women in developing countries, has one of the greatest potential for early detection and cure, that cost-effective interventions for early detection are available and not yet widely used, and that the control of cervical cancer will contribute to the attainment of international development goals and targets related to reproductive health;

Recognizing the value of multidisciplinary management and the importance of surgery, radiotherapy, chemotherapy and other approaches in the treatment of cancer;

Recognizing the contribution of IARC, over 40 years, to research on cancer etiology and prevention, providing evidence on global cancer prevalence and incidence, the cause of cancer, mechanisms of carcinogenesis, and effective strategies for cancer prevention and early detection;

Mindful of the need for careful planning and priority-setting in the use of resources in order to undertake effective activities to reduce the cancer burden;

Recognizing the importance of adequate funding for cancer prevention and control programmes, especially in developing countries;

Encouraged by the prospects offered by partnerships with international and national organizations within the Global Alliance for Cancer Control, and other bodies such as patient organizations;

Welcoming the initiative by IAEA to establish a programme of action for cancer therapy, and research efforts by national cancer institutes in various Member States,

1. URGES Member States:

(1) to collaborate with WHO in developing and reinforcing comprehensive cancer control programmes tailored to the socioeconomic context, and aimed at reducing cancer incidence and mortality and improving the quality of life of cancer patients and their families, specifically through the systematic, stepwise and equitable implementation of evidence-based strategies for prevention, early

detection, diagnosis, treatment, rehabilitation and palliative care, and to evaluate the impact of implementing such programmes;

(2) to integrate national cancer-control programmes in existing health systems that set out outcome-oriented and measurable goals and objectives for the short, medium and long term, as recommended in the Annex to the present resolution, identify evidence-based, sustainable actions across the continuum of care, and make the best use of resources to benefit the entire population by emphasizing the effective role of primary health care in promoting prevention strategies;

(3) to encourage and frame policies for strengthening and maintaining technical equipment for diagnosis and treatment of cancer in hospitals providing oncology and other relevant services;

(4) to pay particular attention to cancers for which avoidable exposure is a factor, particularly in the workplace and the environment, including exposure to chemicals, certain infectious agents, and ionizing and solar radiation;

(5) to encourage the scientific research necessary to increase knowledge about the burden and causes of human cancer giving priority to tumours, such as cervical cancer, that have a high incidence in low-resource settings and that are amenable to cost-effective interventions;

(6) to give priority also to research on cancer prevention, early detection and management strategies, including, where appropriate, traditional and herbal medicine;

(7) to consider an approach in the planning, implementation and evaluation phases of cancer control that involves all key stakeholders representing governmental, nongovernmental and community-based organizations, including those representing patients and their families;

(8) to ensure access to appropriate information in relation to preventive, diagnostic and treatment procedures and options, especially by cancer patients;

(9) to develop appropriate information systems, including outcome and process indicators, that support planning, monitoring and evaluation of cancer prevention and control programmes;

(10) to assess periodically the performance of cancer prevention and control programmes allowing countries to improve the effectiveness and efficiency of their programmes;

(11) to participate actively in implementing WHO's integrated health promotion and prevention strategies targeting risk factors for noncommunicable diseases, including cancer, such as tobacco use, unhealthy diet, harmful use of alcohol and exposure to biological, chemical and physical agents known to cause cancer, and to consider signing, ratifying, accepting, approving, formally confirming or acceding to the WHO Framework Convention on Tobacco Control;

(12) to determine cost-effective minimum standards, adapted to local situations, for cancer treatment and palliative care that use WHO's strategies for nationwide provision of essential drugs, technologies, diagnostics and vaccines;

(13) to ensure the medical availability of opioid analgesics according to international treaties and recommendations of WHO and the International Narcotics Control Board and subject to an efficient monitoring and control system;

(14) to ensure, where appropriate, availability of safe and efficacious traditional and herbal medicine;

(15) to develop and strengthen health system infrastructure, particularly related to human resources for health, in order to build adequate capacity for effective implementation of cancer prevention and control programmes, including a cancer registry system;

(16) to accord high priority to cancer control planning and implementation for high-risk groups, including relatives of patients and those having experienced long-duration and high-intensity carcinogen exposure;

2. REQUESTS the Director-General:

- (1) to develop WHO's work and capacity in cancer prevention and control and to promote effective, comprehensive cancer prevention and control strategies in the context of the global strategy for the prevention and control of noncommunicable diseases, the Global Strategy on Diet, Physical Activity and Health, and resolution WHA57.16 on health promotion and healthy lifestyles, with special emphasis on less developed countries;
- (2) to strengthen WHO's involvement in international partnerships and collaboration with Member States, other bodies of the United Nations system and actors from a wide variety of related sectors and disciplines in order to advocate, mobilize resources, and build capacity for a comprehensive approach to cancer control;
- (3) to continue developing WHO's strategy for the formulation and refinement of cancer prevention and control programmes, by collecting, analysing and disseminating national experiences in this regard, and providing appropriate guidance, upon request, to Member States;
- (4) to contribute to drawing up recommendations on early diagnosis of cancer, especially in order to define and reach the target populations that should benefit from such diagnosis;
- (5) to consider allocating additional resources so that the knowledge provided by research is translated into effective and efficient public-health measures for cancer prevention and control;
- (6) to promote and support research that evaluates low-cost interventions that are affordable and sustainable in low-income countries;
- (7) to support the further development and expansion of a research agenda in IARC and other bodies that is appropriate to the framing of integrated policies and strategies for cancer control;
- (8) to promote guidelines on the ethical care of patients with terminal cancer;
- (9) to provide adequate resources and leadership support to the International Programme on Chemical Safety for its active role in international multisectoral mechanisms for chemical safety, including support for capacity building in chemical safety at country level;
- (10) to support and strengthen mechanisms to transfer to developing countries technical expertise on cancer prevention and control, including surveillance, screening and research;
- (11) to advise Member States, especially the developing countries, on development or maintenance of a national cancer registry containing the type, location of the cancer and its geographical distribution;
- (12) to explore appropriate mechanisms for adequately funding cancer prevention and control programmes, especially in developing countries.

## ANNEX

**NATIONAL CANCER CONTROL PROGRAMMES:  
RECOMMENDATIONS FOR OUTCOME-ORIENTED OBJECTIVES**

National health authorities may wish to consider the following outcome-oriented objectives for their cancer control programmes, according to type of cancer:

- preventable tumours (such as those of lung, colon, rectum, skin and liver): to avoid and reduce exposure to risk factors (such as tobacco use, unhealthy diets, harmful use of alcohol, sedentariness, excess exposure to sunlight, infectious agents, including hepatitis B and liver fluke, and occupational exposures), thus limiting cancer incidence;
- cancers amenable to early detection and treatment (such as oral, cervical, breast and prostate cancers): to reduce late presentation and ensure appropriate treatment, in order to increase survival, reduce mortality and improve quality of life;
- disseminated cancers that have potential of being cured or the patients' lives prolonged considerably (such as acute leukaemia in childhood): to provide appropriate care in order to increase survival, reduce mortality and improve quality of life;
- advanced cancers: to enhance relief from pain and other symptoms and improve quality of life of patients and their families.

Mr ERGANI (Turkey)<sup>1</sup> recalled his earlier mention, in the second meeting, of the important role that cancer institutes could play in the developing countries. The information given by the member for France, that a national cancer institute would soon be set up in that country, indicated that supporting the activities of national cancer institutes was also a health issue in the developed countries. Supported by Mr ASLAM (alternate to Mr Khan, Pakistan), he suggested that the Board might wish to amend the draft resolution by adding a new subparagraph after paragraph 2(11), to read: “(12) to collaborate with Member States in their efforts to establish national cancer institutes;”.

Mr GUZMÁN VALENCIA (Colombia)<sup>1</sup> said that, while the draft resolution welcomed the initiative of IAEA to establish an action plan for cancer therapy, it made no mention of the considerable support given by IAEA. Colombia, and Latin America in general, had received assistance from IAEA through its technical cooperation programme. Two important projects were under way, one on the use of nuclear medicine techniques in the health sector, and the other on strengthening teletherapy services in the national cancer institute. One of the documents submitted to the IAEA's Programme and Budget Committee stated that the Agency would, with WHO and associated nongovernmental organizations, undertake international activities to devise a long-term strategy to combat cancer in view of the expected rise in cancer cases in developing countries and the shortage of qualified professionals and medical equipment. Seconded by Dr HUERTA MONTALVO (Ecuador), he therefore requested the Board to consider including in the final preambular paragraph of the draft resolution some reference to the support given by IAEA in the fight against cancer; the text might be amended to read: “Recognizing the support given by IAEA in the fight against cancer, welcomes the initiative by the Agency to establish a programme of action ...”.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The CHAIRMAN said that he took it that, with those two suggestions, the text was acceptable.

**The resolution, as amended, was adopted.<sup>1</sup>**

**Disability, including management and rehabilitation:** Item 4.2 of the Agenda (Document EB114/4)  
(continued from the fourth meeting)

The CHAIRMAN drew attention to the revised draft resolution proposed by Australia, China, Czech Republic, Ecuador, Ghana, Iceland, Russian Federation and Thailand on disability, including management and rehabilitation, which read:

The Executive Board,  
Having considered the report on disability, including management and rehabilitation,<sup>2</sup>

RECOMMENDS to the Fifty-eighth World Health Assembly the adoption of the following resolution:

The Fifty-eighth World Health Assembly,

Noting that about six hundred million people live with physical and mental disabilities of various types;

Aware of the global magnitude of the health and rehabilitation needs of persons with disabilities and the cost of their exclusion from society;

Concerned by the rapid increase in the number of persons with disabilities as a result of population growth, ageing, chronic conditions, malnutrition, war, violence, road-traffic injuries, occupational injuries (Iceland and Mexico) and other causes often related to poverty;

Stressing that 80% of people with disabilities live in low-income countries and that poverty further limits access to basic health services, including rehabilitation services;

Recognizing that people with disabilities are important contributors to society and that allocating resources to their rehabilitation is an investment; (Thailand)

Recognizing the importance of reliable information on various aspects of disability prevention, rehabilitation and care, and the need to invest in health and rehabilitation services required to ensure good quality of life regardless of disability;

Recalling the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;<sup>3</sup>

Recalling also the United Nations World Programme of Action concerning Disabled Persons,<sup>4</sup> indicating inter alia that the sphere of responsibility of WHO includes prevention of disability and medical rehabilitation;

Noting the African Decade of Disabled Persons (2000-2009), the Asian and Pacific Decade of Disabled Persons (1993-2002), the New Asian Pacific Decade of Disabled Persons (2003-2012) and the European Year of People with Disabilities (2003);

Recalling the United Nations General Assembly resolutions 56/168 of 19 December 2001, 57/229 of 18 December 2002, and 58/246 of 23 December 2003;

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<sup>1</sup> Resolution EB114.R2.

<sup>2</sup> Document EB114/4.

<sup>3</sup> Adopted by United Nations General Assembly resolution 48/96.

<sup>4</sup> United Nations General Assembly resolution 37/52.

Mindful that the internationally agreed upon development goals as contained (USA) in the United Nations Millennium Development Goals Declaration (USA) would not be achieved without addressing issues related to the health and rehabilitation of persons with disabilities,

1. URGES Member States:

- (1) to strengthen national programmes, policies and strategies for the implementation of the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (2) to develop their knowledge base with a view to promoting the rights and dignity of women, men, girls and boys with disabilities and ensure their full inclusion in society;
- (3) to promote early intervention and identification of disability, especially for children, and full physical, informational, and economic accessibility in all spheres of life, including to health and rehabilitation services, in order to ensure full participation and equality of persons with disabilities;
- (4) to promote and strengthen community-based rehabilitation programmes linked to primary health care and integrated in the health system;
- ~~(5) to promote the development of assistive technology and other means which facilitate the inclusion of persons with disabilities in society;~~
- (5) to facilitate access to assistive technology and to promote its development and other means that encourage the inclusion of persons with disabilities in society; (Australia)
- (6) to include a disability component in their health policies and programmes, in particular in the areas of child and adolescent health, sexual and reproductive health, mental health, ageing, HIV/AIDS, and chronic conditions such as diabetes mellitus, cardiovascular diseases and cancer;
- (7) to coordinate policies and programmes on disability with those on ageing where appropriate; (France)
- ~~(7)~~(8) to ensure gender equality in all measures with special attention to women and girls with disabilities, often subject to social, cultural and economic disadvantages;
- ~~(8)~~(9) to participate ~~actively~~ (USA) in the preparatory work for a United Nations comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities;<sup>1</sup>

2. REQUESTS the Director-General:

- (1) to intensify collaboration within WHO in order to work towards enhancing quality of life and promoting the rights and dignity of women, men, girls and boys with disabilities inter alia by including gender-disaggregated statistical analysis and information on disability in all areas of work;
- (2) to provide support to Member States in strengthening national rehabilitation programmes and implementing the United Nations' Standard Rules on the Equalization of Opportunities for Persons with Disabilities;
- (3) to support Member States in collecting more reliable data on all relevant aspects, including cost-effectiveness of interventions for disability prevention, rehabilitation and care, and in assessing potential use of available national and international resources for disability prevention, rehabilitation and care;

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<sup>1</sup> United Nations General Assembly resolution 56/168.

- (4) to further strengthen collaborative work within the United Nations system and with Member States, academia, private sector, and nongovernmental organizations, including disabled peoples' organizations;
- (5) to organize a meeting of experts to review the health and rehabilitation requirements of persons with disabilities;
- (6) to produce a world report on disability and rehabilitation based on the best available scientific evidence;
- (7) to promote a clear understanding of the contributions that people with disabilities can make to society; (Thailand)
- (7)(8) to provide a progress report on implementation of this resolution to the Sixtieth World Health Assembly, through the Executive Board.

Ms VALLE (Mexico),<sup>1</sup> welcoming the resolution, said that Mexico had recently been active in promoting the subject in United Nations forums and, taking into account the recommendation made at the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance (Durban, South Africa, 2001), had proposed at the Fifty-sixth Session of the United Nations General Assembly the preparation of a comprehensive and integral United Nations convention on the promotion and protection of the rights and dignity of persons with disabilities. The number of disabled people was increasing as a result of various conflicts and disasters. Mexico had also sponsored United Nations General Assembly resolution 56/168. At the last two sessions of the Commission on Human Rights, Mexico had sponsored draft resolutions on the human rights of disabled persons. Mexico proposed adding a new preambular paragraph to the draft resolution recognizing the importance of the rapid adoption of a comprehensive and integral United Nations international convention on the promotion and protection of the rights and dignity of persons with disabilities. That would give balance to the draft resolution, whose paragraph 1(8) urged WHO Member States to participate in the preparatory work for the convention. The new preambular paragraph would also complement the reference to the United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities and the United Nations World Programme of Action concerning Disabled Persons. The preamble might also refer to the Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities, 1999 and the ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention, 1983. Paragraph 1(7) in the Spanish text required some revision.

Dr AHMED (alternate to Dr Afriyie, Ghana) proposed adding the words "domestic injuries" to the third preambular paragraph of the draft resolution after "road-traffic injuries". He further proposed revising the beginning of paragraph 1(5) to read: "to facilitate access to appropriate assistive technology and ...".

Dr YOOSUF (Maldives) asked whether the reference to "women, men, girls and boys" in paragraph 1(2) added anything to the meaning of the text, since it excluded the elderly and infants. It might be better to use phraseology which included all persons with disabilities.

Dr STEIGER (United States of America) said that the lack of textual proposals by the representative of Mexico complicated the Board's work. When his Government had supported the fuller participation of observers in the Executive Board, the intention had not been to allow extensive amendments at the last minute. A working group had been discussing the draft resolution for two full days and observers could have attended those meetings. He therefore appealed to members of the Board and observers to take part in working groups if they wanted to submit amendments.

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure.

Dr BELLO DE KEMPER (Dominican Republic)<sup>1</sup> agreed that the Spanish text required some editorial revision; that would not alter the meaning of the draft resolution. Not all delegations were as large as that of the United States of America and for that reason they could not attend all the meetings at which resolutions were considered.

Dr LEWIS-FULLER (alternate to Mr Junor, Jamaica), referring to paragraph 2(4), pointed out, with reference to the phrase “disabled peoples’ organizations”, that the term “persons with disability” would be preferable.

Dr HUERTA MONTALVO (Ecuador) said that, while he fully agreed with the member for the United States of America about the desirability of not raising issues at the last moment, such a course was sometimes unavoidable. What mattered was the relevance of the observation and the principle of not substantially altering the wording and spirit of what members wanted to approve. He would be happy to submit Mexico’s proposals in writing.

Mr AITKEN (Director, Office of the Director-General) read out the suggested amendments. In the third preambular paragraph beginning with “Concerned by the rapid increase”, the member for Ghana had proposed inserting the words “domestic injuries” after “road-traffic injuries,”. Mexico’s proposal was to add a paragraph to the preamble which would read “*Reconociendo la importancia de la pronta conclusión de la convención internacional amplia e integral de las Naciones Unidas para la promoción y la protección de los derechos y la dignidad de las personas con discapacidad;*” (“Recognizing the importance of the rapid adoption of a comprehensive and integral United Nations international convention to promote and protect the rights and dignity of persons with disability;”). That new paragraph should be inserted between the two existing paragraphs beginning “Recognizing”. Mexico had also wished to add a reference to two other conventions, the Inter-American Convention on the Elimination of all Forms of Discrimination Against Persons with Disabilities and the ILO Vocational Rehabilitation and Employment (Disabled Persons) Convention. Since there was no proposed text for those amendments, the Board might wish to note the concerns expressed by Mexico but make no specific addition to the resolution itself. The member for Maldives had suggested that “women, men, boys and girls” should be replaced with “persons with disabilities” to make the text clearer. Ghana had also proposed the addition of the word “appropriate” before “assistive technology” in paragraph 1(5) and Jamaica had proposed the replacement of “disabled people’s organizations” with “organizations for persons with disability” at the end of paragraph 2(4).

**The resolution, as amended, was adopted.<sup>1</sup>**

**The meeting rose at 12:45.**

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<sup>1</sup> Resolution EB114 R3.

## **SIXTH MEETING**

**Wednesday, 26 May 2004, at 14:05**

**Chairman:** Mr D.Á. GUNNARSSON (Iceland)

### **1. STAFFING MATTERS:** Item 5 of the Agenda

**Statement by the representative of the WHO staff associations on matters concerning personnel policy and conditions of service:** Item 5.1 of the Agenda (Document EB114/INF.DOC./2)

Dr NUTTALL (representative of the WHO staff associations) presented the statement contained in document EB114/INF.DOC./2. She regretted that implementation of the recommendations made by the most recent Global Staff/Management Council concerning the introduction of a WHO-wide financial reward and recognition system had been delayed and trusted that they would be implemented in the near future. With regard to types of contract within WHO, the figures referred to September 2003 rather than December 2003, because the latter left out of account all temporary staff who did not have contracts covering the end of the year period. She asked what could be done to prevent the inevitable loss of skills, efficiency and productivity entailed by the departure between July 2006 and February 2007 of 1800 staff members who had served the Organization for more than four years.

Mr SHUGART (Canada) paid tribute to the professionalism and dedication of WHO staff. They were at the heart of the Organization and the repositories of its expertise, technical ability and knowledge. Some of the comments made during the Health Assembly's discussion of the migration of health personnel should be borne in mind in that connection. WHO management should indeed make every effort to ensure uniform compliance with the intent and spirit of Staff Rule 920. His Government fully supported the introduction of the new contract rules for WHO, but considered it important to ensure that the impact of that policy did not lead to the unnecessary, accidental or arbitrary loss of valuable expertise. He therefore urged the Director-General to approach the matter with flexibility and sensitivity and to allow exemptions in exceptional circumstances in order to retain personnel on short-term contracts whose skills were essential to the goals of WHO.

The DIRECTOR-GENERAL, in response to the statement of the representative of the WHO staff associations, said that, while recognition of good performance or long service was very important, there were many ways to express such recognition and it was hard to see how a financial reward and recognition system could be implemented. Although the working conditions of some members of staff were difficult, they were often much better than existed elsewhere. There had been suggestions in the past that extra steps should be introduced in the most senior grades so that people in those posts could be paid a higher salary, but that proposal had been discarded because it had been felt that everyone should be expected to do a good job and that any reward should take the form of job satisfaction. The adding of steps could lead to abuses and for that reason he had no intention of changing the structure of grades and steps.

With regard to temporary staff, WHO was a knowledge-based organization and highly qualified, motivated staff were therefore its biggest asset. Some flexibility was, however, required. In the United Nations system it was extremely difficult to fire someone once they had been recruited and

any attempt to do so usually resulted in a case being brought before the Administrative Tribunal of ILO, with all the expense that such legal action entailed. Great caution was therefore required in respect of fixed-term contracts. In addition, because of the nature of the Organization's work, many short-term staff were needed. Sometimes those people had been asked to stay on and it had then become difficult to terminate their contracts because they had become colleagues. His predecessor had attempted to break the cycle of short-term staff who stayed forever, and had regularized the contracts in some special cases. She had realized, however, that when the new decentralization rule was introduced, there would be a wave of departures; people who had accepted short-term contracts in the past two years had also known what the position was. The departure of 1800 people would not be a catastrophe for the Organization and such a tough decision was demanded for the sake of efficiency. That number was in any event an overall figure and included staff in the regions and individual countries. The main point was that temporary contracts should not henceforth be regarded as a "back door" to a fixed-term contract. The rehiring of retirees was not a very common practice. With regard to geographical distribution, in the African, South-East Asia and Eastern Mediterranean Regions 90% of the 70% of staff on temporary contracts were from the region and so it could not be said that there was any skewing of that distribution. It was necessary to look at the issue from two perspectives; what the staff of WHO wanted was not necessarily what the Member States wanted. WHO's work extended beyond the headquarters building. It was not a commercial company, but had been created to serve Member States, and while it was important to guarantee good conditions of service, and he was sympathetic to staff demands for better living conditions, the Organization had to pay due heed to the expectations of its Member States.

Professor FIŠER (Czech Republic) acknowledged the need for flexibility, but stressed that WHO, as a knowledge-based organization, depended on the expertise of its staff. Short-term contracts might be useful as a means of assessing a person's capabilities, but after several short contracts a decision should be taken about whether to give that person a fixed-term contract. He agreed that, although temporary contracts were cheaper for the Organization, it was necessary to think of the well-being of the staff.

Dr SAMBA (Regional Director for Africa) explained that 73% of staff in the African Region were on short-term contracts because they were employed on the campaign to eradicate poliomyelitis. The disease had been endemic in 31 countries in 1995, but was currently endemic in only two. In 1995 nine people had been engaged on the project compared with a current figure of almost 800. Unfortunately, once people were taken on as temporary staff, they wanted to join the Organization on a permanent basis and health ministries sometimes tried to exert behind-the-scenes pressure in favour of certain temporaries. In Africa, however, the diversity of challenges that had to be faced and extrabudgetary funding meant that many staff members had to be temporary.

Mr HENNING (Health Resources Services) said that, although temporary appointments were not in principle subject to geographical distribution quotas, the Director-General had circulated a memorandum to all the Assistant Directors-General and Regional Directors saying that such an appointment of a candidate from an overrepresented country had to have their personal approval. That meant that, in fact, the criteria regarding geographical distribution were applied to fixed-term and temporary positions. Since 2002, clear rules had been established for short-term staff, who thus knew how long they could stay. Human resources plans and tools being introduced to cope with the large number of departures two years thence would require managers to define their real short-term needs. The transfer of resources to the regions would also have an impact on human resource planning, as funds currently allocated to temporary posts might be affected. Mobility and rotation would be implemented in 2006, which would again influence resources at headquarters and in the field. In addition, the conversion of a short-term appointment into a more expensive, fixed-term position had cost implications and appropriate provision had to be made for that in the budget. Managers would have to measure the impact of regularizing posts that were really of a long-term nature. One of the

premises in the staff associations' presentation was that the 1800 people were on posts of a longer duration than four years. While that was a reasonable assumption, it did not reflect reality. Not all the positions occupied by those 1800 people would continue beyond July 2006.

Dr NUTTALL (representative of the WHO staff associations) pointed out that her statement had been made on behalf and with the approval of all staff associations in Geneva and the regions. It did not reflect the situation of headquarters staff alone.

**The Board noted the statement by the representative of the WHO staff associations and the comments of the Director-General.**

## **2. MANAGEMENT AND FINANCIAL MATTERS:** Item 6 of the Agenda (continued)

### **Implementation of multilingualism in WHO:** Item 6.1 of the Agenda (Document EB114/8)

Dr HUERTA MONTALVO (Ecuador), speaking on behalf of the Latin American and Caribbean Group, welcomed the measures taken to strengthen WHO's status as a multilingual organization. That Group realized that cost was a constraining factor, but urged that multilingualism should not be limited to a few services. In order to benefit countries wishing to access WHO material, the web site should be completely multilingual, and important documents should be printed in Spanish. Similarly, he would encourage the Organization to provide simultaneous interpretation in all official languages for meetings at headquarters. Finally, referring to paragraph 9 of the report, he asked when the dialogue between the Special Coordinator and groups of Member States would begin.

Mr FURGAL (Russian Federation) considered that equality among the languages of the Organization was extremely important, especially for countries whose languages were still insufficiently used in WHO. Despite the improvements made, real equality was still far from being achieved, particularly with regard to printed matter, and he requested, for its 115th session in January 2005, a comparative table showing the amount of printed material produced in the various languages. Although the summary records of the Board's sessions and the Health Assembly were issued in four languages, the Russian version of the record of the 113th session of the Board had appeared too late to be used in preparing for the Health Assembly; that situation needed to be remedied. There should be a significant increase in the amount of material available from WHO in Russian, in printed form and on the web site. He also advocated greater provision of simultaneous interpretation into Russian for the Organization's meetings and technical consultations. The documentation in Russian for the Health Assembly had been of good quality and provided in good time, although the standard of interpretation into Russian at the current session of the Board could have been better. In the interests of the Russian medical community, he asked when WHO would issue the complete version of *The world health report* in Russian.

Dr YIN Li (China) expressed appreciation for the many measures taken since 2000 to strengthen multilingualism in WHO. A broader range of languages on the web site meant wider knowledge of WHO activities. The summary records of the Board's sessions and the meetings of the committees of the Health Assembly were issued in English, French, Russian and Spanish. He expressed the hope that it would be possible to make them available in Chinese and Arabic in the near future and that the WHO Regional Committee for the Western Pacific would be able to translate its resolutions and summary records into Chinese. The Internet permitted easy access to health information, and he looked forward to seeing the WHO web site broadened to include all six official languages.

Mr BRUNET (alternate to Professor Dab, France) said that the strengthening of multilingualism in all international organizations, and particularly with regard to WHO, was very important for his country. The report omitted several points that would help to explain why WHO was, in effect, a monolingual organization. That view was shared by the Joint Inspection Unit which, in a recent report, had noted that almost all texts produced by WHO were originally drafted in English. He had noted that the translation of working documents into French was not always perfect: in particular, the draft resolution on cancer prevention and control examined at the current Board session had contained substantive errors in the retranslation of two amendments by France which should be corrected before the resolution came before the next Health Assembly.

The Joint Inspection Unit had also made WHO the subject of a case-study on respect for multilingualism, which the Board would be examining at its 115th session, and had highlighted a number of shortcomings both in staff recruitment and in its publications. It had also deplored the fact that most of the material on WHO's web site was available only in English, which meant that important information on, for example, the "3 by 5" initiative was difficult to access for many people around the world.

Language was not a mere tool, but reflected a system of thought and permitted the communication of values and ideas, and it was for that reason that the French-speaking countries were fighting to establish cultural diversity. Multilingualism, or at least an active knowledge of the Organization's working languages, must be an essential requirement when recruiting staff for WHO, and it would be useful if a report giving statistics on knowledge of languages among staff could be produced for the Board's next session so that the necessary decisions could be taken regarding training. His country would do all it could to ensure that multilingualism was reinstated in the Organization, and was ready to work with the Director-General and to consult with interested parties to that end. Meanwhile, he counted on the Director-General to ensure that progress was made by the next session of the Executive Board, particularly with regard to the web site, and hoped that the necessary resources would be made available for that priority task.

Dr STEIGER (United States of America) associated himself fully with the statement made by the member for Ecuador. There were about 30 million Spanish-speaking people in the United States of America, not all of whom knew English, and his Government would like to make use of WHO publications in, for example, its health promotion programmes, but could not do so because of the shortage of Spanish-language material. He recognized that there were budgetary restraints, but believed that the promise made 50 years earlier that WHO would work in six official languages should be kept.

Dr LAMATA COTANDA (Spain) supported WHO's policy on multilingualism based on resolutions adopted in recent years, but said that greater efforts were required. He paid tribute to the translation work done by the language staff, and hoped that they would be given sufficient support to improve their performance. He endorsed the views of previous speakers, particularly the statement made by the member for Ecuador, and stressed the importance of translating material produced by the Organization with a view to its dissemination by the media.

Mr SHUGART (Canada) endorsed the views of the member for France on the need to strengthen the use of French in the Organization. Equality in the use of languages was very important to Canada, not only to ensure effective dissemination of information but also to facilitate dialogue between Member States. The Director-General should give priority to promoting wider use of official languages within WHO, thus helping to achieve the objective of equitable geographical representation and improving the quality of its work.

Measures had been taken, but they were insufficient. Multilingualism should be seen as an investment in WHO's infrastructure, on the same lines as further training or improvements in the computer system. Canada welcomed the recent recommendations by the Joint Inspection Unit on

multilingualism in WHO, and looked forward to the report on the subject that the Director-General would submit to the Board at its next session.

Dr YOOSUF (Maldives) said that he understood the importance of multilingualism for WHO, but wanted to know the extra cost to the Organization, given that it would be servicing more meetings and expanding the material provided on its web site. He wanted to know also on what basis – population or number of countries – a language was chosen. Why the restriction to six languages? The South-East Asia Region, for example, was home to 25% of the global population and accounted for 40% of the global disease burden, yet none of the material issued by WHO was published in any of the languages of the Region. He suggested that, cost permitting, some of them might become official WHO languages.

Dr AL-SAIF (alternate to Mr Razzooqi, Kuwait) thanked the Director-General for the report and his efforts to promote the use of all six official languages. He appreciated publication of *The world health report* in Arabic: the quality of both the report and the translation was excellent. He requested the Director-General to allocate additional funds for translation into Arabic at WHO headquarters.

Mr NOGHES (Monaco)<sup>1</sup> said that he hoped that simultaneous interpretation in the official languages would continue to be provided for meetings of governing bodies and working or drafting groups. Knowledge of languages remained an essential element in the recruitment of staff, and language training should be strongly encouraged. Maintaining multilingualism should be a priority in establishing future budgets. He supported the Joint Inspection Unit's recommendation that the Director-General should submit to the Fifty-eighth World Health Assembly a plan of action on multilingualism, and agreed that there was a need to apply multilingualism to the WHO web site. It was important for health personnel in countries that documents should be translated, especially those concerning the "3 by 5" initiative. Achieving the goal of multilingualism was difficult and costly, but it was essential, not only for the sake of cultural diversity but also to enable as many people as possible to have access to WHO's work.

Mr ABDEL LATIF (Egypt)<sup>1</sup> said that promoting multilingualism was important in the United Nations family, but especially in WHO on account of its universal mandate, and he thanked the Director-General for his efforts in that regard. He stressed the need to strengthen the position of Arabic within WHO as one of the official languages. Endorsing the remarks by the member for Kuwait, he urged the Director-General to intensify his efforts towards providing interpretation into Arabic and requested that as many documents as possible should be issued in Arabic. In particular, the summary records of the Board and the committees of the Health Assembly should be provided in Arabic and Chinese, and WHO should publish more technical material in Arabic, especially the more important policy documents and publications. He encouraged the distribution of as much material as possible in Arabic and the use of the Internet to outline recent developments and advances in the field of public health, so that Arabic-speaking countries could participate more fully in the work of the Organization. In addition, documents should be made available faster.

Egypt was a francophone country, too, and he therefore endorsed the comments made by the member for France.

Mrs BOUASSA (Morocco)<sup>1</sup> shared the concerns expressed by previous speakers and supported action to promote multilingualism. Communication had never been as important to global health as it was today, and language would always be by far the most important vehicle for communicating information. It was regrettable that much of the technical information appearing on WHO's web site

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

was in English only, which placed Morocco's health experts at a disadvantage. She supported the requests made by Kuwait, Egypt and the members and representatives of francophone countries.

Dr BEHBEHANI (Assistant Director-General) observed that multilingualism was neither a new problem nor an easy one to solve, but efforts would be made to make progress along the lines set out in the report. The number of staff taking language training had already doubled since the Director-General had taken office. Every effort had been made to ensure that documentation for the Fifty-seventh World Health Assembly and the current session of the Board was available in six languages, and to provide interpretation in six languages for meetings held at headquarters. The web site had been redesigned in three languages, and had links to the web sites of the regional offices where information was provided in other languages. Every effort was being made to produce a larger quantity of material in different languages.

By the time of the next session of the Board, the Organization would have issued a report on actions proposed and their cost. In the meantime, it would continue to produce as much material as possible in other languages than English, even if only in summary form. Credit should be given to those regions that were making provision for languages other than the six official languages.

Responding to specific questions, he said that the Secretariat was looking into ways of producing *The world health report* in Russian and producing summary records in Arabic and Chinese. Technically that was possible, but financially it was a question of deciding whether resources should be allocated to that activity in preference to others.

The DIRECTOR-GENERAL conceded that multilingualism was difficult to achieve and cost time and money, and that the Organization had often produced its material in one language rather than six. However, in the case of Arabic, translation was sometimes outsourced from WHO headquarters to the WHO Regional Office for the Eastern Mediterranean, a practice that could be applied to other languages, for example Russian. With the use of information technology, it was possible to outsource translation of documents and web site content to anywhere in the world. There was no doubt that multilingualism would make WHO a culturally and linguistically richer organization.

Limitation to six languages did indeed cause difficulties for anyone whose mother tongue did not happen to be one of those six, but for the time being WHO had to operate with six official languages. He assured the Board that the Organization would come up with a plan and would seek any additional resources that might be necessary to implement it.

**The Board noted the report.**

**Committees of the Executive Board: Item 6.2 of the Agenda (continued)**

- **Merger of committees: terms of reference and options for membership** (Documents EB114/9 and EB114/9 Add.1)

The CHAIRMAN explained that document EB114/9 set out proposed terms of reference for the new single committee, suggested a name for it and presented terms of office and options for membership. Document EB114/9 Add.1 contained a draft resolution for consideration by the Board; in paragraph 2 of the draft resolution, "Thursday and Friday" should read "Wednesday to Friday".

Dr TANGI (Tonga) sought assurance that documents for the Board would reach him six weeks before the commencement of each session, in accordance with the Rules of Procedure. His question had been prompted by paragraph 4 of the report, which stated that the report of the proposed new committee would be presented to the Board early in each session.

Dr KEAN (Director, Governance) explained that the documents for the proposed new committee would be largely the same as those for the Executive Board or, in the case of the May

session of the Board, those for the Health Assembly, and would have to be dispatched six weeks beforehand, in accordance with the Rules of Procedure. The report of the committee would be presented at the time of the Executive Board. The Secretariat had proposed, on the basis of discussions in the Ad Hoc Open-ended Intergovernmental Working Group to review the Working Methods of the Executive Board, that the report should be given much more prominence at sessions of the Executive Board and should be taken up on the first day, so that the outcome of the work of the committee could be taken into account. By their very nature, a number of documents, such as the document on the payment of arrears, would be submitted later.

The CHAIRMAN said that he took it that the Board wished to adopt the draft resolution contained in document EB114/9 Add.1, as amended.

**The resolution, as amended, was adopted.<sup>1</sup>**

- **Filling of vacancies on committees** (Documents EB114/11 and EB114/11 Add.1) (continued from the first meeting, section 5)

The CHAIRMAN drew the Board's attention to the report on membership of committees contained in document EB114/11 and the proposals in document EB114/11 Add.1 for new members to fill vacancies. The Board had already appointed the members of the Standing Committee on Nongovernmental Organizations on the first day of the session.

#### **Foundation committees**

The CHAIRMAN said that there were no vacancies to fill on the committees for the Darling Foundation and the Ihsan Dogramaci Family Health Foundation.

#### **Léon Bernard Foundation Committee**

**Decision:** The Executive Board, in accordance with the Statutes of the Léon Bernard Foundation, appointed Dr D. Hansen-Koenig (Luxembourg) as a member of the Léon Bernard Foundation Committee for the duration of her term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Dr Hansen-Koenig was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.<sup>2</sup>

#### **Jacques Parisot Foundation Selection Panel**

**Decision:** The Executive Board, in accordance with the Implementing Regulations of the Jacques Parisot Foundation, appointed Dr O. Brînzan (Romania) as a member of the Jacques Parisot Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman and Vice-Chairmen of the Board, members ex officio. It was understood that if Dr Brînzan was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.<sup>3</sup>

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<sup>1</sup> Resolution EB114.R4.

<sup>2</sup> Decision EB114(2).

<sup>3</sup> Decision EB114(3).

**State of Kuwait Health Promotion Foundation Selection Panel**

**Decision:** The Executive Board, in accordance with the Statutes of the State of Kuwait Health Promotion Foundation, appointed Mr M.N. Khan (Pakistan) as a member of the State of Kuwait Health Promotion Foundation Selection Panel for the duration of his term of office on the Executive Board, in addition to the Chairman of the Board and a representative of the founder, members ex officio. It was understood that if Mr Khan was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.<sup>1</sup>

**Sasakawa Health Prize Selection Panel**

**Decision:** The Executive Board, in accordance with the Statutes of the Sasakawa Health Prize, appointed Dr V. Tangi (Tonga) as a member of the Sasakawa Health Prize Selection Panel, in addition to the Chairman of the Board and a representative of the founder, members ex officio. It was understood that if Dr Tangi was unable to attend, his successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.<sup>2</sup>

**United Arab Emirates Health Foundation Selection Panel**

**Decision:** The Executive Board, in accordance with the Statutes of the United Arab Emirates Health Foundation, appointed Dr N.A. Haffadh (Bahrain) as a member of the United Arab Emirates Health Foundation Selection Panel, in addition to the Chairman of the Board and a representative of the Founder, members ex officio. It was understood that if Dr Haffadh was unable to attend, her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Panel.<sup>3</sup>

**Programme, Budget and Administration Committee**

The CHAIRMAN noted that, in adopting resolution EB114.R4, the Board had agreed to the composition of the new Programme, Budget and Administration Committee, with 14 members. Initially, six Board members would be appointed for one year, and six members for two years; from the 116th session of the Executive Board in May 2005, and each year thereafter, six members – one from each region – would be appointed for the full two-year period. He suggested Dr Yoosuf as the ex officio member for the Vice-Chairman's position, since the other three Vice-Chairmen were already members of other committees.

**Decision:** In accordance with resolution EB114.R4, Annex, the newly established Programme, Budget and Administration Committee of the Executive Board comprises 14 members, namely, two from each of WHO's six regions, together with the Chairman and a Vice-Chairman of the Board, members ex officio. The Board decided, having regard to those members of the Programme Development Committee, the Administration, Budget and Finance Committee and the Audit Committee who had not yet completed their two-year term of membership, to provide

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<sup>1</sup> Decision EB114(4).

<sup>2</sup> Decision EB114(5).

<sup>3</sup> Decision EB114(6).

for membership of the Programme, Budget and Administration Committee as follows: Mr D.Á. Gunnarsson (Iceland), Chairman of the Board, member ex officio; Dr A.A. Yoosuf (Maldives), Vice-Chairman of the Board, member ex officio; Mr I. Shugart (Canada), Dr Yin Li (China), Professor B. Fišer (Czech Republic), Dr M. Camara (Guinea), Dr H.N. Acharya (Nepal) and Mr M.N. Khan (Pakistan), appointed for a one-year period; Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Professor W. Dab (France), Mr T. Ramotsoari (Lesotho) (alternate to Dr M. Phooko), Mrs Sudarat Keyuraphan (Thailand) and Dr W.R. Steiger (United States of America), appointed for a two-year period or until expiry of their membership on the Board, whichever occurs first. Subsequent appointments should, to the extent possible, be made with a view to renewing half the elected membership each year, that is, one member from each WHO region.

It was understood that if any member of the Committee was unable to attend, his or her successor or the alternate member of the Board designated by the government concerned, in accordance with Rule 2 of the Rules of Procedure, would participate in the work of the Committee.<sup>1</sup>

### **Representatives of the Executive Board at the Fifty-eighth World Health Assembly**

The CHAIRMAN said that the Chairman and three of the Vice-Chairmen were generally elected as representatives of the Board to the Health Assembly. If any of them were not available, the remaining Vice-Chairman or the Rapporteur could take that person's place.

**Decision:** The Executive Board, in accordance with paragraph 1 of resolution EB59.R7, appointed its Chairman, Mr D.Á. Gunnarsson (Iceland), ex officio, and its first three Vice-Chairmen, Dr A.B. Osman (Sudan), Dr Yin Li (China) and Dr A.A. Yoosuf (Maldives), to represent the Board at the Fifty-eighth World Health Assembly.<sup>2</sup>

**Future sessions of the Executive Board and the Health Assembly:** Item 6.3 of the Agenda (Document EB114/10)

**Decision:** The Executive Board decided that its 115th session should be convened on Monday, 17 January 2005, at WHO headquarters, Geneva, and should close no later than Tuesday, 25 January 2005.<sup>3</sup>

**Decision:** The Executive Board decided that the Fifty-eighth World Health Assembly should be held at the Palais des Nations, Geneva, opening on Monday, 16 May 2005, and that it should close no later than Wednesday, 25 May 2005.<sup>4</sup>

**Nongovernmental organizations: reconsideration of two applications for admission into official relations with WHO:** Item 6.4 of the Agenda (Documents EB114/12 and EB114/19)

The CHAIRMAN recalled that, at its 113th session, the Board had requested more information about the International Council of Grocery Manufacturers Associations and the Confederation of the Food and Drink Industries of the European Union before deciding whether to admit the two

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<sup>1</sup> Decision EB114(7).

<sup>2</sup> Decision EB114(8).

<sup>3</sup> Decision EB114(9).

<sup>4</sup> Decision EB114(10).

organizations into official relations with WHO.<sup>1</sup> The Standing Committee on Nongovernmental Organizations had considered the issue at the current session, and its report appeared in document EB114/19.

Dr HUERTA MONTALVO (Ecuador), speaking as the Chairman of the Standing Committee on Nongovernmental Organizations, said that, as reported in document EB114/19, the Standing Committee's recommendation, reached by a majority decision, was that the two organizations should be admitted into official relations with WHO. The Standing Committee, under paragraph 4.2 of the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations, had considered the applications and recommended to the Board at its 113th session that the two organizations should be admitted. The Board had postponed its decision, however, pending the receipt of more information from the two organizations, intended to determine whether their areas of activity were consistent with WHO's criteria for admission into official relations, that they were not-for-profit bodies and whether they had any links with the tobacco industry.

The information received from the two organizations appeared in document EB114/12. The Standing Committee had considered the two applications again, conscious of the complex nature of the issue, and had decided that the activities of the two organizations were relevant to the work of WHO, particularly the global strategy on diet, physical activity and health. Representatives of other nongovernmental organizations maintained that there would be conflicts of interest. The Standing Committee was satisfied that the two organizations did not operate for profit. Their links with the tobacco industry, described in paragraph 4 of the report, had been noted with concern, however, and if the two organizations were admitted into official relations with WHO, they must be made fully aware of the Organization's position in that regard.

Mr BRUNET (alternate to Professor Dab, France) said that the replies from the two organizations were not very informative. The link with a tobacco manufacturer was acknowledged, but its extent was not explained. What role did the holding company play? The reply from the Confederation stated merely that its by-laws specifically excluded any advocating on behalf of any non-food or drink products. WHO must talk to the agro-food industry in its efforts to promote the global strategy on diet, physical activity and health, but there were undoubtedly other potential partners besides the two organizations under discussion.

Dr HANSEN-KOENIG (Luxembourg) said that the Standing Committee did not appear to be entirely comfortable about its own recommendation, given that a link had been established between the two organizations and the tobacco industry – albeit an indirect and unquantified one. Bearing in mind the strategies needed by the tobacco industry to infiltrate WHO, it might be better to maintain informal relations with the two organizations, rather than admitting them to full official relations, pending further information. An organization could do a lot of damage in the three years it was entitled to display the WHO logo.

Dr STEIGER (United States of America) said that, in his opinion, the two organizations should be admitted to official relations with WHO. The Standing Committee had reviewed their applications twice, and recommended their admission twice: what more did the Board need to know? WHO could not implement many of its resolutions, or the global strategy on diet, physical activity and health, without a formal relationship with private-sector organizations representing food manufacturers. The global strategy stated that the private sector could be a significant player in promoting healthy diets and physical activity and that international collaboration was crucial, since many companies operated globally. It also urged Member States and WHO to encourage mobilization of all concerned social and

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<sup>1</sup> See document EB113/2004/REC/2, summary record of the tenth meeting, section 5

economic groups, including industry associations, with which WHO's relations had generally been satisfactory. WHO and FAO were the United Nations agencies responsible for standard-setting in food safety, and needed to promote those standards in the private sector.

He was satisfied with the answers provided by the two organizations. WHO was always worried about possible conflicts of interest in its relations with the private sector, but did not seem nearly so worried about that possibility in relation to state-owned food or tobacco monopolies. It did not seem likely that a couple of nongovernmental organizations which might, or might not, have links with the tobacco industry posed a great threat to the Organization.

Dr TANGI (Tonga) said that, as a new member of the Board, he had not been party to the discussion at the previous session. If the sum total of the Board's deliberations showed that the two organizations fulfilled the criteria set out in the Principles Governing Relations between the World Health Organization and Nongovernmental Organizations, then he would be satisfied. If not, the Board should discuss the matter further.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho) said that the two organizations apparently owed their existence to for-profit companies. He therefore felt that WHO should not admit them into official relations, but maintain an informal relationship. The situation might be reconsidered following implementation of the WHO Framework Convention on Tobacco Control.

Mr DE CASTRO SALDANHA (alternate to Dr Zepeda Bermudez, Brazil) supported the members for France and Luxembourg. He was not, however, completely satisfied with the two organizations' explanation of their links with the tobacco industry and called for further clarification.

Dr YOOSUF (Maldives) said that the two applications had been discussed at length in the Standing Committee, and the resulting recommendation was reasonable. Some nongovernmental organizations, such as those in the pharmaceutical industry, had more direct links to profit-making bodies. In any case, he had been assured that relationships with WHO had long been monitored for possible abuse.

Ms HALTON (Australia) said that she had found the discussion disappointing, especially in view of the Health Assembly's adoption of the global strategy on diet, physical activity and health. However, as the previous speaker had pointed out, there were many nongovernmental organizations in the pharmaceutical industry that had more to do with profit-making. Given the rapid rise in obesity and its consequences, recognized at the Health Assembly, it would be extremely disappointing if the Organization were to give the two associations the impression that it was not serious. Australia vigorously supported the WHO Framework Convention on Tobacco Control, and she understood the disquiet about tobacco interests. But what was at stake, the food industry and its impact on diet and health, was a different and entirely fundamental issue. Some members had voiced concern that they had not participated in the Standing Committee's work, but the applications had already been reviewed twice, and it had also been made clear that WHO could discontinue a relationship at any time if it so chose. She therefore endorsed the comments made by the member for the United States of America, and suggested that the Board should agree to accept the two applications, noting that relations could be discontinued at any time if difficulties arose.

Mr SHUGART (Canada) supported those in favour of accepting the two applications for admission. In the real world, nothing was clear-cut. Both organizations dealt with food, but apart from that little else could be known about them. Therefore, in view of the safeguards mentioned by the member for Australia and the monitoring process referred to by the member for Maldives, WHO could act in good conscience in admitting the two organizations into official relations.

Ms MAFUBELU (South Africa)<sup>1</sup> said that the Board had deferred a decision pending answers to certain questions, and, at its 113th session, her country had voiced misgivings about the proposed admission of both organizations, considering that neither was free from primarily commercial concerns. The additional information had merely confirmed its view. Both organizations depended for their existence on members whose primary aim was profit, and could never be independent of their members' interests. Moreover it left no room for doubt that both organizations had links with the tobacco industry. Admitting them into official relations would therefore undermine the letter and spirit of the WHO Framework Convention on Tobacco Control. There was no need for organizations to have official relations with WHO in order to provide technical assistance or to engage in dialogue with the Organization. Many nongovernmental organizations, such as *Médecins sans Frontières*, did an excellent job in furthering WHO's aims without being in an official relationship with the Organization. She was also disappointed to note inconsistencies and contradictions in the report of the Standing Committee between its observations and its recommendations to the Board. She urged the Board not to admit either organization into official relations with WHO. She shared the view in paragraph 8 of the Standing Committee's report (document EB114/19) that links with the tobacco industry called for caution. As the members for Lesotho and Luxembourg had said, it would be preferable to maintain working relations on an informal basis.

Dr HUERTA MONTALVO (Ecuador) said that, in the best interests of health worldwide, the procedures followed in deciding whether to admit nongovernmental organizations into official relations with WHO lacked clarity and consistency and should be reviewed. For instance, the rule that they should be international in their structure or scope was relatively easy to comply with in Europe, but posed more of a problem for organizations based in the Americas. It was also difficult to ensure that all the nongovernmental organizations with which WHO maintained official relations were not-for-profit. But the Organization had to maintain relations with the pharmaceutical industry, since medicines accounted for 40% of all health spending in the Americas. The same was true of the food industry, even though that was seen as bearing some responsibility for the increase in obesity and for conditions such as arteriosclerosis, which was linked to the consumption of *trans* fats and the practice of using recycled cooking oil. WHO should review its procedures to ensure that it was able to maintain contact with relevant nongovernmental organizations, and that the criteria for admission into official relations were wholly transparent.

The CHAIRMAN agreed, but pointed out that the interests of different branches of private industry were often closely interlinked. It would be difficult for WHO to find representatives of the food industry that had no connections with tobacco, alcoholic beverages or weapons.

Dr LEWIS-FULLER (alternate to Mr Junor, Jamaica) said that some contradictory points had been made. It might be wise to go back to the beginning and reflect on the reasons for having official relations with nongovernmental organizations in the first place. Should organizations that did valuable work but did not seek an official relationship be debarred from collaborating with WHO? She did not think so, yet they might be inadvertently excluded. As for the WHO Framework Convention on Tobacco Control, the tobacco industry had been precluded from relations with WHO, yet the Organization expected to exercise control over it. Was there not an element of hypocrisy in such an approach? Something was amiss in the definition of the relationship, and it should be revisited.

The CHAIRMAN said that, since the Health Assembly had adopted the global strategy on diet, physical activity and health, it was self-evident that WHO needed to maintain dialogue with partners in private industry. The Standing Committee had recommended acceptance of the two applications in

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<sup>1</sup> Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

question. However, several members had expressed their concern about possible connections with the tobacco industry, and the member for France had suggested identifying other partners representing the food industry. Since the Board usually took its decisions by consensus, he suggested that the Secretariat should be asked to enquire into the ties, if any, the two organizations had with the tobacco industry, whether such ties, if they existed, could be broken, and whether other organizations without such ties could be found, and to report to the Board at its 115th session.

**It was so agreed.**

**3. MATTERS FOR INFORMATION: Item 7 of the Agenda**

**Report on expert committees and study groups: Item 7.1 of the Agenda (Document EB114/13)**

The CHAIRMAN, introducing the item, observed that document EB114/13 contained reports on four meetings.

**The Board took note of the report.**

**4. CLOSURE OF THE SESSION**

The DIRECTOR-GENERAL observed that one of the most significant outcomes of the Fifty-seventh World Health Assembly had been the adoption of the global strategy on diet, physical activity and health. He expressed his appreciation to the Government of Australia, which had just signed an agreement with WHO to provide financial support for the implementation of the strategy. The substantive nature of the issues discussed and the openness of the dialogue in both the Health Assembly and the current session of the Board had been encouraging. In particular, he highlighted the proposed review of the working methods of the Health Assembly, and said that some preliminary proposals would be submitted to the 115th session of the Board for consideration. It was essential that the Health Assembly should retain its role as the flagship of the Organization and he would be proposing specific steps that would further enhance its credibility, efficiency and impact.

After the customary exchange of courtesies, the CHAIRMAN declared the session closed.

**The meeting rose at 17:00.**

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