WHA57/2004/REC/3

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 17-22 MAY 2004

SUMMARY RECORDS OF COMMITTEES
REPORTS OF COMMITTEES

GENEVA
2004

WHA57/2004/REC/3

WORLD HEALTH ORGANIZATION

FIFTY-SEVENTH WORLD HEALTH ASSEMBLY

GENEVA, 17-22 MAY 2004

SUMMARY RECORDS OF COMMITTEES
REPORTS OF COMMITTEES

GENEVA
2004

ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

PREFACE

The Fifty-seventh World Health Assembly was held at the Palais des Nations, Geneva, from 17 to 22 May 2004, in accordance with the decision of the Executive Board at its 112th session. Its proceedings are issued in three volumes, containing, in addition to other relevant material:

Resolutions and decisions, Annexes – document WHA57/2004/REC/1

Verbatim records of plenary meetings, list of participants – document WHA57/2004/REC/2

Summary records of committees, reports of committees – document WHA57/2004/REC/3

CONTENTS

Page

Fourth meeting

Fifth meeting

Sixth meeting

Seventh meeting

Eighth meeting

Page

COMMITTEE B

First meeting

Second meeting

Third meeting

Fourth meeting

Page

Fifth meeting

PART II

REPORTS OF COMMITTEES

OFFICERS OF THE HEALTH ASSEMBLY AND MEMBERSHIP OF ITS COMMITTEES

President
Mr Muhammad Nasir KHAN (Pakistan)

Vice-Presidents
Dr M.E. TSHABALALA-MSIMANG (South Africa)
Mrs A. DAVID-ANTOINE (Grenada)
Mr S. BOGOEV (Bulgaria)
Dr R. MARIA DE ARAUJO (Timor-Leste)
Dr CHUA SOI LEK (Malaysia)

Secretary
Dr LEE Jong-wook, Director-General

Committee on Credentials

The Committee on Credentials was composed of delegates of the following Member States: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea, and Uzbekistan.

Chairman: Dr J. LARIVIÈRE (Canada)
Vice-Chairman: Dr A. MISORE (Kenya)
Rapporteur: Dr F. CICOGNA (Italy)
Secretary: Mr T.S.R. TOPPING, Legal Counsel

Committee on Nominations

The Committee on Nominations was composed of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China, Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, and Uruguay, and Dr Khandaker Mosharraf Hossain, Bangladesh (President, Fifty-sixth World Health Assembly, ex officio).

Chairman: Dr Khandaker Mosharraf HOSSAIN (Bangladesh)
Secretary: Dr LEE Jong-wook, Director-General

General Committee

The General Committee was composed of the President and Vice-Presidents of the Health Assembly and the Chairmen of the main committees, together with delegates of the following Member States: Botswana, Chad, Chile, China, Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America, and Yemen.

Chairman: Mr Muhammad Nasir KHAN (Pakistan)
Secretary: Dr LEE Jong-wook, Director-General

MAIN COMMITTEES

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

Committee A

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)
Vice-Chairmen: Dr D. SLATER (Saint Vincent and the Grenadines) and Mrs A. VAN BOLHUIS (Netherlands)
Rapporteur: Professor M. MIZANUR RAHMAN (Bangladesh)
Secretary: Dr S. HOLCK, Office of the Director-General

Committee B

Chairman: Dr Jigmi SINGAY (Bhutan)
Vice-Chairmen: Professor N.M. NALI (Central African Republic) and Dr S. AL KHARABSEH (Jordan)

Rapporteur: Mrs Z. JAKAB (Hungary)
Secretary: Dr M. KARAM, Scientist, Communicable Disease Control, Prevention and Eradication

AGENDA[1]

PLENARY MEETINGS

1. Opening of the Assembly

    1.1 Appointment of the Committee on Credentials

    1.2 Election of the Committee on Nominations

    1.3 Reports of the Committee on Nominations

    - Election of the President
    - Election of the five Vice-Presidents, the Chairmen of the main committees, and establishment of the General Committee

    1.4 Adoption of the agenda and allocation of items to the main committees

2. Reports of the Executive Board on its 112th and 113th sessions

3. Address by Dr Lee Jong-wook, Director-General

4. Invited speakers

5. [deleted]

6. Executive Board: election

7. Awards

8. Reports of the main committees

9. Closure of the Assembly

ROUND TABLES

10. Round tables: HIV/AIDS

[1] Adopted at the second plenary meeting.

COMMITTEE A

11. Opening of the Committee[1]

12. Technical and health matters

    12.1 HIV/AIDS

    12.2 Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer)

    12.3 Control of human African trypanosomiasis

    12.4 Smallpox eradication: destruction of variola virus stocks

    12.5 Eradication of poliomyelitis

    12.6 Global strategy on diet, physical activity and health

    12.7 Road safety and health

    12.8 Health promotion and healthy lifestyles

    12.9 Family and health in the context of the tenth anniversary of the International Year of the Family

    12.10 Reproductive health

    12.11 Health systems, including primary health care

    12.12 Quality and safety of medicines: regulatory systems

    12.13 Genomics and world health: report of the Advisory Committee on Health Research

    12.14 Human organ and tissue transplantation

    12.15 Implementation of resolutions (progress reports)

    - Reducing global measles mortality (resolution WHA56.20)
    - Severe acute respiratory syndrome (SARS) (resolution WHA56.29)
    - Integrated prevention of noncommunicable diseases (resolution WHA55.23)
    - Quality of care: patient safety (resolution WHA55.18)
    - Infant and young child nutrition: biennial progress report (resolution WHA33.32)

[1] Including election of Vice-Chairmen and Rapporteur.

- Intellectual property rights, innovation and public health (resolution WHA56.27)
- WHO Framework Convention on Tobacco Control (resolution WHA56.1)

12.16 Eradication of dracunculiasis

COMMITTEE B

13. Opening of the Committee[1]

14. Internal audit and oversight matters

- Report of the Internal Auditor and comments thereon made on behalf of the Executive Board

15. Financial matters

15.1 Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board

15.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution

15.3 Scale of assessments for 2005

15.4 [deleted]

15.5 [deleted]

16. Programme and budget matters

16.1 Regular budget allocations to regions

16.2 Programme budget 2002-2003

17. Staffing matters

17.1 Human resources: annual report

17.2 [deleted]

17.3 Appointment of representatives to the WHO Staff Pension Committee

[1] Including election of Vice-Chairmen and Rapporteur.

LIST OF DOCUMENTS

A57/1 Rev.1	Agenda[1]
A57/2	Reports of the Executive Board on its 112th and 113th sessions
A57/3	Address by the Director-General to the Fifty-seventh World Health Assembly
A57/4	HIV/AIDS
A57/5	Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer)
A57/6	Control of human African trypanosomiasis
A57/7	Smallpox eradication: destruction of variola virus stocks
A57/8	Eradication of poliomyelitis
A57/9	Global strategy on diet, physical activity and health
A57/10	Road safety and health
A57/10 Add.1	Road safety and health: update
A57/11	Health promotion and healthy lifestyles
A57/12	Family and health in the context of the tenth anniversary of the International Year of the Family
A57/13	Reproductive health[2]
A57/14	Health systems, including primary health care
A57/15	Quality and safety of medicines: regulatory systems
A57/16	Genomics and world health: report of the Advisory Committee on Health Research
A57/17	Human organ and tissue transplantation
A57/18 and A57/18 Add.1	Implementation of resolutions (progress reports)
A57/19	Report of the Internal Auditor

[1] See page xi.

[2] See document WHA57/2004/REC/1, Annex 2.

A57/20	Financial report and audited financial statements for the period 1 January 2002 – 31 December 2003 (Certified 30 March 2004) and Report of the External Auditor to the World Health Assembly (1 April 2004)
A57/20 Add.1	Financial report and audited financial statements for the period 1 January 2002 – 31 December 2003 (Certified 30 March 2004). Annex: Extrabudgetary resources for programme activities
A57/21	Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board. First report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-seventh World Health Assembly
A57/22	Status of collection of assessed contributions, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution. Second report of the Administration, Budget and Finance Committee of the Executive Board to the Fifty-seventh World Health Assembly
A57/23	Scale of assessments for 2005
A57/24	Regular budget allocations to regions
A57/25	Programme budget 2002-2003. Performance assessment report: summary of initial findings
A57/26	Human resources: annual report
A57/27	Appointment of representatives to the WHO Staff Pension Committee
A57/28 and A57/28 Add.1	Agreement with the *Office International des Epizooties*[1]
A57/28 Rev.1	
A57/29	Rules of Procedure of the World Health Assembly: amendment to Rule 72
A57/30	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine

[1] See document WHA57/2004/REC/1, Annex 1.

A57/31	Collaboration within the United Nations system and with other intergovernmental organizations
A57/32	Policy for relations with nongovernmental organizations
A57/33	Supplementary agenda item: Eradication of dracunculiasis
A57/34	Committee on Nominations. First report
A57/35	Committee on Nominations. Second report
A57/36	Committee on Nominations. Third report
A57/37	Committee on Credentials. First report
A57/38	Election of Members entitled to designate a person to serve on the Executive Board
A57/39 (Draft)	First report of Committee A
A57/40	Committee on Credentials. Second report
A57/41	First report of Committee B
A57/42 (Draft)	Second report of Committee B
A57/43	Third report of Committee B
A57/44 (Draft)	Second report of Committee A
A57/45 (Draft)	Fourth report of Committee B
A57/46 (Draft)	Fifth report of Committee B
A57/47 (Draft)	Third report of Committee A

Information documents

A57/INF.DOC./1	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report of the Director of Health, UNRWA, for 2003)
A57/INF.DOC./2	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report of the Ministry of Health of Israel)

A57/INF.DOC./3	Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine (report submitted by the Permanent Observer of Palestine to the United Nations Office at Geneva)
A57/INF.DOC./4	Regular budget allocations to regions

Diverse

A57/DIV/7	Address by Dr KIM Dae-jung, Former President of the Republic of Korea
A57/DIV/8	Address by Mr Jimmy Carter, Former President of the United States of America
A57/DIV/9	Round tables: HIV/AIDS
A57/DIV/10	Round tables: HIV/AIDS

PART I

SUMMARY RECORDS OF MEETINGS OF COMMITTEES

GENERAL COMMITTEE

FIRST MEETING

Monday, 17 May 2004, at 12:20

Chairman: Mr Muhammad Nasir KHAN (Pakistan)
President of the Health Assembly

1. ADOPTION OF THE AGENDA (Document A57/1)

The CHAIRMAN reminded the Committee that, under its terms of reference as defined in Rule 33 of the Rules of Procedure of the World Health Assembly, its first task was to consider item 1.4 (Adoption of the agenda and allocation of items to the main committees) of the provisional agenda, which had been prepared by the Executive Board and issued as document A57/1. The Committee would also consider proposals for the addition of two supplementary agenda items and the programme of work of the Health Assembly.

Deletion of agenda items

The CHAIRMAN indicated that, if there were no objections, four items on the provisional agenda would be deleted, namely, item 5 (Admission of new Members and Associate Members), item 15.4 (Assessment of new Members and Associate Members), item 15.5 (Amendments to the Financial Regulations) and item 17.2 (Amendments to the Staff Regulations and Staff Rules).

It was so agreed.

2. PROPOSED SUPPLEMENTARY AGENDA ITEMS (Documents A57/GC/3 and A57/GC/4)

First proposed supplementary agenda item

The CHAIRMAN drew the Committee's attention to the proposal for inclusion of a supplementary agenda item, in accordance with Rule 12 of the Rules of Procedure of the World Health Assembly and contained in document A57/GC/3, from the Government of the Sudan, "Eradication of dracunculiasis".

Seeing no objection, he took it that the Committee agreed that a recommendation to that effect should be made to the Health Assembly in plenary.

It was so agreed.

Second proposed supplementary agenda item

The CHAIRMAN drew the Committee's attention to document A57/GC/4, which contained a proposal for the inclusion of a supplementary agenda item, "Inviting Taiwan to participate in the World Health Assembly as an observer", from the Governments of Burkina Faso, Dominican Republic, El Salvador, Honduras, Kiribati, Marshall Islands, Nicaragua, Paraguay, Saint Kitts and Nevis, Sao Tome and Principe, Senegal, Solomon Islands and Swaziland.

The delegate of CHINA, said that, with the growing threat of diseases to public health, the Health Assembly should focus on health issues and effective strategies to deal with them. Unfortunately that responsibility had once again been disregarded by the few countries that had submitted the proposal and openly challenged the "one-China" principle widely recognized by the international community. The Chinese Government was firmly opposed to the inclusion of such an item in the provisional agenda.

First, the proposal violated international law, ran counter to the purposes and principles of WHO, and was unacceptable to the overwhelming majority of Member States. Membership of WHO, a specialized agency of the United Nations, was restricted to sovereign States. By United Nations General Assembly resolution 2758 (XXVI) and resolution WHA25.1, China's representation in political, legal and procedural terms had been settled once and for all. Taiwan, as a province of China, was not eligible to join WHO as a full or Associate Member or to participate in its activities as an observer. The rejection of such a proposal each year for the past seven years showed clearly the desire of most Members to defend the dignity and authority of those resolutions. The authors of the proposal had acted against the will of most Member States and had reinforced the efforts by the Taiwanese authorities to create "two Chinas".

Secondly, WHO should concentrate on health rather than political issues. For political reasons, the Taiwanese authorities had repeatedly instigated such proposals, disrupting the orderly functioning of WHO, provoking political confrontation and wasting precious resources and energy. The Health Assembly had a heavy agenda and should not waste time on such a matter.

Thirdly, the Chinese Government attached great importance to the health rights and interests of the people of Taiwan and the promotion of cooperation and exchanges in health matters. Despite obstruction from the Taiwanese authorities, hundreds of group visits and thousands of exchanges of health workers took place between the two sides each year. In response to the outbreak of severe acute respiratory syndrome (SARS), the Chinese Government had, through various channels, provided information and technical support, hosted seven symposia attended by medical professionals and health workers from Taiwan, supplied Taiwan with a diagnostic test reagent and invited Taiwanese professionals for field inspections. It had immediately informed Taiwan about recent outbreaks and the need to take precautions. It had also facilitated Taiwan's access to relevant WHO information and the participation of Taiwanese experts in international health exchanges. With the approval of the Chinese Government, WHO had on many occasions sent experts to Taiwan and invited Taiwanese professionals to its technical meetings.

On several occasions, the Chinese Government had made it clear that Taiwanese medical professionals were welcome to join the Chinese delegation to the Health Assembly, but the Taiwanese authorities had refused to respond. Further, it had stated on many occasions that anything could be discussed provided that the one-China principle was respected. The Chinese Government made four proposals that demonstrated its concern for the health of people in Taiwan: it would welcome medical and health professionals from Taiwan to join the Chinese delegation to the Health Assembly; it was ready to hold cross-Straits talks on Taiwan's appropriate participation in relevant WHO technical activities; pending agreement between the two parties, it was ready as a special arrangement to work with WHO to promote participation by Taiwanese medical professionals in WHO technical exchanges; and it would consider any requests for WHO technical support that Taiwan submitted to it.

For the past seven years, the General Committee had rejected Taiwan-related proposals. China urged that the Committee reject the proposal and resolve the issue as in previous years.

The delegate of the RUSSIAN FEDERATION affirmed that the Government of the People's Republic of China was the sole legitimate representative of China, and that Taiwan was an inalienable part of China. That position, set out in formal Sino-Russian texts, was enshrined in Article 5 of the Treaty of Good Neighbourliness, Friendship and Cooperation between the People's Republic of China and the Russian Federation (16 July 2001), which had entered into force on 28 February 2002. The Russian Federation was opposed to the "two Chinas" concept and to any participation by Taiwan in the United Nations or other international organizations.

The Chairman of Committee A (LAO PEOPLE'S DEMOCRATIC REPUBLIC) recalled that the main purpose of the United Nations was to safeguard peace and promote equitable social and economic development. As a United Nations agency, WHO should respect the principles of that body, which had long recognized Taiwan as a province of China. In each of the past seven years the majority of Member States had rejected similar proposals for inclusion of a supplementary item in the agenda; the current proposal should be rejected since the consequences of its acceptance would be detrimental to peace and stability. The Chairman should, with the consent of the Committee, decide to reject the proposal.

The Chairman of Committee B (BHUTAN) regretted that the matter had been raised once again despite resolutions by the United Nations General Assembly and the Health Assembly. WHO's mandate concerned global health issues and no initiative should be allowed to divert the attention of the international community from such matters, which were of crucial importance to developing countries.

The delegate of CUBA said that the issue was clearly political and not related to health. The Health Assembly should not deal with political issues but should respect the territorial integrity of China as enshrined in resolutions adopted by the United Nations General Assembly and the Health Assembly. The People's Republic of China had for many years promoted cooperation on health issues, including SARS, that affected Taiwan and always maintained an open attitude towards the Taiwanese health authorities. The Health Assembly should not spend more time dealing with an issue not strictly related to health. The Committee should decide to reject the proposal.

The Vice-President of the Health Assembly (TIMOR-LESTE) reiterated the position of his Government, which recognized only one China, namely the People's Republic of China, of which Taiwan was a province. In accordance with WHO's Constitution and the Rules of Procedure of the World Health Assembly, Taiwan did not qualify to be invited as an observer. The proposal lacked the necessary legal basis and the item should not be included in the agenda of the Health Assembly.

The delegate of CHILE said that his country had long supported the one-China principle. Taiwan was an inalienable part of China and the Government of China was the only legal representative of the Chinese people. Since WHO was composed of sovereign States, Taiwan, as a province of China, could not become a Member or Associate Member of the Organization or participate as an observer.

The delegate of CHAD said that the issue was the health of the 23 million people in Taiwan who had the same right to benefit from WHO cooperation as anyone else. The international community expected the world to ensure that all populations were covered by health services, in accordance with WHO's principles. Given recent developments such as SARS and avian influenza, it was unacceptable to ignore part of the world's population. Nor would the inclusion of an item in the agenda of the Health Assembly inviting Taiwan to participate as an observer contradict the basic texts and fundamental principles of WHO. Taiwan had been accepted by certain other organizations of the United Nations system, such as WTO, and the Asia-Pacific Economic Cooperation forum.

The delegate of YEMEN said that the proposal to include the supplementary item constituted an attempt to disrupt the smooth running of the Health Assembly and to transform that body into a political forum. The repeated rejection of such a request over the past seven years showed the opposition of most Member States. He regretted the loss of time it occasioned for the work of the Health Assembly. Yemen supported the one-China policy and opposed the proposal.

The delegate of NIGER said that his country maintained diplomatic relations with the People's Republic of China and recognized Taiwan and Macau as provinces of China. It supported the one-China principle in all international organizations.

The delegate of the UNITED STATES OF AMERICA expressed support for the proposal. The advancement of global public health required Taiwan to have appropriate access to, participation in, and interaction with, WHO, including in the Health Assembly. Taiwan had much experience to offer, but would also benefit through observer status, so improving the effectiveness of international public health measures. Taiwan did not qualify to be a Member of WHO, but the Health Assembly should distinguish between full membership and observership, and not hinder legitimate interaction with WHO. At the practical level, interaction between WHO and Taiwan on public health issues of pressing concern should not have to be conducted solely through the United States Centers for Disease Control and Prevention.

The delegate of BOTSWANA said that, because no legal basis existed for Taiwan's participation in the Health Assembly, the proposal violated United Nations General Assembly and WHO resolutions. His Government did not support the proposal.

The delegate of SOUTH AFRICA stated that South Africa recognized the Government of the People's Republic of China as the legitimate representative of the Chinese people. The proposal should thus be rejected because it had no basis in law. She pleaded that existing WHO and United Nations resolutions should be respected and that the issue would no longer be brought up each year at the Health Assembly.

The Vice-President of the Health Assembly (GRENADA) said that WHO's mandate concerned health, not politics. Grenada, therefore, supported inclusion of a supplementary agenda item inviting Taiwan to participate as an observer in the Health Assembly so that the health of 23 million people could be given the priority it deserved.

The observer of PAKISTAN[1] said that the proposal was a blatant attempt to interfere in the internal affairs of the People's Republic of China and contravened the resolutions of the United Nations General Assembly and the Health Assembly on Taiwan's representation. He recalled the clear statement of the Chinese Government's care for the health of people of Taiwan. The proposal was untenable and he strongly recommended its rejection by the General Committee.

The observer of MAURITANIA,[1] also citing United Nations and Health Assembly resolutions, said that Taiwan was a province of China and could not claim membership of WHO. He referred to the statement by the Chinese delegate on his Government's concern for the health of the people of Taiwan and cooperation with Taiwanese health professionals. The proposed supplementary agenda item was merely a disguised way of denying the one-China policy and the legitimacy of the Government of the People's Republic of China as the sole representative of the Chinese people in the

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

United Nations. The proposal also cut short the time available for consideration of items on the Health Assembly agenda. He did not support inclusion of the supplementary agenda item.

The observer of TANZANIA[1] confirmed her country's belief in State sovereignty and that Taiwan was a part of China. The United Nations recognized China as a single country and the Health Assembly, in accordance with its rules of procedure, should do the same. Tanzania rejected the proposal.

The observer of NICARAGUA[1] requested the inclusion, in accordance with Rule 12 of the Rules of Procedure of the World Health Assembly, of the proposed supplementary agenda. It was crucial that Taiwan should participate directly in the Health Assembly, particularly in view of the serious diseases that had appeared in Asia recently and the humanitarian spirit that imbued the Organization. Taiwan's participation was in the interest of all WHO Members.

The observer of the DEMOCRATIC REPUBLIC OF THE CONGO[1] said that his Government supported the one-China principle. Taiwan was a province of China and could not therefore be admitted as an observer to the Health Assembly; to do so would constitute a violation of the relevant United Nations General Assembly and Health Assembly resolutions. China respected the right of the people of Taiwan to health and well-being, and catered for their needs; he recalled the invitation to Taiwan health officials to join the Chinese delegation to the Health Assembly. The proposal amounted to an infringement of the principle of non-interference in the internal affairs of a Member State, and he rejected it.

The observer of COSTA RICA[1] expressed support for the proposal and regretted past refusals to admit Taiwan, one of the pioneers of WHO, as an observer to the Health Assembly. The aspirations of its population should be taken into account in the work of WHO. The recent outbreaks of SARS and avian influenza were evidence that all should be included in international assistance and cooperation on health matters.

The observer of the ISLAMIC REPUBLIC OF IRAN[1] reiterated the view that the Government of the People's Republic of China was the sole representative of the Chinese people and that only sovereign States were qualified to participate in the work of WHO. He supported the idea, however, of helping health experts from Taiwan to attend international health events and to receive technical assistance from the Government of the People's Republic of China, based on the one-China principle. He rejected the proposal which appeared only to widen current divisions between China and Taiwan.

The observer of EL SALVADOR[1] expressed firm support for the participation of Taiwan as an observer in the Health Assembly, based on the principle of universality contained in the United Nations Charter. The proposal to include the supplementary agenda item was based solely on health and humanitarian reasons and should not be interpreted as interference in the internal affairs of a state or as a hindrance to reunification. Taiwan could make a valuable contribution to WHO; the proposal should be accepted.

The observer of the DOMINICAN REPUBLIC[1] said that the appearance of new diseases such as AIDS, SARS and avian influenza had emphasized the need to enhance cooperation worldwide so as to ensure the rapid exchange of information in order to prevent epidemics. The SARS outbreak in 2003 had shown the need for Taiwan to be fully integrated into WHO's response capacity. She therefore supported Taiwan's participation in the Health Assembly as an observer; the health needs of

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

its population would be better met, and the international community would benefit from Taiwan's health experience.

The observer of ETHIOPIA[1] rejected the proposal, reiterating the reasons adduced by previous speakers and noting that almost all delegations had supported those views. He regretted that the subject had arisen again. Membership criteria remained unchanged: only sovereign States could be Members of WHO.

The observer of HONDURAS[1] said that it was not surprising that the matter was under discussion again. For reasons totally unrelated to health, the Taiwanese people had been denied access to WHO. In virtual isolation, Taiwan had recorded great social and economic developments and made medical and scientific progress. Through participation in the Health Assembly it could make a valuable contribution to the Organization and meet the many health needs of its people. The request should be analysed purely on its health-related merits and not seen as a way of disrupting the Health Assembly. Taiwan should be admitted to the Health Assembly in accordance with the legal basis in the Constitution.

The observer of NEPAL[1] said that, despite previous decisions, a similar proposal had again been made. It would divert precious time away from the business of the Health Assembly. Previously cited arguments made it clear that Taiwan did not qualify for observer status. Nepal supported the one-China policy and viewed any attempt to invite Taiwan to participate in the activities of WHO as tantamount to denying that concept. Noting the comprehensive proposals made by the delegate of China, he opposed any proposal to give Taiwan observer status in the Health Assembly and to include the proposed item on its agenda.

The observer of BRAZIL,[1] reiterating his country's support for the one-China principle in conformity with the relevant United Nations and Health Assembly resolutions, opposed the proposal.

The observer of ZIMBABWE[1] said that the proposal by a few Members seeking to meddle in the internal affairs of a State and to violate its territorial integrity infringed important and long-standing international decisions on the representation of China. The objective of the proposal was to further concerns unrelated to health under the guise of caring for the welfare of the people of Taiwan. Adequate measures had been made to meet the health needs of the Taiwanese people and the Committee should not spend time on the issue. Zimbabwe strongly opposed inclusion of the proposed supplementary item.

The observer of CAMEROON[1] also opposed the inclusion of the supplementary agenda item and considered it time to stop dealing with that frequently repeated proposal.

The observer of PARAGUAY[1] pointed out that the population of Taiwan was being deprived of the fundamental right of all people to the enjoyment of health without discrimination through lack of representation in WHO. Their wish to participate in the Health Assembly in order to access health-related information and receive assistance, especially in view of the outbreak of SARS and Taiwan's position as a transport hub, was justified. Paraguay supported the proposal.

The observer of PANAMA[1] supported the legitimate aspirations of Taiwan to become an observer at the Health Assembly, a status that was not precluded by WHO's basic instruments and principles, and requested that the item be put to the vote.

---

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The observer of BELIZE[1] supported the proposal to give Taiwan observer status at the Health Assembly. Globalization had facilitated the spread of communicable diseases across national boundaries, making it essential for WHO to be able to combat disease and promote health to all nations. Everyone, including the people of Taiwan, should have access to, benefit from, and contribute to that international forum.

The observer for INDONESIA[1] said that WHO, as a specialized agency of the United Nations, should be consistent with regard to the United Nations General Assembly's recognition of the Government of the People's Republic of China as the sole legitimate representative of China to the United Nations. The experience of managing the outbreak of SARS in 2003 showed that the current arrangements had not hindered fulfilment of WHO's mandate. He referred to the measures provided by China to handle health matters in Taiwan, and opposed the proposal.

The observer for BARBADOS,[1] also recalling the relevant United Nations General Assembly and Health Assembly resolutions and her country's long-standing one-China policy, asserted Barbados' opposition to the proposal.

The observer for BURUNDI,[1] adducing the same resolutions, affirmed his country's recognition of one sole China, indivisible, and opposed the proposal.

The observer for EGYPT[1] also opposed the proposal, urging the Health Assembly to continue to act in line with WHO's Constitution, the relevant resolutions and the rule of international law by maintaining a one-China policy within WHO. His country appreciated China's announced position and gestures to provide health assistance to the people of Taiwan, which would continue.

The observer for the DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA,[1] stating his country's adherence to the one-China principle, said that acceptance of the supplementary agenda item would represent a violation of the sovereignty and territorial integrity of the People's Republic of China. He opposed the proposal because it could also adversely affect the exchanges and cooperation that WHO conducted with Taiwan with the consent of the Chinese Government, and thus hamper health promotion.

The observer for MYANMAR[1] said that his country could not accept any initiative that ran counter to its long-standing one-China policy. He opposed the proposal, which was a political issue, and rejected the pretext of the control of SARS or other diseases as a ploy to advance the cause of seeking observer status for Taiwan at the Health Assembly. He called for the matter to be resolved as in previous years.

The observer for SRI LANKA,[1] recalling previously cited resolutions, said that the proposal had no legal basis, as only sovereign States could participate in the Health Assembly and Taiwan was a province of China. She dismissed the need for a vote.

The observer for BANGLADESH,[1] stressing that Taiwan was an inalienable part of China and that the Chinese Government was the sole legitimate representative of all parts of the country, opposed the proposal, which lacked legal basis.

The observer for CAMBODIA[1] recalled that similar proposals had been rejected by Health Assemblies since 1997 and urged the Committee to repudiate the proposal as in previous years.

---

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The observer for GAMBIA[1] supported the inclusion of the supplementary agenda item. Denying Taiwan's population access to high-quality health care and access to WHO's support on purely political grounds was untenable. Citing Taiwan's scientific and medical advances and its efforts to control recent outbreaks of SARS and avian influenza, he underlined Taiwan's capacity to contribute to the Organization. In the interest of humanity, that input could not be refused.

The delegate of KAZAKHSTAN said that, in accordance with relevant resolutions, his country supported the one-China policy and, in its bilateral agreements and instruments with China, recognized the People's Republic of China as the sole legitimate representative of all the Chinese people. He opposed the proposal.

The observer for HAITI[1] commented on the repetition of the same arguments in discussions on similar proposals over the past seven years. He affirmed that the Charter of the United Nations should not be violated and the People's Republic of China should not be offended, but, when technical matters were being dealt with, the proposal for observer status for Taiwan was a question of equity and should not cause offence. Therefore he supported the proposal.

The observer for MALAWI[1] pointed out that WHO's role was to deal with international health and not political matters. Because Taiwan's population was not represented in the Health Assembly and did not enjoy the benefits of membership of WHO, he supported the proposal.

The observer for SAINT VINCENT AND THE GRENADINES[1] supported the proposal, which he did not consider merely a political issue. The idea of health for all, initiated by WHO, ought not to exclude Taiwan's 23 million people. Health should have no boundaries – political, ethnic or any other. Taiwan's experience in health and development justified its participation as an observer in the Health Assembly.

The observer for PALAU[1] supported the arguments of other protagonists of the proposal, in particular the delegate of the United States of America, and the call for a roll-call vote. He urged Member States to demonstrate to other sectors of the United Nations system that the Health Assembly was concerned only with health.

The observer for MEXICO,[1] supporting the sovereignty and territorial integrity of China, said that inclusion of the supplementary agenda item would be incompatible with the aims of WHO. As there was no justification to question the validity of the relevant United Nations General Assembly and Health Assembly resolutions, Mexico opposed the proposal.

The CHAIRMAN said that, having heard the various speakers, he took it that the Committee agreed not to recommend the inclusion of the supplementary item on the agenda and that a recommendation to that effect should be conveyed to the plenary. The agenda, as otherwise amended, would therefore be submitted in plenary later that afternoon.

It was so agreed.

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

3. ALLOCATION OF ITEMS TO THE MAIN COMMITTEES AND PROGRAMME OF WORK OF THE HEALTH ASSEMBLY (Documents A57/1 and A57/GC/1)

The CHAIRMAN said that the Committee's recommendations on item 1 would be transmitted to the plenary meeting later that afternoon. Items 2-4 and 6-9 would also be taken up in plenary.

With regard to item 10 (Round tables: HIV/AIDS), he proposed four concurrent round tables, each being considered as a separate committee of the Health Assembly, with membership limited to those ministers of health or delegates designated to represent ministers of health who had registered for participation. All other delegations, representatives of Associate Members and observers, including members of the delegation of the ministers of health participating in the round table, could attend as observers. Since the purpose of the round tables was to enable everyone to benefit from an exchange of views, they would have no mandate to adopt resolutions. He proposed the following ministers as chairmen of the four round tables: Dr M. Phooko (Lesotho), Dr M. Bethel (Bahamas), Dr D. Keber (Slovenia) and Dr U. Olanguana Awono (Cameroon). He would ask one of the chairmen to make an oral report to the Health Assembly.

It was so agreed.

The CHAIRMAN said that he would transmit the Committee's recommendation to the plenary that afternoon. He took it that the Committee wished to recommend to the Health Assembly acceptance of the allocation of items between the main committees, as set out in the provisional agenda.

It was so agreed.

The delegate of YEMEN requested, on behalf of Arab health ministers, that item 19 (Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine) should be brought forward to Wednesday, 19 May as the first item for consideration in Committee B and that the work of Committee A should be suspended until the end of the debate of item 19 in order to enable other delegations to participate in the discussions. Also, that practice should be instituted in subsequent Health Assemblies.

After a clarification by Mr AITKEN (Director, Office of the Director-General), the delegate of the UNITED STATES OF AMERICA said that, recognizing the importance of the subject, he could agree to advancing item 19 in the order of business of Committee B but, in view of the rest of the work to be considered, he could not support the simultaneous suspension of Committee A.

The delegate of YEMEN said that he would accept that decision, if the Committee so agreed.

The observer for EGYPT,[1] supported by the observer for the ISLAMIC REPUBLIC OF IRAN,[1] said that the request had been made in the light of the unprecedented deterioration of the health conditions of the Palestinian people in the occupied Arab territories. Each year the Health Assembly gathered health leaders to confront major health issues, among which health in the occupied Palestinian territories was currently central. The Arab group had submitted its request in order that the Health Assembly might accord appropriate importance to the discussion of item 19 by making suitable provisions for all delegations to participate in those discussions. He therefore asked the General Committee to reconsider the possibility, not only of starting the work of Committee B with item 19 but by temporarily suspending Committee A until the end of those discussions, without prejudice to the importance of Committee A's work.

---

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the World Health Assembly.

The observer for CANADA,[1] recalling a similar debate in the Committee in the previous year, remarked that the Health Assembly's agenda lengthened each year – including not only new health conditions but new solutions, such as partnerships, to existing problems. Committee A had to consider many technical and health matters that were as important to the populations of the occupied territories as was the debate on agenda item 19 in isolation. He agreed with bringing forward item 19 on the agenda of Committee B but opposed the temporary suspension of Committee A during Committee B's consideration of that important item.

The CHAIRMAN, in light of the views expressed, proposed that Committee B should be requested to move agenda item 19 to first place on its order of work, but that Committee A should continue to hold a meeting at the same time.

It was so agreed.

The CHAIRMAN suggested that, as the Committee had agreed to the inclusion of a supplementary agenda item on eradication of dracunculiasis, that item should be allocated to Committee A. He invited the Committee to agree to the proposed allocation of agenda items to the respective committees.

It was so agreed.

The CHAIRMAN drew attention to the preliminary timetable prepared by the Executive Board[2] and suggested minor amendments. He proposed that a second meeting of the Committee should be held on Wednesday, 19 May, and a third meeting on Thursday, 20 May to review progress and decide on any change in the allocation of items to the committees, or to the timetable, if necessary.

It was so agreed.

The General Committee then drew up the programme of work for the Health Assembly until Wednesday, 19 May.

The CHAIRMAN drew attention to decision EB112(9), whereby the Executive Board had decided that the Fifty-seventh World Health Assembly should end no later than Saturday, 22 May 2004.

Referring to the list of speakers for the general debate, he suggested that, in accordance with established procedure, the order of speakers on the list should be strictly adhered to, with subsequent speakers following in the order in which their inscriptions were received by the Assistant to the Secretary of the Health Assembly. In the absence of any objection, he would inform the Health Assembly of those arrangements at the following plenary meeting.

It was so agreed.

The meeting rose at 14:20.

---

[1] Participating by virtue of Rule 32 of the Rules of Procedure of the Executive Board.

[2] Document A57/GC/1.

SECOND MEETING

Wednesday, 19 May 2004, at 18:20

Chairman: Mr Muhammad Nasir KHAN (Pakistan)
President of the Health Assembly

1. PROPOSALS FOR THE ELECTION OF MEMBERS ENTITLED TO DESIGNATE A PERSON TO SERVE ON THE EXECUTIVE BOARD (Document A57/GC/2)

The CHAIRMAN reminded members that the procedure for drawing up the list of proposed names to be transmitted by the General Committee to the Health Assembly for the annual election of Members entitled to designate a person to serve on the Executive Board was governed by Article 24 of the Constitution and by Rule 102 of the Rules of Procedure of the World Health Assembly. To help the General Committee in its task, three documents were before it. The first indicated the present composition of the Executive Board by region, on which list were underlined the names of the 12 Members whose term of office would expire at the end of the Fifty-seventh World Health Assembly and which had to be replaced. The second (document A57/GC/2) contained a list, by region, of the 12 Members that it was suggested should be entitled to designate a person to serve on the Executive Board. The third document tabulated, by region, Members of the Organization which were or had been entitled to designate persons to serve on the Executive Board. Vacancies, by region, were: Africa, 2; the Americas, 3; South-East Asia, 1; Europe, 2; the Eastern Mediterranean, 2; and the Western Pacific, 2.

As no additional suggestion was made by the General Committee, he noted that the number of candidates was the same as the number of vacant seats on the Executive Board. He therefore presumed that the General Committee wished, as was allowed under Rule 80 of the Rules of Procedure, to proceed without taking a vote since the list apparently met with its approval.

There being no objection, he concluded that it was the Committee's decision, in accordance with Rule 102 of the Rules of Procedure, to transmit a list comprising the names of the following 12 Members to the Health Assembly, for the annual election of Members entitled to designate a person to serve on the Executive Board: Australia, Bahrain, Bolivia, Brazil, Jamaica, Kenya, Libyan Arab Jamahiriya, Lesotho, Luxembourg, Romania, Thailand and Tonga.

It was so agreed.

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

The General Committee heard a report from Dr Ponmek DALALOY (Lao People's Democratic Republic), Chairman of Committee A, on the progress of work in that committee. Dr Jigmi SINGAY (Bhutan), Chairman of Committee B, reported that, although the Committee had not yet started its work, he was confident of making good progress.

The CHAIRMAN proposed to review progress of work with the Chairmen of the committees and to revise the programme accordingly, if necessary.

It was so agreed.

The General Committee then drew up the programme of meetings for Thursday, 20 May, Friday, 21 May, and Saturday, 22 May.

The CHAIRMAN reminded the Committee that its next meeting would be held on Thursday, 20 May, at 17:30.

The meeting rose at 18:30.

THIRD MEETING

Thursday, 20 May 2004, at 17:55

Chairman: Mr Muhammad Nasir KHAN (Pakistan)
President of the Health Assembly

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

The General Committee heard reports from Dr Ponmek DALALOY (Lao People's Democratic Republic), Chairman of Committee A, and Dr Jigmi SINGAY (Bhutan), Chairman of Committee B, on the progress of work in their committees.

The CHAIRMAN proposed to review progress of work with the Chairmen of the committees and to revise the programme of work and allocation of items accordingly.

It was so agreed.

The General Committee then drew up the programme of meetings for Friday, 21 May and Saturday, 22 May.

2. CLOSURE

After the customary acknowledgements, the CHAIRMAN declared the work of the Committee closed.

The meeting rose at 18:05.

COMMITTEE A

FIRST MEETING

Tuesday, 18 May 2004, at 16:15

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)

1. OPENING OF THE COMMITTEE: Item 11 of the Agenda (Document A57/1 Rev.1)

The CHAIRMAN welcomed participants and introduced Dr Afriyie and Dr Modeste-Curwen, who would attend the Committee's meetings in their capacity as representatives of the Executive Board.[1] Any views they expressed would therefore be those of the Board, not of their national governments.

Election of Vice-Chairmen and Rapporteur (Document A57/36)

The CHAIRMAN drew the Committee's attention to the third report of the Committee on Nominations, in which Dr D. Slater (Saint Vincent and the Grenadines) and Mrs A. Van Bolhuis (Netherlands) had been nominated as Vice-Chairmen of Committee A and Professor M. Mizanur Rahman (Bangladesh) as Rapporteur.[2]

Decision: Committee A elected Dr D. Slater (Saint Vincent and the Grenadines) and Mrs A. Van Bolhuis (Netherlands) as Vice-Chairmen and Professor M. Mizanur Rahman (Bangladesh) as Rapporteur.[3]

2. ORGANIZATION OF WORK

The CHAIRMAN encouraged delegates to participate in the debate but to limit the length of their interventions to three minutes. He suggested that the Committee should discuss agenda item 12.15 (Implementation of resolutions (progress reports)) at the beginning of the afternoon meeting the next day, so that Ms Ruth Dreifuss, Chairman of WHO's Commission on Intellectual Property Rights, Innovation and Public Health, could introduce the item.

It was so agreed.

---

[1] By virtue of Rules 44 and 45 of the Rules of Procedure of the World Health Assembly.

[2] See page 237.

[3] Decision WHA57(4).

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda

HIV/AIDS: Item 12.1 of the Agenda (Resolution WHA56.30; Documents A57/4 and A57/DIV/10)

The CHAIRMAN noted that HIV/AIDS had been the subject of that morning's round-table discussions,[1] and a draft resolution, cosponsored by Norway and Sweden, would be available later in the week, when the Committee might wish to resume the debate.

Dr AFRIYIE (representative of the Executive Board) said that, at its 113th session in January 2004, the Executive Board had welcomed the "3 by 5" initiative and the coordinating role of WHO, as a cosponsor of UNAIDS, in HIV/AIDS treatment and care. The initiative represented an interim step towards universal access to HIV/AIDS treatment. The Board had supported the expansion of access to that treatment within national strategies and had noted that the "3 by 5" target was consistent with the United Nations Millennium Development Goals. In most countries, the number of people requiring treatment, which would be life-long, far exceeded the resources available. Continued funding and political commitment were vital to ensure the long-term sustainability of treatment programmes.

Mr JOHANSSON (Sweden) said that his Government had designated HIV/AIDS as a priority in its development cooperation activities. WHO's role in expanding access to treatment and increasing preventive efforts was crucial and needed adequate resources. His Government had therefore decided to contribute US$ 5 million to the "3 by 5" initiative in the current year.

Document A57/4 emphasized the importance of partnership, particularly as considerable resources were becoming available at country level along with increasing investment by governments. Sweden supported the "Three Ones" principle, agreed in Washington, DC in April 2004, as an important step towards better coordination of AIDS responses at country level. The principle comprised one agreed HIV/AIDS action framework for the coordination of the work of all partners, one national AIDS coordinating authority with a broad-based multisectoral mandate, and one agreed country-level monitoring and evaluation system. It was also important to create a sense of national ownership of HIV/AIDS programmes. Governments were responsible for running the programmes, while WHO provided support in setting standards and producing guidelines in areas such as pharmaceutical quality control. Sweden also affirmed the great importance of strengthening health systems overall, if resources were not merely to be diverted to HIV/AIDS from other programmes, such as maternal and child health. The "3 by 5" initiative must state clearly how that could be avoided.

He noted that the knowledge, tools and services that young people in countries with high HIV prevalence needed in order to avoid HIV infection were the same as those for protection against other sexually transmitted infections and unwanted pregnancies: sex education in schools to promote safer sexual behaviour, increased rates of condom use for protection, and confidential treatment for sexually transmitted infections, provided with respect for young people. Nevertheless, young people did not currently have access to the necessary knowledge, tools and services. In view of this fact, it was important to coordinate HIV/AIDS programmes with activities to promote sexual and reproductive health and rights. It was essential to find a common ground for action, based on sound evidence and clear of entrenched moral positions.

Although it was important to ensure access to treatment, HIV/AIDS activities must continue to focus primarily on prevention. In this regard, there was a need for more concrete information. How did WHO plan to implement the global health-sector strategy on HIV/AIDS and other aspects of prevention? The "3 by 5" initiative must have a clear strategy and follow-up mechanism for strengthening and supporting prevention.

---

[1] See document A57/DIV/10.

Sweden and Norway had prepared a draft resolution on the scaling-up of treatment and care, in support of the "3 by 5" initiative. Many countries had already sponsored the draft, and he invited others to join them.

Professor IVANOV (Bulgaria) said that, although HIV/AIDS raised social, moral and ethical issues, it was basically a health care problem and had to be treated as such; in some regions, in Africa in particular, the assistance of the international health-care community was needed. His country had a low prevalence of HIV/AIDS; most of its 449 reported cases were in men, with sexual transmission accounting for infection in more than 90% of cases. Uptake of free blood tests had increased to around 250 000 persons per year over the past three years. His Government was implementing the global strategy on HIV/AIDS, and HIV/AIDS prevention and control constituted an integral part of the national health strategy. Bulgaria had successfully applied for resources to the Global Fund to Fight AIDS, Tuberculosis and Malaria. His country considered the "3 by 5" initiative to be a timely means of strengthening health systems. Prevention, treatment, care and support services had to be accessible if they were to be effective.

Dr UĞURLU (Turkey) reported that his country had a low prevalence of HIV/AIDS, with a total of 1711 cases reported since 1985. Nevertheless, the problem was being taken seriously: a national AIDS commission, under the presidency of the Ministry of Health, had been established in 1996, involving public institutions, universities and nongovernmental organizations. The national AIDS action plan included nationwide programmes on safer sex and the prevention of HIV infection for all sectors of the population and made provision for diagnosis, treatment and support services. In his country, all patients had equal rights and people with HIV/AIDS had access to diagnosis and treatment without compromising their health insurance position. Turkey wished to be associated with the "3 by 5" initiative in order to control possible drug resistance and to improve provision of treatment and follow-up services. Steps had also been taken to strengthen the work of nongovernmental organizations and to encourage national and international cooperation in favour of vulnerable groups – a high priority.

Miss CHA-AIM PACHANEE (Thailand) welcomed the strong social movement represented by the "3 by 5" initiative and commended WHO's recognition that treatment of HIV/AIDS should be accompanied by prevention. The success of the initiative depended strongly, however, on the equitable availability of human resources. Some countries were experiencing a serious shortage of health workers, which could only hinder implementation of the initiative and draw human resources from other health sectors. Most antiretroviral drugs were expensive; effective and prompt implementation of the safeguard measures in the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health was essential so that developing countries could have better access to affordable drugs.

A massive global preventive movement should be created. Successful implementation of the "3 by 5" initiative would mean that by 2005 huge resources, beyond the means of the developing countries, would be needed each year for treatment alone; effective prevention was the only way of establishing a financially sustainable initiative. WHO should set up a programme to help countries that did not have the capacity to manufacture antiretroviral drugs to apply the compulsory licensing mechanism under the Doha Declaration. Annual reports should be made to the Health Assembly on progress made in implementing the policy on expansion of treatment and prevention. WHO should support long-term, sustainable strengthening of health infrastructure and of human resources for health in particular. She urged the Health Assembly to recommend that the coming decade be "a decade of human resource development".

Ms HALTON (Australia) welcomed the leadership provided by WHO and UNAIDS through the "3 by 5" initiative. The approach gave fresh impetus to prevention efforts and sought to strengthen health systems that were severely strained – essential elements of a sustainable long-term response.

Although her country had been successful in its response to HIV/AIDS, it was not relaxing its efforts and would be releasing its fifth strategy for combating HIV/AIDS and sexually transmitted infections shortly.

The rapid spread of HIV/AIDS in the Asia-Pacific region was a matter of great concern, with the risk that the epidemic might spread from high-risk populations to the general population. Quick and decisive action was called for. Her Government had recently increased its commitment to the Global Fund to Fight AIDS, Tuberculosis and Malaria to Aus$ 250 million so that the disease could be tackled strategically, in partnership with other agencies. The worsening HIV/AIDS crisis in the region should be a global priority, with attention given to the compounding factors of poverty, injecting drug use and discrimination. Her country would continue to support multisectoral and partnership approaches and effective, equitable and sustainable treatment programmes and would promote political commitment at the highest level. Her Government's HIV/AIDS and development programme would continue to focus on poor and vulnerable communities in the Asia-Pacific region, to assist its neighbours in eliminating factors that compromised their growth, prosperity and development. The Second Asia-Pacific Ministerial Meeting on AIDS would be held in Bangkok on 12 July, in conjunction with the XV International AIDS Conference, providing an opportunity for ministers to renew their commitment, and to revise their strategies on the basis of others' experience.

Mrs GUIGAZ (France), recalling that France had been the first country to stress the importance of general access to antiretroviral therapy, welcomed the pressure being exerted by WHO on the international community in that regard. Expansion of efforts would require both global and local action.

At the global level, both structured and structuring responses were needed. Institutions should cooperate with one another and coordinate their actions rather than competing, thereby putting an end to the excessive number of external missions that served only to confuse countries and waste their scarce human resources. Urgent responses were needed, but they should allow room for manoeuvre in respect of future activities. Bilateral agreements that removed the flexibility afforded by the Doha Declaration on the TRIPS Agreement and Public Health would be destructuring. WHO should provide ethical, technical, scientific and managerial guidance, with particular attention to drug procurement and prequalification issues.

The real challenges lay at the local level, where populations would have to fight for their health, lives and futures. Local communities had to have the opportunity to mobilize their potential energy, which far exceeded that of the international community. Again, guidance from WHO would be needed, and she therefore endorsed the proposed strategic plan, although greater clarity regarding the expected outcome, in terms of the numbers to be treated, would be appreciated. She supported the formation of a scientific council, with appropriate links to all major institutions concerned, to steer the "3 by 5" initiative and provide the necessary coherence. France was making substantial multilateral contributions through the Global Fund to Fight AIDS, Tuberculosis and Malaria which, she had understood, was participating fully in the "3 by 5" initiative while needing to continue development of its own financing mechanisms. France was also providing considerable bilateral technical support. It had created a network, ESTHER (*Ensemble pour une Solidarité thérapeutique hospitalière en Réseau*), which linked hospitals in countries of the North and the South to help the latter to develop their own strategies. Negotiations were under way to use that network in support of the "3 by 5" initiative.

Professor WU Zunyou (China) commended the "3 by 5" initiative, which was particularly important for developing countries. Antiretroviral treatment was a vital part of comprehensive HIV/AIDS control, but other aspects such as health education also required promotion and strengthening. Recent years had seen the epidemic spread in China; in 2003, estimates indicated 840 000 people infected with HIV and 80 000 with AIDS. Governmental programmes and actions, including the establishment of a national HIV/AIDS prevention committee, the convening of a national conference to formulate policy and the implementation of various control measures, had

produced good results, and it was projected that by 2010 the number of people infected with HIV would be kept below 1.5 million.

Because of its large population and uneven development of the economy, attitudes and health services across the country, China had experienced difficulties in implementing its HIV/AIDS control policy and would continue to require domestic and international support, such as that provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria in 2003. China wished to participate fully in the "3 by 5" initiative; he looked forward to financial and technical support from WHO and other partners to enable his country to strengthen the capacity of its primary health-care system, give support to the activities of health-care workers and enable more patients to receive standard treatment. He urged WHO to send a study team to China as soon as possible to assess problems with implementation of the initiative, including the provision of high-quality, affordable antiretroviral drugs. Some medicines currently being used were past their expiry dates, and side-effects had led some 20% of patients to discontinue treatment. For cultural and social reasons, some people were still reluctant to reveal their HIV status, making it difficult to target treatment effectively. He endorsed the proposal to draw on experience gained in developing the strategy of directly observed treatment, short course (DOTS) for tuberculosis in improving the management of the HIV/AIDS epidemic.

Ms BLACK (Canada) noted with appreciation the progress made by WHO towards the "3 by 5" target. The Organization was showing leadership in efforts to expand access to antiretroviral treatment – the least advanced component of the response to HIV/AIDS. Through its recently announced contribution of Can$ 100 million to the "3 by 5" initiative and Can$ 70 million to the Global Fund to Fight AIDS, Tuberculosis and Malaria for 2005, as well as its continuing technical support, Canada remained actively involved in the global response to the epidemic, in coordination with WHO, Member States and their development partners. The initiative must respect human rights and gender equality. It should be implemented in a coordinated and harmonized way as part of a comprehensive approach that included prevention and care; it should reach the most affected groups and be integrated into strengthened health systems. WHO should assess the role of nurses and midwives, which would be vital in the initiative, in order to maximize its impact at all levels. Assessment of the human resources implications of the initiative should include consideration of the migration, recruitment and retention of health-sector personnel.

She welcomed WHO's partnership with a broad range of stakeholders and its focus on harmonizing in-country activities with those of the "3 by 5" initiative. She stressed the importance of promoting the "Three Ones" principle for the coordination of national responses. The Organization should work with partners to strengthen its capacity in human rights, advocacy and community mobilization. She endorsed WHO's comments on the links between HIV/AIDS and sexual and reproductive health and encouraged the Organization to continue to promote the integration of national programming in those areas.

She announced that the funding for the Canadian strategy on HIV/AIDS would be doubled over the coming five years. Furthermore, Canada's Governor General had recently given royal assent to legislation that would permit the exportation of Canadian-produced generic drugs, in line with the 2003 decision by WTO in that regard. She urged other Member States to consider the promulgation of similar legislation.

Dr MAHJOUR (Morocco) fully supported the "3 by 5" initiative, which would contribute to strengthening health systems in the neediest countries. It was essential to guarantee respect for patients' rights and to involve the community at each step. It would also be important to provide treatment that met national standards. The treatment package should be complete and sustained and should be complemented by prevention activities. Innovative experience should be shared between countries, in the context of South-South cooperation. Morocco had implemented a prevention programme based on interventions of proven efficacy. People living with HIV were assured of the basic right to access to testing and treatment, and triple therapy was available throughout the country.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the global burden of disease was aggravated by the fact that 14 million children had been orphaned by the disease. That figure was set to rise to 25 million by 2010. The current Health Assembly might prove to be a historic turning point because of its emphasis on the fight against HIV/AIDS. All Member States should do more to avert a human tragedy.

Expansion of the multisectoral strategies in place in many countries was indispensable if the Millennium Development Goals were to be achieved, and the objectives of the Declaration of Commitment, set at the United Nations General Assembly special session on HIV/AIDS in 2001, to be met. However, there were financial barriers to the implementation of such strategies. For that reason, the developed countries and international organizations, including the United Nations and its bodies, would have to provide substantial economic resources to support the poorest countries of the world where the HIV/AIDS epidemic was most acute. He fully supported the idea of offering antiretroviral treatment to three million people by 2005, but why stop at three million if six million people needed such drugs? An effort should be made to reach all those in need of such treatment; the "3 by 5" initiative should be just a first step. The response to HIV/AIDS required an integrated strategy in which the health sector played an active role.

In Cuba, the epidemic was growing slowly and only 0.05% of the population was infected. A prevention and control programme included all the components that WHO considered essential for curbing the spread of HIV. Since 1983, a health ministry working group had secured the support of all sectors in the country for a national plan compatible with the WHO global strategy to combat HIV/AIDS and which ensured that the population had easy access to diagnostic tests. In order to ensure universal access to effective antiretroviral treatment, his Government had decided to produce generic drugs; for more than two years, it had been manufacturing four reverse transcriptase inhibitors and one protease inhibitor. Free treatment was available to all who needed it at specialized centres. Although his country could not supply financial resources, it was offering the services of some 17 000 Cuban doctors who were working in 65 countries. They were doing much to deal with health problems and to combat AIDS.

Dr FUKUDA (Japan) commended the great attention paid by WHO to the global HIV/AIDS epidemic and advocacy of the "3 by 5" target. A special initiative was urgently needed to achieve certain goals that should already have been reached in 2003. Disease-control measures were an important part of the international cooperation involving WHO, UNAIDS and the Global Fund to Fight AIDS, Tuberculosis and Malaria. At the same time, it was vital to prevent HIV infection and to develop public-health systems that minimized the risk of drug-resistant strains of HIV appearing. Without strategic support, emergence of drug resistance was most likely, nullifying the effectiveness of the current highly active antiretroviral therapy. WHO's treatment and HIV drug-surveillance guidelines were welcome, but the implementation of the "3 by 5" initiative should be carefully tailored to specific country or regional circumstances. The development of human resources, including village health workers and drug-resistance surveillance staff, was essential. Effective, practical plans, and more than US$ 5000 million were needed to achieve the "3 by 5" goal.

Ms BUIJS (Netherlands) commended WHO's prioritization of measures to combat HIV/AIDS. Care and treatment, which formed the focus of the "3 by 5" initiative, had to be accompanied by more strenuous efforts to prevent the spread of HIV. In doing so, particular attention had to be paid to the rights of young people. Their sexuality had to be accepted and their participation in the fight against HIV/AIDS encouraged.

Dr AGARWAL (India) said that, in his country, an estimated 4.58 million people were infected with HIV, with an adult prevalence rate of 0.8%. The National AIDS Control Organization conducted annual sentinel surveillance of high-risk groups and the general population. There was strong political commitment to the fight against HIV/AIDS, with the national programme according equal importance to prevention and the treatment of people living with HIV/AIDS. In collaboration with civil society,

targeted interventions were being implemented for segments of the population at high risk of infection. Campaigns were being undertaken to bring about behavioural changes, and services for the diagnosis and treatment of sexually transmitted infections were being facilitated through the existing network of clinics in the public and private sector.

In order to treat, care for and support people living with HIV/AIDS, free treatment for opportunistic infections was provided in all public-sector hospitals. It was his Government's policy to reduce excise and customs duties on antiretroviral drugs in an effort to make them more readily available to those people. A fresh approach to the management of HIV/AIDS was being tried out; within the health sector a start had been made on integrating service delivery with the reproductive-health and tuberculosis-control programmes. In one stroke, the initiative had provided an amazing array of linkages that would cut costs, render services highly accessible and reduce stigmatization and exclusion. As from April 2004, antiretroviral therapy had been introduced in selected tertiary-level medical institutions in six high-prevalence states and the national capital territory. On the basis of the experience gained through that move, expansion of the antiretroviral treatment programme would proceed step by step until therapy was accessible to all people living with HIV/AIDS throughout the country. Representatives of networks of people living with HIV/AIDS would be included in all decision-making committees at central and state levels.

As adequate health infrastructure and continued availability of funds for sustainable treatment were important issues, his Government supported the strategies contained in the report.

Mr HUR (Republic of Korea) said that, since the first case of HIV/AIDS had been reported in his country in 1985, the number of cases had risen to 2700. Recognizing the relationship between prevention and care and the need for a flexible response, the Government had enacted legislation in 1987. Currently, anonymous and confidential testing was available to all. People found to be infected with HIV were reported to the Government through a real-name registration system, so that they could be provided with the appropriate health care. His country supported WHO's "3 by 5" initiative, but it noted that the work should be carried out in an effective, standardized manner that was easy to monitor and that reflected the situation in individual countries.

Mr ASLAM (Pakistan) pointed out the major global public-health challenge posed by the fact that only 300 000 out of the 5-6 million people infected with HIV in developing countries had access to antiretroviral therapy. WHO's "3 by 5" initiative, coupled with the commitment by UNAIDS and other partners to provide support, was a heartening and commendable response. Antiretroviral treatment, although an essential component in the campaign to tackle the HIV/AIDS epidemic, had to be accompanied by renewed and vigorous efforts to promote and accelerate preventive interventions. Furthermore, prevention, treatment, care and support services would not be effective unless they were accessible to those in greatest need. In many countries, stigmatization and discrimination remained significant barriers to use of health-care services by people living with HIV/AIDS and members of marginalized communities. WHO should promote the human rights of people thus affected to ensure that they had access to treatment and care.

Eleven antiretroviral agents had recently been included in Pakistan's essential medicines list. The national AIDS control programme had revised its guidelines for treating the disease, including the use of such drugs. It had also produced a manual for trainers on treatment modalities and regimens. He expressed his support for the proposals made by Thailand.

Dr CICOGNA (Italy) said that increased international commitment was needed, as the HIV/AIDS epidemic had not yet been brought under control and was, in fact, spreading in many parts of the world, including central Asia and Europe. He welcomed the strategic framework for reaching the "3 by 5" target, stressing the importance of strengthening health systems and acknowledging the global leadership of WHO and UNAIDS. He also welcomed the recognition of the need for a balanced approach and a comprehensive response that included antiretroviral treatment, prevention and care, particularly in resource-poor settings. Partnerships among all the actors, including organizations in the

United Nations system, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and civil society through the country-coordinating mechanism were also essential in any successful anti-HIV/AIDS strategy. Italy's support for WHO initiatives was demonstrated by its renewed financial contribution for 2003. It had also established initiatives such as the ESTHER project. That project was designed to stimulate solidarity for people with AIDS, based on a twinning system between selected health structures with expertise in combating AIDS in Italy and other European and African countries. Italy wished to be included in the list of sponsors of the proposed draft resolution.

Dr GØTRIK (Denmark) pointed out that 60% of people living with HIV in Africa were women. Young women between 15 and 24 years were two and a half times more likely to be infected than young men, mainly because they lacked access to services in sexual and reproductive health, and education. It would not be possible to win the fight against HIV/AIDS unless those issues were tackled through a strategy that improved women's legal position, and gave them access to treatment and female-controlled HIV-prevention methods. It would be necessary to engage both men and women in processes aimed at putting an end to sexual harassment and violence against women and young girls. The report described the need to build strong partnerships to ensure successful implementation of the "3 by 5" initiative. His Government urged WHO, as well as other partners, such as multilateral and bilateral donors, specific HIV/AIDS initiatives and nongovernmental organizations, to make use of the "Three Ones" agreement on the need for a common framework for HIV/AIDS activities at country level. The "3 by 5" initiative was set in the context of the overall strengthening of health systems. Without access to good basic health systems, treatment would be difficult to sustain. WHO should continue to develop the initiative in a strategic manner that focused on areas of treatment where the Organization had a specific comparative advantage, and in close cooperation with other partners within the United Nations system.

In recent years, attention had increasingly been focused on the HIV/AIDS epidemic in Europe and central Asia, which was mainly driven by risky behaviour among injecting drug users and sex workers. HIV prevalence was still low compared to other regions, but some areas were experiencing significant growth rates. There was a need for targeted interventions aimed at preventing further spread of infection among those specific risk groups.

Dr VIOLAKI-PARASKEVA (Greece) said that Greece welcomed the "3 by 5" initiative, which had proved helpful in coordinating emergency plans for tackling AIDS. WHO's leadership had catalysed action that had facilitated access to treatment. WHO should continue to strengthen collaboration at all levels with international agencies and governments to implement the "3 by 5" initiative. It should also continue to promote effective public health strategies related to HIV/AIDS, including prevention, research and development of palliative care, epidemiological surveillance, and the building of partnerships.

Greece had based its own strategy for the prevention and control of HIV/AIDS on WHO's global health-sector strategy for HIV/AIDS. It consisted of preventing viral transmission; reducing the personal and social impact of HIV infection; unifying national efforts and collaborating closely with international organizations; reinforcing information and educational programmes for the general public and target audiences; protecting the rights and dignity of people infected with HIV; providing free hospital treatment; and avoiding discrimination and stigmatization. Despite important advances in confronting HIV/AIDS, global inequalities in access to treatment persisted.

Dr SONGANE (Mozambique) said that his delegation welcomed the report and WHO's renewed leadership in the fight against HIV/AIDS, and the approach of using the initiative on HIV/AIDS as a way to strengthen health systems; the continued inability to combat the scourge was the clearest possible indicator of the weakness of health systems; no efforts would avail if the system itself failed. In that regard, treatment and prevention needed to be properly balanced. Preventive measures in particular were lacking in quality as insufficient assessment was made of their efficacy; as a result, despite a great deal of expenditure, behavioural patterns had hardly altered. A more

professional approach to prevention was called for; although the need for professionalism in treatment was recognized, the view regarding prevention seemed to be that anyone could do it. Prevention was certainly the responsibility of everyone, but efforts urgently required professional back-up, including operational research and monitoring to ensure that resources were not being wasted. Coordination, internal and external, was also important. While the agreement of bilateral and multilateral partners (Washington, DC, 25 April 2004) on the "Three Ones" principle was welcome, the outcome must be speedily translated into action, including adequate coordination among the partners themselves and with countries, to avoid duplication of initiatives and confusion.

It was urgent to think beyond 2005, especially in terms of money and degree of preparedness. The future would judge the preparation efforts by the number of youths and adolescents who grew up free from HIV; that would be the main criterion. His delegation wished to sponsor the proposed draft resolution.

Dr PRESERN (United Kingdom of Great Britain and Northern Ireland) endorsed previous speakers' comments on harmonization and supported the "Three Ones" principle. She also agreed with views expressed on balance and prevention, and on sexual health and reproductive rights as an essential component of the response to HIV/AIDS. Because it was important to focus on longer-term investments, she agreed with the delegate of Mozambique that the quality of investment was just as important as its quantity. Efforts in the areas of microbicides and HIV vaccines were vital, even though remedies might still be a long way off.

She welcomed the fact that equity was a key component of the "3 by 5" initiative and business plan. Naturally, decisions had to be taken at national level, but the test of a successful strategy was the percentage of women and children receiving treatment. Moreover, she agreed with previous speakers that human resources were crucial in strengthening health services and, in that context, the "3 by 5" initiative offered an outstanding opportunity. Her country aligned itself with the signatories of the draft resolution. She welcomed the articulation of WHO's role within its cosponsorship of UNAIDS. She urged States with the necessary resources to consider more flexible financing of WHO, to help the Organization to respond to its agreed budgetary priorities. The United Kingdom would shortly be publishing a strategy on HIV/AIDS which expressed support for many of the initiatives currently under discussion.

Dr SALAWU (Nigeria) welcomed the "3 by 5" initiative. She said that, in 2003, her country had had a 5% HIV prevalence rate, meaning 3 to 4 million people infected, which constituted the third largest HIV/AIDS population in the world. Nigeria was currently providing highly subsidized antiretroviral drugs to 14 000 persons and had set a target to raise that figure to 300 000 by 2007. Several actions had already been taken, such as translation of high-level political commitment into budgetary allocations for antiretroviral drug procurement, a health-sector plan to coordinate all types of support, preliminary steps to encourage local drug production, and ongoing health-sector reforms to strengthen the health system.

She invited WHO to consider setting up an emergency fund or drug supply under the "3 by 5" initiative, as a stop-gap in times of stock depletion. She endorsed the draft resolution.

Professor RASAMINDRAKOTROKA (Madagascar) said that, although HIV/AIDS prevalence in her country was only 1.1%, the authorities were committed, at the highest political level, to combating the scourge. Measures included the preparation of programmes based on local response, supported by well adapted prevention and curative services. Ethological and behavioural surveillance had been introduced to ensure the successful implementation of programmes, but much remained to be done, including the adoption of detection and identification measures. Madagascar saluted WHO's introduction of the "3 by 5" initiative; but the latter could only succeed if screening services, and community and health service efforts generally, were strengthened. She urged WHO to take the lead in ensuring broader access to treatment, stressing prevention. Operational research should be conducted to evaluate the impact of the "3 by 5" initiative on prevention and high-risk behaviours.

Dr FERDINAND (Barbados), speaking on behalf of the countries of the Caribbean Community, expressed appreciation for WHO's leadership in the combat against HIV/AIDS. The provision of staff at country offices, WHO's guidelines, and the "3 by 5" initiative, would be of great assistance. HIV/AIDS was severely affecting the Caribbean, the second-worst affected region in the world, with an adult prevalence rate of 1.9% to 3.1%. Comparisons among the countries showed gaps in treatment and diagnosis; in some places 90% of people with AIDS had not been treated and a similar proportion was not even aware of being infected with HIV. That situation called for urgent attention. Reliable information for proper planning was essential, as was integrated voluntary testing and counselling, and treatment in each country. In a few countries, governments had been able to provide suitable antiretroviral treatment. However, costs continued to hamper procurement. Where intervention had been possible there had been a dramatic reduction in some indices. For example, in Barbados the number of HIV/AIDS-related hospital admissions had been reduced by 42%; total hospital days had been reduced by 59.4%, with an overall reduction in AIDS-related mortality of 56%. The rate of mother-to-child transmission of HIV had been reduced to 5%. In the Bahamas, the transmission rate had fallen to below 3%. Of great concern, however, was the pending introduction of the Agreement on Trade-Related Aspects of Intellectual Property Rights as it related to the production and use of generic drugs, which would have an extremely negative effect on the small gains made. In order to minimize such effects, WHO was asked to exercise its good offices in any relevant negotiations.

A positive step had been in the bringing together of public health commitments, resources, scientific tools and activities which had led to significant progress in the region. Adoption of best practice from other countries, the use of innovative models and the mobilization of resources were some examples. Efforts must continue unabated, including measures to ensure the extension of such advances to all countries.

Mr COSTA LIMA (Brazil), speaking on behalf of the countries of the Latin American and Caribbean Group, said that, in order to cope with the HIV/AIDS epidemic, a broad and comprehensive approach was required, including measures not only for prevention, diagnosis and treatment but also for strengthening institutional and human capacity, and steps to discourage the "brain drain" of health professionals. Adequate financial resources for all activities were essential; the Group therefore welcomed the recent increase in funds earmarked for HIV/AIDS treatment, although such increases were still not commensurate with the international commitment to curb and reverse the trend by 2015. The countries recognized the outstanding roles played by WHO, UNAIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Forum. Their coordinated work and the complementarity of their activities should help to achieve positive results. The Group also welcomed WHO's efforts to give priority to prevention and to promote a more comprehensive approach to the problem. Preventive measures should remain on WHO's agenda, in view of the continuing need for increased cooperation in diagnosis and treatment. Experience in some countries of the region had shown that treatment strengthened prevention if both activities were conducted simultaneously. Dissemination of information had proved to be more effective in countries that had strong policies of treatment and support.

The increased mobility of people had heightened the risk of infection and called for the strengthening of multinational, regional and subregional strategies. In that regard, the human rights aspect should not be overlooked. The Commission on Human Rights had recognized the importance of access to treatment and information without discrimination or stigmatization. In particular, the economic benefits of allowing affected people to continue to work and pursue their education without discrimination should be borne in mind.

Progress had been made towards reducing the cost of antiretroviral drugs, which WHO should support. Experience had shown that effective treatment with those drugs was possible even with scant resources, but there was still room for improvement, especially in public health structures. The Group believed in the fundamental importance of the "3 by 5" initiative in broadening access to high-quality antiretroviral treatment, especially in view of countries' limited resources. WHO's activities should give priority to low-income countries with rising HIV prevalence.

It was also important not to overlook the situation of middle-income countries, whose diverse societies contained many pockets of extreme poverty with high, and rising, levels of infection. The countries of the Latin American and Caribbean Group thanked those donor governments that had contributed to the "3 by 5" initiative, and urged countries that had not yet done so to participate. WHO must ensure the utmost transparency in activities involving Member States, civil society and international organizations in the use of funds. WHO should lead a campaign similar to the "3 by 5" initiative for prevention and for the development of vaccines, ensuring and promoting the growth of research funding. The "3 by 5" initiative was a significant step forward towards universal access to treatment and to high-quality medicines.

Mr HOHMAN (United States of America) said that his country welcomed all responsible efforts to control the HIV/AIDS emergency and to focus on prevention, care and treatment. He recognized WHO's important leadership role and expressed appreciation for the high priority given to HIV/AIDS by the Director-General.

The United States' five-year US$ 15 000 million emergency plan was the largest commitment ever made by a single nation to an international health initiative. The targeted countries of the emergency plan would receive treatment for two million people with AIDS, and care for 10 million people infected with HIV or affected by HIV/AIDS, including orphans and other vulnerable children, the target also being to prevent seven million new infections. Furthermore, the emergency plan continued bilateral programmes supported by the United States in more than 100 countries and raised his Government's pledge to the Global Fund to Fight AIDS, Tuberculosis and Malaria by US$ 1000 million over five years. That pledge, currently the largest of any donor, was US$ 1970 million. The United States appreciated the opportunity to coordinate its initiative with WHO, UNAIDS, the World Bank, the Global Fund and other organizations with significant global HIV/AIDS activities, in order to maximize effectiveness and eliminate duplication.

The WHO strategic framework enhanced the availability of antiretroviral therapy in various ways, such as encouraging in-country leadership and strong partnerships; providing assistance to countries in developing sustainable policies and coordinating the provision of antiretroviral drugs; offering simplified and standardized tools to deliver that therapy; providing safe and effective therapy and high-quality diagnostics at the lowest possible cost, including fixed-dose combinations as an effective means to foster patient adherence; and the provision of technical cooperation with countries in developing logistic and distribution systems for drugs and commodities.

His Government continued to pledge its support for HIV/AIDS research in the fields of prevention, care and treatment. It welcomed WHO's role in ensuring the rapid identification and application of new knowledge in antiretroviral therapy. It looked forward to working with research-based and generic pharmaceutical industries and the international community, with a view to providing high-quality drugs at low cost. He thanked WHO, UNAIDS and the Southern African Development Community for their cosponsorship of a conference on fixed-dose combination drug products held in Botswana in March 2004. He welcomed the resulting joint statement on principles that should be taken into account when considering drug products for HIV/AIDS, tuberculosis and malaria. His delegation was eager to discuss the draft resolution.

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

The meeting rose at 18:20.

SECOND MEETING

Wednesday, 19 May 2004, at 10:00

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer): Item 12.2 of the Agenda (Resolution EB113.R1; Document A57/5)

Professor AKOSA (Ghana) congratulated WHO on having called attention to Buruli ulcer, a neglected disease. Ghana had identified cases in the early 1980s and had been grappling with the problem ever since. Although the disease was endemic in only a few areas, its consequences were devastating. It occurred predominantly among very poor people and affected children. Treatment was expensive. Science had not yet unravelled all the causative factors of the disease and he urged WHO to speed up the process of finding solutions. In partnership with Japan, Ghana had started to fight the disease and upgrade the skills of local human resources, for example in plastic surgery. The country did not, however, have the capability to deal with the problem alone and would welcome technical and financial support from WHO.

Dr CICOGNA (Italy) said that the public health significance of Buruli ulcer, a neglected disease with great social and economic impact, especially on poor countries, called for action. Its many poorly-understood features required multidisciplinary research, and its control required improvements in diagnosis, treatment and rehabilitation. He strongly supported the draft resolution contained in resolution EB113.R1.

Dr FUKUDA (Japan) said that his country recognized the magnitude of the socioeconomic impact of Buruli ulcer on affected countries. He urged WHO to ensure good coordination among the many organizations participating in the Global Buruli Ulcer Initiative, which Japan supported. Japan was not opposed to WHO exploring coordination and support for research on Buruli ulcer through the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases, as requested by the Executive Board at its 113th session, but a mechanism must be established to review the list of existing targeted diseases when considering adding a new one, in order to make the best use of the limited budget. Japan looked forward to further progress in research into, and control of, the disease.

Professor KANGA (Côte d'Ivoire) praised the work of the Global Buruli Ulcer Initiative and commended WHO's identification of the disease as a major public health issue. Côte d'Ivoire, where the disease was highly endemic, had more than 16 000 cases with 2000 new cases each year. Understanding of the disease was still poor and sufferers sought assistance late, thus exacerbating the situation. Poor access to medical care and high costs were impediments to effective treatment. The social consequences of the disease, including exclusion and stigmatization, were unimaginable. The medical infrastructure was insufficient and public hospitals could not cope with the demand.

Some progress had been made with health personnel and researchers. A pilot mass-screening and early-treatment programme had been set up in 1998 and the results had been very encouraging: for example, people currently went to hospital as soon as any nodule appeared, thereby practically eliminating ulceration. The programme was to be extended to other regions. Chemotherapy was being tested, with encouraging results.

He supported the draft resolution which reflected many of the problems experienced in his country.

Dr CUI Gang (China) said that, although no case of Buruli ulcer had been reported in China, his country wished to take part in worldwide action to combat the disease and to learn more about the means of diagnosis and treatment so as to be able to cooperate actively with the countries affected.

Dr AGARWAL (India) observed that there were few reports of Buruli ulcer in India. Welcoming the Global Buruli Ulcer Initiative, he emphasized the importance of early detection, in view of the fact that the disease was completely curable by medical treatment and surgery in the early stages. The emphasis on education for early diagnosis was also appropriate. WHO should provide technical support, foster technical cooperation and promote research so that the burden of disease was assessed properly, effective control programmes were established, early detection and treatment accelerated and partnerships between various stakeholders established, in order to ensure that sufficient resources were available. He supported the draft resolution.

Dr KRIT PONGPIRUL (Thailand) expressed his appreciation for the Global Buruli Ulcer Initiative. Pointing out that there were many other neglected diseases, such as liver fluke infections, requiring attention in many regions of the world, he urged WHO to set up global strategies for them too. In the draft resolution, he proposed that in paragraph 2(2) the following words should be inserted after "disease": "as well as to integrate Buruli ulcer into the national disease surveillance system", and insertion in paragraph 4(3) of the following words at the end of the sentence: "through the coordination and support by the Special Programme for Research and Training in Tropical Diseases".

Dr VIOLAKI-PARASKEVA (Greece) said that the information in the report that 70% of those infected were children under the age of 15 years was shocking. It was regrettable that no simple diagnostic test for field use was currently available. Expressing her full support for the draft resolution, she proposed that two new subparagraphs should be inserted at the end of paragraph 1, as follows: "(6) to provide training to general doctors to improve surgical skills; (7) to provide training to all health workers in the prevention of disability".

Dr LARUELLE (Belgium), welcoming the report, said that the Institute of Tropical Medicine in Antwerp was taking an active part in combating the disease. He strongly supported the draft resolution.

Dr KAMUGISHA (Uganda) observed that Buruli ulcer disease had long been present. Buruli was the name of the county in Uganda in which the disease had first been identified in the late 1960s and early 1970s. The number of cases recorded in Uganda – altogether 1056 at the end of 2001 and a further 117 in 2002 – was probably a mere fraction of the actual number of cases in the country. Uganda wanted to work with WHO in a programme to increase surveillance, early detection and health education and to create awareness among the population. WHO should work with the health-care system at the rural and primary health-care levels. At the same time, more effort and resources were needed to develop laboratory capacity.

Ms VALDEZ (United States of America) commended WHO's leadership and the progress it had made since 1998 in raising awareness, securing funding and coordinating the efforts of partners and activities to control Buruli ulcer. Much remained to be done. She strongly encouraged WHO to focus on strengthening surveillance and defining the epidemiology of *Mycobacterium ulcerans* infection in order to assess more accurately the burden of the disease and to formulate effective prevention strategies. WHO and affected countries should fully integrate surveillance of Buruli ulcer into national surveillance systems, taking as example the African Region's Integrated Disease Surveillance system.

The Centers for Disease Control and Prevention within the United States Department of Health and Human Services had analysed data for 2003, which allowed estimation of the direct (out-of-pocket) and indirect (productivity loss) costs to individuals and households due to the disease among households in the Ashanti and Central regions of Ghana. There were plans to assess the economic impact of the disease, in terms of opportunity costs, on affected household members and to identify the socioeconomic, demographic and situational factors associated with the disease and its progression in affected individuals. WHO support had been crucial in that regard. The United States remained a committed partner in the Buruli ulcer control programme and supported the draft resolution.

Dr LARIVIÈRE (Canada) noted that inadequate medical knowledge, lack of general access to effective treatment, and unfortunate traditional beliefs and myths about Buruli ulcer had seriously complicated its management and contributed to the burden it posed. WHO's potential role in demystifying the disease and opening it to effective community action would contribute greatly to its control. The Global Buruli Ulcer Initiative was a good example of a broad grass-roots activity which deserved to be supported and strengthened. His delegation supported the draft resolution and the call on the Special Programme for Research and Training in Tropical Diseases which had acquired a unique level of expertise on mycobacterial diseases. That Programme, given its involvement previously with leprosy control and currently with tuberculosis control, could support the development of better management tools for Buruli ulcer control. The Scientific and Technical Advisory Committee of the Special Programme was aware of the request made by the Executive Board for its assistance and would be prepared to consider current information on the prospects for new therapeutic approaches to the disease. That was an encouraging development. He commended WHO's excellent documentation on the disease.

Dr MATIUR RAHMAN (Bangladesh) observed that, although his own country was not affected, the disease currently existed in more than 30 countries. One could not know how it spread from one region to another, and living in a "global village" made it essential to tackle any serious disease that arose anywhere. Buruli ulcer was crippling and costly, but little was known about it. Efforts must be devoted to all kinds of research to permit its early diagnosis and proper treatment. His delegation strongly endorsed the draft resolution.

Dr BODZONGO (Congo) confirmed that his country was among those affected by Buruli ulcer. In addition to the disease's physical effects, a further consequence might also be experienced by other affected countries: some teachers, because of popular beliefs about the disease, refused to work where it was prevalent. Ignorance and superstition were thus creating a situation which, if it continued, might leave many children in those areas deprived of education because of a lack of teachers. He supported the draft resolution.

Dr ASAMOA-BAAH (Assistant Director-General), thanking speakers for their comments, said that the fact that the Health Assembly was discussing Buruli ulcer for the first time was cause for joy, but also for sadness since it was a horrible disease that affected children, the poor and the voiceless in society. The occasion was nevertheless uplifting because the draft resolution would give the disease the necessary additional visibility and, more importantly, provide the voice that was needed. The positive comments made and the experiences shared were encouraging. He had noted well the suggestions made with regard to partnerships, research, integration with national disease surveillance systems, training for health workers, socioeconomic studies on the impact of the disease, and the need to do more to reduce the stigmatization associated with it.

The CHAIRMAN invited the Committee to consider the amended draft resolution.

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

Control of human African trypanosomiasis: Item 12.3 of the Agenda (Resolution EB113.R6; Document A57/6)

Dr LARUELLE (Belgium) said that the excellent report illustrated clearly the critical situation in some regions of countries affected by trypanosomiasis, which had rightly been classified as one of the so-called "neglected" diseases. Fortunately, with the adoption of resolution WHA56.7 on the Pan African tsetse and trypanosomiasis eradication campaign, a first step had been taken. He welcomed the substantial progress made since then with regard to both new methods of controlling the disease and the development of new treatments. That progress was attributable to a solid partnership among WHO, the private sector and interested governments. His country had long been interested in the disease; many Belgian scientific institutions, foundations and universities (notably the Institute of Tropical Medicine in Antwerp) and the Belgian development cooperation had devoted and continued to make considerable efforts both to supporting the prevention programme in affected countries and to financing research, through funding for the Institute of Tropical Medicine and for the Special Programme for Research and Training in Tropical Diseases. He was gratified that the draft resolution contained in resolution EB113.R6 built on that determination to work together to combat a terrible disease which, if left untreated, was always fatal.

Dr THAKSAPHON THAMARANGSI (Thailand) regretted that the report contained inadequate epidemiological information. Clear targets should be set, with a balance between prevention, screening and treatment. Given that trypanosomiasis was a neglected disease occurring in many countries, mainly affecting the poor, he appreciated WHO's successful input into the Special Programme for Research and Training in Tropical Diseases and the Drugs for Neglected Diseases initiative. He expressed his great concern about prospects for treatment and, in that connection, urged WHO to continue to collaborate closely with all partners concerned, including the private sector, to secure the long-term availability of the necessary drugs. Financial support was required to fund research and development of a new treatment, possibly from the pharmaceutical industry through an international, targeted contribution.

He strongly supported the draft resolution, proposing that paragraph 2(4) be modified to read as follows: "to keep the Health Assembly informed of progress in every first year of the biennium".

Mr TOMPSON (Mozambique) said that trypanosomiasis had long been endemic in Mozambique, cases having been reported in the north of the country in 1909. Until the early 1980s Mozambique had had an active control programme, whose implementation had been seriously impeded by the country's 17-year war. Reporting had also been affected, although one case had been reported very recently after two years in which no reports had been made. The disease was still prevalent in certain areas but the extent of endemicity was unclear. Mozambique was collaborating with the Regional Office for Africa to prepare an action programme to redraw the map of, and estimate the burden of, trypanosomiasis in Mozambique. The main activities envisaged were: active screening, particularly given the difficulty of detecting cases with passive screening; capacity building for treatment; and collaboration with the veterinary services on tsetse fly control, which had also been adversely affected by the war. In view of the importance of active surveillance, technical and financial support were necessary in order to reach the remote, rural areas particularly affected by the disease.

---

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA57.1.

Ms MOTSUMI (Botswana) reaffirmed the need for new knowledge and control tools to eradicate human African trypanosomiasis and for sustained, vigorous control efforts. In 2001 there had been a resurgence of tsetse flies in north-west Botswana, accompanied by an outbreak of disease in cattle; there had been no disease in cattle for one decade before that, and two decades for human disease, as a result of intensive vector-control efforts until 1991. The implementation by Botswana's veterinary services of an integrated tsetse fly and trypanosomiasis eradication campaign had controlled the resurgence of the vector and disease in animals, and preparations for the final stage of the campaign were under way which would involve the release of sterile insects. She urged WHO to continue to foster collaboration between the health and agricultural sectors to control trypanosomiasis; to continue to mobilize funds for its control; and to promote exchange of positive control experiences between Member States. She endorsed the draft resolution.

Dr TOIKEUSSE (Côte d'Ivoire) welcomed and encouraged WHO's continued efforts to create the conditions for the eradication of the often-neglected disease of trypanosomiasis. Despite his country's commitment to eradicating the disease there had been a resurgence of trypanosomiasis, particularly in rebel-held areas. He would welcome support from WHO with regard to capacity building and disease-prevention methods, and looked forward to the approval of the draft resolution.

Dr LOUM (Senegal) said that human African trypanosomiasis had ceased to be a health priority for Senegal from the end of the 1960s but that vectors of animal trypanosomiasis and potentially of human trypanosomiasis were present in some of the country's rural regions. There was a real risk of the emergence of human African trypanosomiasis in Senegal, given the outbreaks in western and central Africa, the relaxation of epidemiological surveillance, and the migration of infected persons. Studies of vector populations should therefore be stepped up to improve knowledge of the bio-ecology of *Glossina* populations. Senegal would fully participate in the initiative to eradicate tsetse flies and trypanosomiasis that was being implemented in Africa. He supported the draft resolution.

Mr YOSHIDA (Japan) supported the draft resolution and looked forward to its recommendations being put into practice. Because of the epidemic's sporadic pattern, a sound monitoring system was necessary for effective control. Efforts should be stepped up in that area. Diagnostic skills, pharmaceutical development and human resource development were of great importance for overall parasitic disease control. Japan attached high priority to international partnership for parasitic disease control and to that end, in March 2004, it had held an international workshop in Bangkok for promoting antiparasitic control.

Dr KAMUGISHA (Uganda) observed that, although human African trypanosomiasis was not as neglected in Uganda as Buruli ulcer, it still required considerable work for its control and eradication. The disease had been successfully controlled in the past, but in the previous decade both the animal and human diseases had re-emerged with devastating medical and economic effects. Two foci of human trypanosomiasis in Uganda, in the south-east of the country and the West Nile Region, were the targets of disease-control action, including passive and active surveillance. A national policy had been developed to guide efforts to control tsetse flies and trypanosomiasis; work on drawing up that policy had demonstrated the need for a multisectoral approach to maximize impact. Those efforts were being undertaken jointly by two government ministries; one dealing with the human aspects and one with the animal aspects, especially relating to vector control. His country supported the Pan African tsetse and trypanosomiasis eradication campaign and had developed a proposal to create tsetse-free zones in the country. He commended the disease-control support Uganda had received from the European Union and looked forward to the implementation of the sterile-insect technique, which would, it was hoped, lead to eradication of the disease. He endorsed the draft resolution.

Dr AGARWAL (India) recalled that the Health Assembly had previously drawn attention to human African trypanosomiasis and its eradication. Although vector eradication had been identified as the only effective strategy, other measures such as secondary prevention had also been highlighted. Despite free drug supply and effective treatment, the eradication programme was hindered by the difficulty of early diagnosis, the ineffectiveness of treatment once the protozoa had crossed the blood-brain barrier, and the deaths caused by the treatment itself. Even though trypanosomiasis and its vector were not found in India, he supported the draft resolution.

Professor DUSHIMIMANA (Rwanda) said that human and animal trypanosomiases had existed in Rwanda in the 1950s, with devastating effects on animal and human health and on the economy. He thanked WHO for its wake-up call to countries and partners to continue to control re-emerging diseases such as human trypanosomiasis. He commended the draft resolution.

Dr MATIUR RAHMAN (Bangladesh) said that, even though trypanosomiasis was not a problem in Bangladesh, it had to be taken seriously as a re-emerging disease. African countries were already burdened by so many diseases, particularly HIV/AIDS, and it was therefore important to tackle the problem, particularly since trypanosomiasis was vector-borne: to control the vector was to control the disease. He expressed his strong support for the draft resolution.

Dr BODZONGO (Congo) affirmed the importance attached by his Government to the problem of trypanosomiasis, given the re-emergence of the disease after it had been brought under control in the 1960s. Accordingly, an international congress had been held in Brazzaville in March 2004 on trypanosomiasis and the tsetse fly, attended by several African and European countries. The congress had set out to assess the situation in the African Region; exchange experience in the area of patient treatment and eradication strategies; and draw up and adopt a plan for regional action. He endorsed the draft resolution.

Dr ASAMOA-BAAH (Assistant Director-General) thanked delegates for their encouraging remarks. Trypanosomiasis was a classic example of a neglected disease; it had almost been eradicated in the 1960s but had come back to haunt the world, putting 60 million lives at risk. He regretted the use of the term sleeping sickness to describe the disease, as the disease had a 100% fatality rate when untreated. On a more positive note, work carried out by governments, research institutions, academics, and nongovernmental organizations in recent years had led to fresh hope. The draft resolution would add to the growing sense of hope and would help to elicit the necessary investment in the health and agricultural sectors.

The CHAIRMAN invited the Committee to consider the draft resolution contained in resolution EB113.R6, as amended.

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

Smallpox eradication: destruction of variola virus stocks: Item 12.4 of the Agenda (Document A57/7)

Dr THAKSAPHON THAMARANGSI (Thailand) stated his country's long-standing concern about the potential impact of deliberate or accidental release of variola virus. The longer the stocks were retained in the two authorized sites the greater the risk to the global community. Thailand therefore advocated retention of only the necessary stock, to be determined by the Advisory

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA57.2.

Committee. It furthermore wanted the Committee to set a clear target for research, so that a firm deadline could be set for the destruction of variola virus stocks. He requested the Director-General to report to the Fifty-eighth World Health Assembly on those matters.

Dr UĞURLU (Turkey) said that, pursuant to WHO's recommendations, Turkey had ceased producing smallpox vaccine in 1980 and had destroyed all virus stocks in 2000. Precautionary measures were needed, with the support of WHO, to make the vaccine rapidly and easily available to countries in the event of a global threat. Turkey supported the research into new, safe antiviral drugs.

Dr LEVENTHAL (Israel) asked whether WHO was aware of the existence of variola virus stocks in locations other than the authorized storage sites. The matter was of great concern to many countries, including his own.

Mr YOSHIDA (Japan) welcomed the reported progress made in variola virus research conducted at the initiative of WHO. The outcomes should be used globally, for the benefit of all nations and human beings. He stressed the importance of the Advisory Committee's recommendations and of their effective implementation. Research deemed necessary by that Committee should be conducted in strictly protected biosafety level-4 facilities; particular care should be given to virus handling; records should be kept of the destruction of viral isolates; and sequence analysis should be continued for reasons of traceability. The ultimate goal remained the complete eradication of smallpox through the destruction of remaining virus stocks. The validity of claims of scientific justification for retention should be carefully examined.

Dr AL KHARABSEH (Jordan) endorsed the report of the fifth meeting of the Advisory Committee, welcoming in particular the recent developments in research and the Committee's recommendation that viral isolates whose retention had no scientific justification should be destroyed.

Dr AGARWAL (India) supported the retention of stocks of variola virus, which should be maintained under the aegis of WHO and made available to countries that had the expertise and infrastructure for research and development relating to the virus. Given the possible intentional or accidental release of the smallpox virus, stocks had to be retained in order that diagnostic tests, treatment and means of prevention might be developed. A cautious and secure public-health response must be maintained in the face of the changed world circumstances. The progress made in strengthening repositories, viral sequencing, and developing diagnostic tests, antiviral drugs and vaccines was encouraging, but the outcome of the research should be shared among all Member States, given the need for sufficient stocks of vaccine to be available to respond to a threat of biological warfare or bioterrorism.

Professor SZCZERBAN (Poland) observed that progress made over the previous 20 years in research on vaccine quality improvement and in the development of better diagnostic tests and treatment strategies appeared to be modest. Meanwhile, a serious public health threat had been disclosed with the news that large stores of variola virus or its highly virulent mutated strain had been developed as a biological weapon. It was impossible to locate all the repositories of variola virus or to assess the quantity of material stored, the conditions of storage or the likelihood of intentional or unintentional release. It was therefore of the utmost importance to continue to improve prophylaxis, diagnosis and treatment of smallpox. Destruction of variola virus stocks in the two official repositories would have to be postponed until relevant trials were completed.

Dr CUI Gang (China) stressed the importance of the ultimate goal of definitively destroying variola virus stocks. Research should be conducted on recombinant viruses, because the artificial production of variola virus could have a catastrophic impact on mankind. WHO should strengthen the management of existing variola virus stocks and help the countries concerned to establish research

programmes in order to set a target date for final destruction of the stocks. The Committee's recommendations in paragraph 5 of the document were both feasible and necessary, but he proposed that subparagraph (d) should be amended to read: "Details on methodologies for smallpox screening and diagnostic tests being developed should be made available regularly to Member States, and relevant reagents could be provided to Member States on request.".

Mr BRIEM (Iceland) said that his country, having supported resolutions WHA52.10 and WHA55.15 on account of the threat of intentional or unintentional release of variola virus, endorsed the Advisory Committee's report, welcomed the progress made in diagnostic tests and hoped that research would lead to the development of effective drugs and safe vaccines.

Ms GILDERS (Canada) said that Canada agreed with the Advisory Committee's conclusions and recommendations and, in particular, favoured postponing the destruction of existing variola virus stocks until research essential for public-health security was completed. Meanwhile, research should continue in order to improve diagnostic tests and to refine the animal model for the eventual testing of new drugs and vaccines. Any decision on the destruction of the remaining stocks of virus must be reached on the basis of a consensus.

Mr ASLAM (Pakistan) agreed that variola virus stocks should be retained for a limited period, but said that WHO should set a target date for their destruction. Pending a consensus on the destruction of the stocks, he supported the Advisory Committee's recommendations. The authorized research work should be open to full inspection and audit by WHO, and an inventory of the material used for research should be made. The research results should be published in the open peer-reviewed literature for the benefit of all countries.

Mr FURGAL (Russian Federation) supported the recommendations and conclusions of the Advisory Committee, including the continuation of research into new antiviral agents and vaccines. In accordance with resolutions WHA52.10 and WHA55.15, the Russian Federation had elaborated a national research programme aimed at creating a new generation of diagnostic, prophylactic and treatment tools. All the research was being done at the "VECTOR" State Research Centre of Virology and Biotechnology in strict accordance with established recommendations and requirements, under the control and with the active participation of WHO. Russian experts considered it exceptionally important to continue research on all the isolates held, including the chimaeric strains, in full compliance with resolution WHA55.15. He therefore could not concur with the views of the delegates of Thailand, Jordan and China. He thanked all partners, in particular the United States of America, for their participation in joint research and development, and WHO for its invaluable support.

Dr GARBOUJ (Tunisia) said that the destruction of stocks had been postponed because research was ongoing. She trusted that such research would continue to be transparent so that developments could be followed case by case. She entirely agreed with the Advisory Committee's recommendations and asked WHO to establish a technical committee to keep research into all new vaccines, including that for poliomyelitis, under review.

Dr ZAHER (Egypt) commended the efforts made to eradicate smallpox and stated that Egypt had no stocks of variola virus. She agreed that all stocks should be destroyed.

Dr STEIGER (United States of America) supported many of the report's recommendations, in particular the need for additional research into diagnostic tools, antiviral drugs and refinement of the animal model, in order to protect the world's population from the potential deliberate or accidental release of smallpox virus. He noted the significant progress in research on the stocks held at the two authorized repositories, including the development of new diagnostic tests, characterization of the isolates held and better understanding of the genomic diversity of the virus. He associated himself with

the comments made about the need for continuing research, and disagreed with the recommendation to destroy a specific portion of the stocks held. He saw no need for further committees to be established to review research, since the Advisory Committee that had produced the report and several others were already performing that task. The two authorized repositories, in the United States and the Russian Federation, were in constant contact with WHO and were subject to inspection by and close collaboration with the Organization.

Mr HUR (Republic of Korea) fully supported the Advisory Committee's recommendations and the continuation of research. It was particularly important to share the results of all the research carried out in recent years. He reiterated that, if retention of stocks of certain viral isolates could not be justified scientifically for research purposes, those stocks should be destroyed.

Dr ASAMOA-BAAH (Assistant Director-General), responding to the comments made, noted that the desire of Member States was to maintain the ultimate goal of destruction of all stocks, and that they hoped that procedures and a timeline for doing so could be agreed on by consensus. Meanwhile, given the threat of accidental or intentional release, essential research should continue under the supervision of the Advisory Committee, and the results thereof should be shared, especially with regard to diagnostic tests, antiviral drugs and vaccines.

Replying to the question from the delegate of Israel, he stated that the Secretariat was not aware of the existence of any other stocks. If any Member States knew of such stocks, he would welcome the information.

The Committee noted the report.

Eradication of poliomyelitis: Item 12.5 of the Agenda (Document A57/8)

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that progress in poliomyelitis eradication had been impressive, from 125 countries with endemic poliomyelitis and 1000 children paralysed each day in 1988 to only six countries with endemic disease and fewer than 800 cases by the end of 2003. The partnership for eradication of poliomyelitis, consisting of UNICEF, the Centers for Disease Control and Prevention in the United States of America, Rotary International, WHO and countries, had remained strong. On 15 January 2004, the Director-General had invited the ministers of health of the six countries with endemic poliomyelitis (Afghanistan, Egypt, India, Niger, Nigeria and Pakistan) and three countries in which imported cases had been identified (Burkina Faso, Chad and Ghana) to a meeting with core partners, to review progress and launch a final effort to eradicate the disease. The data presented at the meeting showed that it was epidemiologically feasible to interrupt transmission of poliovirus in all countries before the end of 2004. Both the number of countries with cases of poliomyelitis and the proportion of those cases resulting in paralysis in most of those countries were at an all-time low. After the meeting, activities had been strengthened, and in many parts of the world the incidence of the disease had begun to decrease rapidly.

On 17 May 2004, the Director-General had invited the ministers of health of the countries with endemic poliomyelitis to provide progress reports for the first three months of 2004. During that time, there had been only 11 cases of poliomyelitis in Pakistan, eight in India, two in Afghanistan and one in Egypt. Those low figures meant that the disease could best be eliminated in those countries case by case. The next step, which could be taken much earlier than expected, would be large house-to-house "mop-up" campaigns in the areas around each identification of poliovirus. At the same time, the number of cases in Africa had increased to its highest level in nearly five years, and, as a result, there had been importations into central and western Africa and as far south as Botswana; nine countries in sub-Saharan Africa had become re-infected with the virus, while in Niger and Nigeria the disease remained endemic. The decision taken by the ministers of health on 17 May echoed a decision made several days previously at a meeting of the African Union to mount immunization campaigns in

22 central and western African countries. There were two possible outcomes: either the biggest outbreak on record would occur in central and western Africa or the disease would be eradicated. He believed the latter would happen, as did the ministers of health from the African countries. Additional funds of about US$ 100 million were being sought, technical assistance was being increased to improve the quality of campaigns in central and western Africa, and UNICEF and governments were cooperating to build community confidence in the safety of the poliomyelitis vaccine.

The Organization and the ministers of health of affected countries were committed to poliomyelitis eradication. Interruption of poliovirus transmission was feasible epidemiologically by the end of 2004, and WHO and its partners would continue to work with countries to see that that goal was reached.

Dr CICOGNA (Italy) noted with satisfaction the progress made so far, thanks to the strong commitment and vigorous efforts of the international community. The "final push" was crucial, particularly in the light of the persisting funding gap. Italy had always attached great importance to the eradication of poliomyelitis. Since the 1990s, through contributions to WHO and UNICEF, it had supported all efforts to reach that global goal and would continue to support the Global Polio Eradication Initiative. The first part of its contribution would be transmitted to WHO by the end of 2004.

Mr BRIEM (Iceland) said that every effort must be made to eradicate poliomyelitis in the remaining six countries by the end of 2004. He expressed full support for maintaining worldwide surveillance until global certification was obtained, perhaps by 2008, after which immunization with oral vaccine could be terminated. As individuals with immunodeficiency could become chronic transmitters of the virus, surveillance and immunization with inactivated vaccines would nevertheless have to be continued. Access to affordable inactivated vaccines must be secured for all countries, so that they could be delivered to all children.

Professor PEREIRA MIGUEL (Portugal) endorsed the Global Polio Eradication Strategic Plan for the period 2004-2008. The Portuguese health authorities were preparing a post-eradication action plan aimed at maintaining high immunization coverage, sustaining the programme of clinical, epidemiological and laboratory surveillance for acute flaccid paralysis and ensuring laboratory containment of wild-type poliovirus. That plan was an integral part of the national health strategy for 2004-2010, prepared in close collaboration with the Regional Office for Europe. Acknowledging that insufficient financing was a threat to fulfilment of the goals established by the Global Polio Eradication Initiative, Portugal had made a contribution of US$ 400 000. His country was committed to working with WHO, both directly and in the framework of the European Union, to ensure that children of all countries were protected against poliomyelitis.

Dr AZIZ (Pakistan), affirming that her country was one of the six where poliovirus was still transmitted, said that the geographical extent of transmission had been substantially reduced. The General Declaration for the Eradication of Poliomyelitis, signed by the ministers of health of the affected countries on 15 January 2004 at the start of a new campaign for the final push, and the Global Polio Eradication Strategic Plan for 2004-2008 were extremely important developments. Pakistan had managed to limit transmission to only three areas of the country, despite difficulties such as climate and lack of access to target populations and of education, malnutrition and poor health conditions of children. Every effort would be made to ensure that all eligible children were reached during 2004. Pakistan had achieved the global standards for surveillance; an efficient, sensitive system for detecting acute flaccid poliomyelitis was functioning. A laboratory had been accredited by WHO and was also serving as the WHO regional referral laboratory for Afghanistan. The Government was fully committed to poliomyelitis eradication. She thanked all the agencies that were helping its efforts.

Dr SUGIE (Japan) commended WHO's commitment but noted that certain issues remained, including the destruction of wild polioviruses in laboratories and immunization strategies after eradication. Japan expected WHO to take the initiative in addressing those matters. Global eradication of poliomyelitis should be achieved as soon as possible so that vaccine-induced poliomyelitis could be eliminated, and activities should be enhanced so as not to miss the target year of 2008. WHO should give priority to eradication programmes and mobilize resources. Technical assistance should be transferred from countries free of poliomyelitis to those in which the disease was endemic. The poliomyelitis eradication programme should not be hindered by the introduction of other infectious disease eradication programmes; for example, the measles eradication programme should not be introduced where poliomyelitis cases were still being observed. Japan also expected WHO to enhance its efforts to control importation of poliomyelitis, many cases of which had occurred in 2002 and 2003. Maintaining high immunization coverage and good surveillance systems was crucial for preventing further importations. The period between eradication of poliomyelitis and termination of immunization with oral vaccine should be discussed. In order to complete the eradication initiatives in India, Nigeria and Pakistan, political commitment was needed, and WHO should provide full support, including technical assistance for areas with low coverage. Knowledge and assistance should be drawn from countries in which poliomyelitis had already been eradicated. Japan had contributed to the eradication of poliomyelitis in the Western Pacific Region by providing development assistance to China and other countries. It would continue to offer its technical expertise and vaccine, in support of other countries' eradication programmes.

Mrs BELLA ASSUMPTA (Cameroon) noted that several countries had reached the standard for certification, including Cameroon, where wild-type poliovirus had not been observed since 1989. During the current year, however, two imported cases had been found. That development called for vigilance by the relevant authorities and would require material and financial resources over and above those that had been expected in view of the achievement of certification standard. It was urgent to take vigorous and coordinated action to return to satisfactory rates of immunization coverage in the subregion. She thanked those countries had had pledged funds to help her country in that effort.

Dr RODGER (Canada) recalled that her country had long been a champion of poliomyelitis eradication. Since 1999, the Canadian International Development Agency had committed Can$ 105.4 million to the Global Polio Eradication Initiative. It had supported activities in Nigeria, with Can$ 6 million in 2000-2001 and another Can$ 20 million, through WHO, in 2001-2004. In March 2004, the Minister for International Cooperation had announced a further contribution of Can$ 13 million to the Global Polio Eradication Initiative. Canada welcomed the strategic plan for 2004-2008. It would be important to complete poliomyelitis eradication within the narrow window of opportunity currently open, and Canada urged all G8 countries to contribute more to the Initiative, so that the challenge could be met by 2005. Her country also welcomed efforts to find an efficient and effective way to integrate the current poliomyelitis eradication infrastructure into the mainstream of health-care systems at the country level.

Ms VALDEZ (United States of America) noted that progress in poliomyelitis eradication had been impressive and that the leadership of WHO had been essential. The core partners – WHO, UNICEF, Rotary International, the United States Department of Health and Human Services and the United States Agency for International Development – had also been crucial in mobilizing the necessary resources, ensuring international standardized surveillance and promoting high-quality, sustainable immunization strategies. The exercise was an excellent example of the power of public-private partnerships. United States experts based in more than 40 countries were dedicated to interrupting poliovirus transmission while strengthening routine immunization and disease-control programmes.

The difficulties ahead should not be underestimated. Local leadership and government authorities should take the responsibility to reach every child in endemic areas. Although the primary

focus was on endemic countries, all countries had to be involved to achieve global certification, and vigilance was needed to preserve the progress made to date. High levels of routine immunization were essential to maintain immunity and avoid importations, and certification-standard surveillance had to be maintained everywhere. Noting that the Initiative faced a considerable funding shortfall, the United States encouraged other donors to join it in fulfilling their pledges. An important element of successful poliomyelitis eradication was effective containment of laboratory stocks of poliovirus; all countries should ensure effective, secure and safe containment of poliovirus stocks. The goal of global poliomyelitis eradication was close, and the global community must pull together to achieve it.

Ms BUIJS (Netherlands) pointed out that the significant results attained by the Global Polio Eradication Initiative were due to the strong support of donors. She stressed the importance of the plans for sustaining the long-term elements of poliomyelitis eradication. It would be desirable to keep intact the infrastructure of the laboratory network, which was already being used in some countries in programmes to combat other diseases such as measles and yellow fever, which were essential elements of national health plans.

Mr FURGAL (Russian Federation) said that eradication of poliomyelitis would be a further glorious link in the chain of history of WHO. Great efforts were being made under the global strategic plan, and impressive progress had been achieved, although the final push still had to be made. Noting that the report referred to an alarming shortage of financial resources, he announced that his Government was looking into the possibility of making an additional voluntary contribution to the Global Polio Eradication Initiative of US$ 4 million over 2004-2005.

Dr NAAMA SAID (Iraq) thanked WHO for its support to his country's poliomyelitis eradication programme. The programme had been successful, and the last case of poliomyelitis had been seen in January 2000. The current situation in the country, however, posed numerous challenges for routine immunization. The coverage rate had fallen to below 70%, notwithstanding major efforts. The disease had been endemic in some regions of the country; if the virus was imported into those regions, the disease would recrudesce. The Health Ministry of Iraq had a political commitment to eradicate poliomyelitis. He expressed his country's thanks for the assistance received to preserve what had already been achieved, notwithstanding the enormous difficulties being faced.

(For continuation of the discussion, see summary record of the third meeting, page 44.)

The meeting rose at 12:30.

THIRD MEETING

Wednesday, 19 May 2004, at 14:35

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)
later: Dr D. SLATER (Saint Vincent and the Grenadines)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Implementation of resolutions (progress reports): Item 12.15 of the Agenda

- **Intellectual property rights, innovation and public health** (Resolution WHA56.27; Documents A57/18 and A57/18 Add.1)

Ms DREIFUSS, speaking as Chairman of the Commission on Intellectual Property Rights, Innovation and Public Health, reported on the Commission's activities following its first meeting on 5 and 6 April 2004. The Commission appreciated the importance of the task entrusted to it and was aware of its remit. Resolution WHA56.27 made clear that more, and more effective, investment was needed to develop new drugs and other products to treat diseases that had a disproportionate impact on developing countries. Developments in scientific research resulting from new technologies such as genomics would have to be taken into consideration, together with the spiralling cost of pharmaceutical research and the introduction of new mechanisms such as public-private partnerships for developing and distributing medicines. Account should also be taken of the concern that access to new drugs and new technologies had to be assured for all those in need of them. The Commission would endeavour not only to produce an evidence-based analysis of the links between intellectual property rights, innovation and public health, but also to provide concrete proposals for facilitating decision-making and implementing appropriate measures.

Under its mandate the Commission had to consider the burden of disease affecting developing countries and how far current priorities and investment in research and development addressed that burden. It had to consider how innovation could be promoted through the intellectual property system, but also through incentives outside it, and how regulatory regimes could offer incentives and disincentives for research. It recognized the importance of innovation in traditional medicine and of building innovation capacity in developing countries.

A wide range of expertise was needed to study how all the incentives available could be mobilized to promote innovation and affordable access to medicines and vaccines for people in developing countries. The Commission had therefore decided to review critically existing knowledge on the various aspects of its mandate, in order to understand better the issues raised. It would also conduct wide consultations with the many parties concerned, particularly in developing countries.

Having reviewed the work to be done, the Commission had concluded that it would not be possible to finish it in time to submit its report to the Executive Board in January 2005. A more realistic option would be to submit the report to the Board in January 2006, and she asked the Health Assembly to look favourably on that request. She would be glad to inform the Board in January 2005 on progress made, and to present an interim report to the next Health Assembly.

Mr ZEPEDA BERMUDEZ (Brazil) welcomed the setting up of such a high-level body as the Commission, whose work he would follow closely. Its paramount concern should be to ensure access to medicines for those in need of them in developing countries. Commercial considerations should not be allowed to compromise a public health approach. Another cause for concern was the impact of bilateral agreements, which could jeopardize access to medicines despite the flexibilities provided for

in the Doha Declaration on the TRIPS Agreement and Public Health. In view of the importance of the Commission's task, he supported the request for an extension of its work schedule.

Ms MOTSUMI (Botswana), commending the relevant reports, said that the effect of the patent protection system on drug prices and consequently access to essential medicines was a global concern. It was also important to recognize the role of intellectual property rights in promoting research and development of new drugs for treating diseases with a major public-health impact in developing countries. Botswana was currently buying antiretroviral medicines at discount prices, and benefiting from donations from certain multinational drug manufacturers. Botswana's Intellectual Property Act and other relevant national legislation were being harmonized with international trade agreements. She urged WHO to continue its efforts to improve access to essential medicines in developing countries.

Dr KASAI (Japan) welcomed the establishment of the Commission. The proper protection of intellectual property rights was vital for pharmaceutical development and the Commission ought not to advocate any action that would deny the existence of those rights or result in a revision of existing systems or agreements. Instead, it should focus on incentives for promoting research and development and on improving understanding of existing systems and the public-private partnership regarding intellectual property rights. The expertise of WIPO should be sought in that connection.

He urged that in order to ensure transparency the Commission should use the Internet, and suggested that Member States might be given the opportunity to comment on its discussions. Since in 2005 the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) would take full effect and the "3 by 5" initiative would be in its final stages, there was no need for the Commission to rush its work in order to meet a pre-set deadline.

Dr SCALLY (United Kingdom of Great Britain and Northern Ireland) said that his Government saw increasing access to medicines in developing countries as a high priority and welcomed the reports. The Commission would have to devise easily-implemented, practical solutions, and it was important to consider how its recommendations would be dealt with. He supported the request for an extension of the time frame to ensure a thorough analysis which should complement, but not duplicate, previous studies, and he endorsed the proposal that a progress report should be submitted to the Executive Board in January 2005. His Government looked forward to participating in the Commission's consultations.

Professor AYDIN (Turkey) said that his country took care to fulfil all its obligations on the protection of disclosed data within the framework of the TRIPS agreement. Turkey would take positive steps to comply with the new legislative arrangements on trade-barrier regulations following the European Union's objection. In addition, a concentrated effort had been made to meet the obligations on data exclusivity in respect of the Customs Union. Public health issues should not be affected by compliance with those obligations.

Professor SZCZERBAN (Poland) drew attention to the complex nature of the pharmaceutical sector, which involved many stakeholders. His country's drugs policy prioritized the provision of safe, effective drugs as the most cost-effective treatment compared with other therapeutic alternatives. As most pharmaceutical products were on sale in different countries and thus subject to different regulatory systems, WHO's work to coordinate those systems was very important. His country had recently had to adapt its own legislation to comply with European Union regulations.

The objective of any regulatory system was to ensure equitable access to safe and effective medicines, produced according to quality standards, and that was achieved through the reimbursement system and monitoring of the licensing process. In Poland, marketing permits for medicinal products were granted by the Minister of Health, after submission by the manufacturer of evidence of quality, efficacy and safety and satisfactory analysis of trial results. Once the product was on the market, its effectiveness was monitored constantly by physicians and pharmacists, who reported any adverse

reactions to a central register. It was particularly important to review and update data on over-the-counter medicines, as they accounted for a significant share of the market.

The provision of reliable information to patients was vital to ensure that they used medicines appropriately. The promotion of good pharmaceutical care based on clear information could be a valuable addition to the modern regulatory system, ensuring safe, effective and high-quality pharmacotherapy.

Dr GONZÁLEZ FERNÁNDEZ (Cuba), thanking Ms Dreifuss for her contribution as Chairman of the Commission, asked for clarification of what was meant by "capacity building" as a focus of the Commission's work. He also asked whether the focus on research and development included genomics, because serious problems were posed by the possible use of recent advances in that area. He therefore advocated including genomics in the list of the Commission's priorities if it were not already included.

As many of the issues to be dealt with by the Commission related to the pharmaceutical industry, he would have liked to see some reference to intellectual property rights in relation to the Doha Declaration on the TRIPS Agreement and Public Health and some follow-up of the progress made since that Declaration.

He supported the proposal to extend the time allowed for completion of the Commission's work, but proposed that a work programme be drawn up indicating when reports were to be submitted and at what point interested countries would be able to have access to the proceedings or participate in them, either physically or by electronic means.

Ms GILDERS (Canada) expressed support for the Commission's mandate, and stressed the need for a broad approach to the discussion of intellectual property rights in order to provide adequate support for innovation on a wide range of public health problems. Such an approach might be time-consuming, and she supported extending the time frame for the Commission for another year.

Dr AGARWAL (India) welcomed the creation of the Commission. As a member of WTO, his country fulfilled its commitments under the TRIPS agreement and had amended its National Patents Act accordingly; several of its provisions were designed to enhance access to medicines by the public.

India believed that the flexibility permitted by the TRIPS agreement and the Doha Declaration should be reflected in national legislation, particularly that of the developing and least developed countries. At the same time, developing countries needed to oppose any bilateral or multilateral agreements that went further than that on TRIPS. A concerted effort needed to be made to strengthen local capacity to produce low-cost, affordable, effective and safe pharmaceutical products, and India, Brazil and South Africa, members of the India-Brazil-South Africa Dialogue Forum, had decided to submit a joint document on the subject to the Commission by mid-July 2004. He supported the extension of the Commission's term by one year.

Mr GROENEWEGEN (Netherlands) suggested that the Commission should also explore possibilities for the local development and production of vaccines, in order to provide affordable access on a sustainable basis.

Dr ZAHER (Egypt) thanked the Director-General for having established the Commission. His Government had taken measures to promote national production of medicines to ensure equal access to treatment, and encouraged national companies to engage in research and development to that end.

Dr SUWIT WIBULPOLPRASERT (Thailand) urged that the work of the Commission should be transparent and open, and supported the proposal made by Japan and others for broad participation in the information-gathering process. He too supported the extension of the Commission's term. He urged the Director-General to support transfer of technology relating to medicines to Member States, and to cooperate with them in analysing the health implications of relevant international agreements.

Dr CAPELLA MATEO (Venezuela) commended the work of the Chairman of the Commission and her statement to the Committee. He expressed concern at the lack of research on diseases related to poverty, which he urged the pharmaceutical industry to address as a public health problem. Following the Doha Declaration, trade-related intellectual property rights should not obstruct the protection of public health and, in particular, access to drugs. The provisions of the Declaration should permit a flexible approach, with countries adapting their own patent legislation to promote public health and clinical innovation, while protecting intellectual property so as to encourage further research. Venezuela approved the principles underlying the Declaration and was currently adapting its national legislation relating to intellectual property and regulations for compulsory licensing accordingly. Member States should not go beyond the provisions of the TRIPS agreement, which already provided adequate regulation of intellectual property. He urged the countries of the Americas to reject chapter XX on intellectual property rights in the Draft Agreement of the Free Trade Area of the Americas, since it allowed for a prolongation of drug patents, thereby introducing the concept of industrial secrecy and delaying the entry of drugs and agrochemical products onto the market.

He endorsed the favourable stance of the delegates of Brazil and Cuba towards an extension of the mandate of the Commission and for broader participation of countries in its work, either physically or electronically. A preliminary report providing information on future work should be made available by the end of 2004.

Mr SILBERSCHMIDT (Switzerland) commended the balanced composition and independence of the Commission, and supported the extension of its mandate by one year. He welcomed the technical collaboration between the secretariats of WHO, WIPO and WTO. The Commission's report should appropriately balance intellectual property, innovation and access to drugs, and suggest innovative approaches. However, it was not necessary to wait for the report before implementing measures to improve public health.

Mrs DE LA MATA (European Commission) welcomed the report on the work of the Commission. She endorsed the work programme and priorities identified and supported the extension to January 2006 of the time limit for the completion of its work. The European Community had taken some important actions in the area concerned, which should be taken into account, and was committed to supporting fully the task at hand.

Dr WANG Bin (China) welcomed WHO's action on intellectual property rights in relation to medicines and the establishment of the Commission. Given the harm caused by communicable diseases such as tuberculosis, HIV/AIDS and malaria, she shared the concerns of other delegates regarding procurement and access to medicines, especially those protected by patents. She expressed appreciation for the action taken by Canada in revising its drug patent legislation and urged other developed countries and pharmaceutical companies to take similar practical steps.

Socioeconomic changes, the emergence of drug-resistant pathogens, the re-emergence of certain communicable diseases, such as tuberculosis, and other new challenges were giving rise to various public-health problems in China. The price of drugs was a major constraint to access to treatment, and in particular, the cost of antiretroviral drugs for the treatment of HIV/AIDS was beyond the reach of most people. The pharmaceutical industry nevertheless continued to implement monopolistic pricing policies for patented drugs and to focus attention on the development of products that would generate profits, neglecting basic drugs including those needed to treat poverty-related diseases.

WHO, WTO and other relevant organizations should extend their cooperation in order to resolve differences between developed and developing countries in relation to access to drugs and their local production in developing countries. WHO should also provide technical support to developing countries to increase their capacity to produce essential medicines.

Dr TÜRMEN (Representative of the Director-General) said that she had taken note of the call for wider participation, increased transparency and a holistic approach to the work of the Commission. In reply to the delegate of Japan, she said that WIPO had offered the assistance of two staff members to the Commission, a patent lawyer and the Director of the Global Issues Division. WHO was making every effort to ensure transparency. It had set up a web site which provided access to all the information relating to the Commission, including background papers and submissions received and an electronic newsletter. An open forum for discussion among interested parties would soon be available. Submissions to the Commission from any Member State would be welcome. In reply to the delegate of Cuba, she confirmed that genomics would be covered by the Commission. Capacity building was aimed at enabling countries themselves to provide long-term solutions to questions of access.

Ms DREIFUSS, speaking as Chairman of the Commission, said that the numerous comments, including the wish for greater participation by Member States, reflected the importance they attached to public health and to the work of the Commission. Submissions from Member States would be welcome and would contribute significantly; it would soon be possible to submit them electronically via the open forum on the web site. She assured the delegate of the Netherlands that vaccines would be considered by the Commission, as would diagnostic tools. The Commission looked forward to receiving the submissions promised for the coming months. It would report on its progress by the 115th session of the Executive Board and during the course of 2005. The Commission was currently preparing a programme of visits and contacts with various interested groups, which should expand the opportunities for exchanges of views.

Mr ASLAM (Pakistan), referring to the compulsory licensing provisions included in the Doha Declaration, asked how countries with the capacity to manufacture drugs covered by those provisions could obtain the necessary raw materials during public health emergencies, since procurement of such materials was already a major constraint.

Dr LEPAKHIN (Assistant Director-General) suggested that the previous speaker should contact the appropriate WHO technical staff for further information in that specific area, as the point raised did not fall within the remit of the Commission.

Decision: Committee A decided to recommend to the Fifty-seventh World Health Assembly that it request the Director-General to delay submitting the final report on the outcome of the work of the Commission on Intellectual Property Rights, Innovation and Public Health, established pursuant to resolution WHA56.27, until the 117th session of the Executive Board in 2006 to give additional time for the Commission to complete its work.[1]

The CHAIRMAN announced that the remaining subitems under item 12.15 of the agenda would be taken up at a later stage in the work of Committee A.

(For continuation of discussion, see summary record of the fifth meeting, page 77.)

Eradication of poliomyelitis: Item 12.5 of the Agenda (Document A57/8) (continued from the second meeting)

Dr VIOLAKI-PARASKEVA (Greece), noting that Greece was free from poliomyelitis, commended the comprehensive report and the presentation by Dr Heymann, who had indicated where

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as decision WHA57(9).

greater efforts were needed. Referring to the last sentence of paragraph 11 of the report, she asked for further information on the proposed guidelines for national policy-makers regarding decisions after cessation of oral poliovirus vaccination. Such guidance was important since many countries were not clear about that situation.

Dr KHAZAL (United Arab Emirates) said that her country had eradicated poliomyelitis and respected the criteria for laboratory containment of the virus established by WHO. Referring to paragraph 11 of the report, she urged consideration of the review of oral immunization programmes with a view to replacing oral poliovirus vaccine with an injectable inactivated vaccine, especially in countries that had eradicated the disease due to the wild-type poliovirus, in order to maintain high rates of immunization for the three-year period following the interruption of transmission. Member States could replace the vaccine without affecting plans for global eradication and thereby avoid the risks inherent in the continued use of the oral poliovirus vaccine. Her country needed such advice in order to review its national immunization programmes and begin preparations for the introduction of the latest techniques available.

Dr KRIT PONGPIRUL (Thailand) paid tribute to WHO's long-standing commitment to poliomyelitis eradication. Since 1992, Thailand had established an acute flaccid paralysis surveillance system, whose performance had been of the required standard since 1998. National coverage with three doses of oral poliovirus vaccine was 97.6% and wild-type poliovirus had not been detected for seven consecutive years. Thailand should therefore have been certified free of the disease, a status that would have relieved it of the financial and human resources burden of implementing national immunization days. However, because some countries in the same WHO Region still had reported cases of poliomyelitis due to wild-type poliovirus, Thailand had been advised to continue such activities. In contrast, countries in the adjacent Region, some of which were contiguous with countries with reported wild-type poliovirus and thus a higher risk of infection, had not been so advised. The declaration of poliomyelitis-free status appeared to be based on WHO regional structure rather than geographical proximity of risk. He requested reconsideration of the criteria for certification. Thailand would, however, continue to respect WHO advice.

Mr KIFLEYESUS (Eritrea), welcoming the report, expressed appreciation for the excellent technical guidance and support received from WHO. No case of poliomyelitis had been reported in Eritrea since 1997 and it was only a matter of time before the country was certified as poliomyelitis-free. Reiterating support for the Global Poliomyelitis Eradication Strategic Plan for the period 2004 to 2008, which should remain unchanged, he recommended that WHO and donor agencies should provide additional support to countries where poliomyelitis continued to affect health and productivity. He expressed appreciation for the support announced by the delegate of Italy at the previous meeting.

Dr HASSAN BIN ABDUL RAHMAN (Malaysia) said that, although his country had been certified free of poliomyelitis, it would not relax its vigilance until the disease was eradicated globally. At the national level, progress would be carefully monitored through high-quality acute flaccid paralysis surveillance and everything would be done to ensure wide poliomyelitis immunization coverage. Advocacy strategies would be further strengthened with a view to enlisting the support and collaboration of the private sector and the community at large. Regional collaboration had been boosted in order rapidly to detect, contain and isolate any cases of poliomyelitis due to wild-type poliovirus imported into the country or region. The requisite laboratory inventory had been completed and comprehensive, sustained post-certification measures would be implemented until transmission of wild polioviruses was interrupted worldwide. His Government would therefore contribute US$ 1 million to bridge the funding gap for activities in 2004-2005 to eradicate poliomyelitis from the six remaining countries where it was endemic and urged other States to assist WHO in the final push to interrupt poliovirus transmission by the end of 2004.

Dr CHIRWA (Zambia) congratulated WHO on the progress made towards global eradication of poliomyelitis and announced that his country was about to embark on the procedure for poliomyelitis-free certification. It had the privilege of hosting a WHO-accredited virology laboratory which was crucial for acute flaccid paralysis surveillance in Zambia and its neighbours. More funds would, however, be required to sustain those achievements and, for that reason, he agreed with the delegate of Cameroon that further resources should be made available for continued work, especially in resource-poor countries.

Mr SEKOATI (South Africa) said that, as Botswana was the only country in the African Region to have completed the laboratory containment survey and inventory, it would be useful if WHO could support other Member States in the Region to do likewise. In order to avert the danger that the wild-type poliovirus might be imported into countries previously free of the disease, his Government had put all health workers on the alert, stepped up acute flaccid paralysis surveillance and developed a national plan to deal with poliovirus importation.

Dr GARBOUJ (Tunisia) said that no case of poliomyelitis had been detected in his country since 1993. A comprehensive surveillance system was in place and the immunization campaign would be pursued. A national containment programme had been introduced in 2002 and laboratory results were being assessed.

Dr MZIGE (United Republic of Tanzania) said that no case of poliomyelitis had been reported in his country after the mass immunization campaigns in 1996. That achievement was being reinforced by routine vaccination, and Tanzania aimed to achieve the WHO target in the final push against poliomyelitis.

Dr SADRIZADEH (Islamic Republic of Iran) said that three of the countries in which wild-type poliovirus was still being transmitted were in the Eastern Mediterranean Region, where 0.8% of the world's population lived and 6.3% of all poliomyelitis cases occurred, 83% in just one country. Owing to WHO's efforts, wild-type poliovirus transmission had been interrupted in the vast majority of the countries in which the disease had been endemic, yet it appeared likely that the target for eradicating poliomyelitis globally would be postponed for a second time.

Interrupting transmission of wild-type poliovirus throughout the world should be given top priority. Countries in which the disease was endemic must commit themselves to ensuring that wild-type poliovirus transmission from their territories was halted by the end of 2004, and other countries should work together to prevent importation. Global eradication of poliomyelitis called for international solidarity, high-level political commitment and strong community involvement and support at the national level. The poliomyelitis eradication campaign was reaching its final stage. The conclusions and recommendations of the meeting of Member States of the Organization of the Islamic Conference held the previous day in Geneva would certainly help to stamp out the virus in all Islamic countries.

Dr LOB-LEVYT (United Kingdom of Great Britain and Northern Ireland) welcomed the encouraging results reported by WHO and the recent announcements from Canada and France regarding funding. The resurgence and spread of poliomyelitis in central and western African was a matter of concern. Overall, immunization systems should therefore be strengthened and health systems consolidated in order to prevent further outbreaks. The decision of the African Union to bring the eradication initiative back on track in 21 countries was therefore to be commended. His Government would continue to support and fund the final push.

Dr UĞURLU (Turkey) said that a poliomyelitis eradication programme had been initiated in his country in 1989 and the last case due to wild-type poliovirus had been reported in 1998. Turkey had

been certified poliomyelitis-free in 2002. Since regional cooperation was crucial to global eradication, his Government would continue to support routine vaccination and surveillance of acute flaccid paralysis in high-risk regions until eradication was complete. To that end it was ready to cooperate fully with countries in the Eastern Mediterranean Region.

Ms MOTSUMI (Botswana) said that, despite her country's poliomyelitis eradication strategies, Botswana had suffered a significant setback in April 2004, when a seven-year-old boy had contracted paralytic poliomyelitis due to a viral strain that was closely linked genetically to the wild-type poliovirus circulating in western Africa. That case had illustrated the challenges posed by globalization in controlling communicable diseases and had highlighted the crucial importance of active surveillance in the process, even where immunization coverage was extensive. The case had also prompted the country to examine the effectiveness of its eradication strategies. As a result, improvements were being made in vaccine and cold-chain management, logistics and surveillance. Resources had been mobilized internally and generous technical and material support had been provided by UNICEF and WHO. A nationwide house-to-house immunization campaign would be carried out in two phases during the current year in order to interrupt viral transmission. Laboratory tests had shown no evidence that the virus had been passed on to any of the child's contacts. Her Government was fully committed to the goal of global poliomyelitis eradication and deemed it achievable with continuing support from WHO and other partners.

Mr GAO Qiang (China) welcomed the progress towards global eradication of poliomyelitis through the efforts of WHO and its Member States. In 2000 his Government had applied for poliomyelitis-free certification, but had difficulty in retaining that status owing to the risks of both importing the virus and the spread of a vaccine-derived strain. A high immunization coverage with oral vaccine would therefore be maintained and surveillance tightened. WHO should continue to provide financial support for countries, including China, which faced problems from transmission of vaccine-derived viruses. WHO should, as soon as possible, formulate a vaccine strategy to be implemented once wild-type poliovirus had been globally eradicated.

Dr OLIVEROS (Philippines) observed that certification of a country as poliomyelitis-free signified not the end of the battle against the disease but the start of a more aggressive effort to maintain that status. More resources must therefore be devoted to maintaining high-level immunization coverage, strict vigilance against viral importation, and certification standards, and to ensuring acute flaccid paralysis surveillance. Countries certified free of the disease should allocate funds to, and be ready to embark on, an immediate and massive immunization response in the event of the poliovirus being imported or an outbreak of vaccine-derived poliomyelitis, as had happened in the Philippines. A standard outbreak-response procedure was essential for containing such outbreaks.

Mr FARIA DE BRITO (Cape Verde) congratulated WHO on its efforts to combat poliomyelitis. His country strongly supported the Global Poliomyelitis Eradication Strategic Plan for the period 2004 to 2008 and, with the support of WHO, was about to introduce injectable vaccine.

Dr MBAIONG (Chad) welcomed the news of the voluntary contributions pledged by the international community for poliomyelitis eradication. The disease was a matter of great concern to Chad, hence its determination to wage an all-out war against it. Although the countries around Lake Chad were high-risk areas for poliomyelitis, active international cooperation in the near future should soon kick the disease out of the region.

Dr AWOSIKA (Nigeria) reaffirmed her Government's commitment to eradicate poliomyelitis and to implement measures to achieve poliomyelitis-free status by December 2004. All tiers of government were involved in those efforts. Advocacy and mobilization campaigns in the countries' different zones had been mounted. The active participation of all partners and stakeholders had been

sought. National meetings of Commissioners for Health and Directors of Primary Health Care had been held and key resolutions adopted to ensure achievement of the poliomyelitis eradication initiative goals. The coordination of partnerships at national and international levels had been improved and the initiative's four strategies were being implemented with a focus on ward-by-ward microplanning. Preparations were under way to recommence supplementary immunization in Kano State, which had become an epicentre for the transmission of wild-type poliovirus after the suspension of earlier campaigns.

Nevertheless, difficulties remained. The effectiveness of national immunization days would have to be improved in order to ensure that every child up to the age of five was vaccinated in the current year. Increased funding was required for the monitoring and supervision of all supplementary immunization programmes and for early support for states and local government. Her Government hoped that all bodies within the United Nations system and donor countries would continue to offer support and partnership so as to ensure that Nigeria could be freed from poliomyelitis.

Mr SHARMA (India) said that his Government was deeply committed to the eradication of poliomyelitis. The initiative to stamp out the disease in his country had made substantial progress since its start in 1995. The number of cases had declined sharply from almost 2000 in 1998 to eight in the current year. The current low level of viral transmission offered a great opportunity to achieve the goal. For 2004, five nationwide rounds of vaccination were planned, covering all the vulnerable states including the traditional reservoir areas. They would be followed by mop-up action on an unprecedented scale. There was tremendous political and administrative backing for the programme to stop poliovirus transmission by 2005. Any cases reported in the latter half of the year would be treated as a public health emergency.

Professor SZCZERBAN (Poland) said that an acute flaccid paralysis surveillance programme meeting WHO requirements called for a uniform system of reporting, collection and examination of samples and for adequate national and international communication procedures. On the basis of adequate documentation of cessation of wild-type poliovirus transmission, Poland, along with other countries of the European Region, had been certified free of poliomyelitis on 21 June 2002. However, it was essential to continue good-quality surveillance of acute flaccid paralysis and to maintain high vaccination coverage in view of the risk of importation of wild-type poliovirus, which would necessitate urgent action to prevent an outbreak of poliomyelitis. There was growing evidence that vaccine-derived strains with increased neuropathogenicity posed a serious threat to eradication of the disease. To ensure that cases of acute flaccid paralysis were not poliomyelitis, all surveillance procedures should remain in place, with a sensitivity of detection of 1 case in 100 000 children under 15 years of age, timely collection of two stool samples and virological examination of those samples in the WHO-accredited National Poliovirus Laboratory (which was mandated to renew its accreditation each year). Gradual replacement of oral poliovirus vaccine containing live, attenuated polioviruses with the inactivated vaccine was under way. The inactivated vaccine had been introduced for the first three doses; oral vaccine was still being used for the two supplementary doses.

Dr AMATHILA (Namibia) said that Namibia had been poliomyelitis-free since 1995 and had met WHO's standards for certification on acute flaccid paralysis surveillance in 2003, but it would continue to strengthen its surveillance system and continue with its "Kick Polio out of Namibia" campaign. He thanked WHO for its tireless support.

Ms BOLORMAA (Mongolia) congratulated WHO on its successful leadership in the bid to eradicate poliomyelitis. Mongolia had been certified poliomyelitis-free but would continue to improve prevention, owing to the increased risk arising from globalization. She asked WHO to provide information on outbreaks in other countries for the sake of timely response. Her country was fully committed to global efforts to eradicate the disease.

Dr ACHARYA (Nepal) said that Nepal had introduced an Expanded Programme on Immunization in 1979 with two antigens in three districts, extending it by 1988 to cover all 75 districts of the country with the six globally recommended antigens. Nepal had joined the Global Polio Eradication Initiative in 1996 and had been conducting supplementary immunization activities ever since. "Polio Eradication Nepal" had been established in collaboration with WHO in 1998 and currently had 14 field surveillance offices. Passive surveillance was conducted by 398 networked health facilities. Three committees specifically dealt with poliomyelitis eradication. Fifteen cases of poliomyelitis due to wild-type poliovirus had been detected since 1995, most recently in November 2000. Nepal had met WHO's standards since 2001 and had plans to cope with outbreaks due to wild-type poliovirus or vaccine-derived viruses. Cross-border coordination with India, by which Nepal set great store, had been functioning since 2001. Measles control and neonatal tetanus surveillance had been combined with the poliomyelitis eradication programme since 2003. Thanks to support from WHO and other agencies, Nepal was ready for poliomyelitis-free certification.

Mr DA ROCHA PARANHOS (Brazil) said that the last case of poliomyelitis had occurred in 1989 and Brazil had been certified free of the disease since 1994. Intensive efforts had been made regarding immunization, surveillance and laboratory containment of the virus. Twice yearly immunization campaigns vaccinated more than 16 million children to keep the country poliomyelitis-free and minimize the risk of importation. More recently, routine immunization coverage had been stepped up to avoid the accumulation of clusters of susceptible children. Brazil supported the proposals for the eradication of poliomyelitis by the end of 2004 and agreed that wild-type poliovirus transmission must be interrupted in the six remaining countries where poliomyelitis was endemic through high-quality immunization programmes and appropriate surveillance. National and international commitment and resources were essential to that goal. Brazil commended WHO's strong leadership and supported the Global Polio Eradication Strategic Plan for the period 2004 to 2008.

Dr LOUM (Senegal) said that the various strategies used to eradicate poliomyelitis had given satisfactory results in his country. No wild-type poliovirus had been recorded since 1998 and the surveillance of acute flaccid paralysis had performed well since 2001. The African Regional Certification Commission had asked Senegal and seven other African countries to submit a document with a view to wild-type poliovirus-free certification. Senegal would, however, continue to strengthen epidemiological surveillance and routine vaccination with the aim of achieving 80% coverage in all districts by December 2004. It also needed to prepare an effective response to the possible importation of wild-type poliovirus. He invited the international community to increase its support to the few remaining countries with poliomyelitis so that, by December 2004, a further step could be taken towards eradication.

Dr MOHAMMED (Oman) commended WHO's efforts to eradicate poliomyelitis and expressed support for the amended strategy for 2004-2008. It was most important to make that final push mentioned in paragraph 3 of the report. Referring to paragraph 9, he said that so long as the virus continued to exist it would represent a danger to all neighbouring and even more distant countries since the wild-type poliovirus could spread quickly. Efforts should be made to find the most suitable approaches to wipe out the virus. Surveillance also needed to be intensified and countries must remain vigilant. Oman thanked WHO and its partners for their help and hoped that the Eastern Mediterranean Region would soon join the three regions already certified poliomyelitis-free.

Dr TAPIA HIDALGO (Chile) said that his country's immunization programme enjoyed the legal, political and economic support of the Government and that the population was aware of the benefits of vaccination. As a result, Chile had in 1975 been the third country in the world to eradicate poliomyelitis. It was currently continuing to use the oral vaccine until the technical bodies concerned stated that it should cease vaccination, as had happened in the case of smallpox. It was also continuing

surveillance for acute flaccid paralysis. It was important for WHO to support the eradication of the wild-type poliovirus even in countries and regions certified free of the disease.

Dr MATIUR RAHMAN (Bangladesh) commended WHO's efforts to ensure the global eradication of poliomyelitis. Because of the high cost of treatment Bangladesh had always given priority to prevention. It had an effective Expanded Programme on Immunization and had been free of poliomyelitis since 2000. Unfortunately, the South-East Asia Region had not yet been declared poliomyelitis-free, which meant that Bangladesh would have to wait a while for certification. He stressed the need for strong cross-border cooperation and was confident that WHO would continue to provide technical support to keep the region poliomyelitis-free. His country had engaged 600 000 health workers, including doctors and nurses, in its national immunization days programme and had achieved 97% coverage with oral poliovirus vaccine. Coordination with programmes for vitamin A supplementation and deworming had produced commendable benefits.

Dr LEWIS BELL (Jamaica) commended WHO's work in the fields of immunization and poliomyelitis eradication. Jamaica and other countries in the Caribbean had been poliomyelitis-free since 1982 but globalization brought with it the risk of reimportation. For that reason adequate supplies of oral poliovirus vaccine, whose stocks might be affected by intensified action for national immunization days in the remaining endemic countries, must be ensured. She endorsed Botswana's call for maintaining high levels of coverage and timely surveillance. As global eradication drew closer, the containment of wild-type poliovirus and the transition from an oral to an injectable inactivated vaccine became crucial. She thanked WHO for its support but felt that more work was needed to increase public awareness about vaccine-safety issues at a time of growing anti-vaccine sentiment.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the WHO strategy for the global eradication of poliomyelitis had been a great success since the disease remained endemic in only six countries, three of which accounted for 96% of all cases. The report mentioned the new strategic plan for 2004-2008 with its four proposed major objectives. To ensure eradication, however, two critical factors had to be considered. Because replacement of the oral vaccine by an inactivated poliovirus vaccine would increase costs about 10-fold, financial help was needed to ensure 95% coverage in the poorest countries. At the same time, secure laboratories would be needed to ensure containment of wild-type poliovirus, whose escape would have potentially catastrophic consequences. In Cuba, poliomyelitis had been eradicated in 1962; 10 vaccines (three produced in Cuba) were used to protect its children from 13 diseases, with an immunization coverage of 95%, resulting in the eradication of six diseases by the mid-1990s. The strategy for 2004-2008 should enable poliomyelitis to be the second disease eradicated from the face of the earth.

Dr SAM (Gambia) said that the Gambia had had no case of poliomyelitis due to wild-type or vaccine-related poliovirus for two years, despite the active investigation of all suspected cases. All the documentation required for certification had been forwarded to WHO. Gambian experts had been helping other countries of the subregion to eradicate the disease. One additional advantage of the Global Initiative was its contribution to the strengthening of national surveillance systems for other diseases and immunization programmes for other vaccine-preventable diseases. All such programmes should help to strengthen health systems so that the country's health as a whole could benefit from the various initiatives.

Dr FAIHUN (Benin), speaking of behalf of Member States in the African Region, welcomed the progress made by most States towards eradicating poliomyclitis. However, the persistence in some countries of the wild-type virus seriously threatened the eradication of poliomyelitis in the African Region. The reduction in external funding and personnel for poliomyelitis eradication hindered progress. The number of countries conducting supplementary immunization campaigns in the Region had dropped from 33 in 2002 to 12 in 2003 and the low coverage in several countries was endangering

the poliomyelitis-free status of other countries. The Region was committed to maintaining a high level of immunization coverage and strengthening routine vaccination; to maintaining high-quality surveillance of acute flaccid paralysis in each Member State to ensure that local or imported cases of poliomyelitis were rapidly detected and contained; and to using the experience gained from poliomyelitis eradication to strengthen control over other communicable diseases. He exhorted the Director-General to plead for increased and sustained financial resources from international partners to finance poliomyelitis eradication and routine vaccination, to ensure that funding needs were satisfied in time, and to offer timely technical support to Member States for additional activities to eradicate the remaining reservoirs of wild-type poliovirus, and he urged international partners to provide that necessary financial support.

Dr HUR (Republic of Korea), commending the report, said that in his country the public health infrastructure, including hospitals and private-sector facilities, had contributed enormously to the national surveillance system relating to the WHO poliomyelitis eradication programme. The Government would shortly introduce inactivated poliovirus vaccine to replace the oral poliovirus vaccine in its national immunization programme. WHO should provide updated guidelines on the use of inactivated vaccines and the surveillance of vaccine-derived polioviruses.

Dr MANGUELE (Mozambique) said that Mozambique had gradually improved its acute flaccid paralysis surveillance, thanks to an effective Expanded Programme of Immunization. After several national immunization days, no case of poliomyelitis had been found in the country for more than a decade. However, that Programme needed strengthening, particularly in view of the presence of many refugees from other countries that were affected by conflict and therefore had very deficient immunization programmes. Mozambique asked for help to improve the quality of the Programme and particularly of its poliomyelitis surveillance system. It affirmed its full support for the final push to rid the world of poliomyelitis.

Dr ZAHER (Egypt) welcomed the efforts to eradicate poliomyelitis and the assistance given by international organizations to the countries affected. Egypt had taken a major step forward, with only one case having been recorded in 2003. It was doing its utmost to become poliomyelitis-free and immunization coverage was 99%. In two door-to-door campaigns more than 10 million children under the age of five had been immunized. Surveillance and monitoring had been improved through public and private channels and no positive sample had been found since 2003. The Government gave financial and political support to the efforts to immunize children through school services and countrywide campaigns.

Dr EL RAMLAWI (Palestine) said that, before the intifada of 2000 and the ensuing political instability, Palestine had met all the performance targets for WHO's poliomyelitis eradication strategies, including acute flaccid paralysis surveillance. Subsequently, however, the poliomyelitis eradication programme had been seriously disrupted with grave consequences for Palestine and its neighbours. He therefore urged WHO to provide the necessary support to enable all the countries concerned to resume work towards their own and WHO's goals.

Mr BOSTRÖM (Rotary International), speaking at the invitation of the CHAIRMAN, said that his organization pledged continued commitment to eradicating poliomyelitis. It had been gratifying to note the dedication of the world's health leaders to achieving the goal of a poliomyelitis-free world and Rotary International fully supported their efforts. The existence of an effective vaccine meant that no child need suffer from the disease, which was why poliomyelitis eradication had been Rotary International's top priority for the past 20 years. By the time the world was certified poliomyelitis-free, the organization's contribution to the global poliomyelitis eradication effort would have reached nearly US$ 600 million. Its 1.2 million members had also spent countless hours immunizing more than 2000 million children in 122 countries. In 2003, they had raised an additional US$ 119 million in

response to an urgent call for more funding. Governments, United Nations agencies and the private sector had cooperated in unprecedented ways to prevent the virus from spreading across borders. An astonishing US$ 3000 million had been provided by donor governments, foundations and private citizens. Volunteers and health workers had lost their lives trying to reach children in conflict areas. As a result of their efforts, significant progress had been made: in 1988, about 1000 children in 125 countries had been infected with poliovirus every day; in 2004, poliomyelitis had been eliminated from all but six countries. Yet completing a historic health initiative would be the most challenging phase; the opportunity, if missed, would almost certainly not recur. If the last endemic pockets, stubbornly entrenched and spreading, were not eradicated, the disease would again spread rapidly and cripple hundreds of thousands of children each year as in the past.

Rotary International extended its appreciation and admiration for WHO's prioritization of global poliomyelitis eradication and offered its support in the final push towards a poliomyelitis-free world.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) thanked delegates for their comments and the financial and technical partners, especially Rotary International, for their extraordinary efforts to mobilize increased resources. He also thanked the countries that had provided additional funding in response to the commitments of the G8 countries and the Organization of the Islamic Conference in 2003. Following the African Union discussions, which had resulted in a decision to conduct synchronized campaigns in 22 African countries, WHO and its partners intended to work with countries in central and western Africa to budget those activities accurately. An emergency appeal would be launched within two weeks. Unless additional funding was forthcoming by August 2004, half the 22 countries would be unable to begin activities in October and November as planned.

WHO and UNICEF were markedly increasing their technical assistance to affected countries; the poliomyelitis-free countries were encouraged to do the same. The first priority of the new strategic plan was the interruption of poliovirus transmission. The plan also outlined an explicit programme of work to ensure that the infrastructure established for poliomyelitis eradication fully contributed to broader disease-control initiatives over the period 2006-2008. It reaffirmed the need to strengthen routine immunization systems, and to extend the surveillance and laboratory capacity that had been established for poliomyelitis eradication to other communicable diseases. The plan also placed greater responsibility on countries to decide whether to continue poliomyelitis eradication campaigns. It recommended that campaigns be conducted only in countries where routine immunization coverage was thought not high enough to prevent transmission of imported virus. Countries would also have greater responsibility in deciding on policies after cessation of use of oral poliovirus vaccine. Guidelines were being developed to provide information and evidence for countries to use in formulating post-eradication immunization policies. The strategic plan also emphasized the need for cross-regional representation in certification committees, to enable them to base their recommendations and guidelines on epidemiological data. Finally, ongoing research by WHO and its partners was providing a firm scientific understanding of the risks associated with circulating vaccine-derived polioviruses and their long-term excretion by immunodeficient people. That research would also provide the evidence necessary for post-eradication policies. As progress towards poliomyelitis eradication continued, recommendations would be submitted to the Executive Board on all elements of post-eradication policy, such as global surveillance and notification, vaccine stockpiles and response to suspect cases of poliomyelitis, containment of all strains of poliovirus, and cessation of use of oral poliovirus vaccine, including the guidelines which were being developed. Smallpox had been certified eradicated in 1980. However, in 1981 a new infectious disease, AIDS, had been recognized and, in 1984, it had emerged that smallpox vaccines could not safely be used on people infected with HIV. A great opportunity would have been lost if smallpox had not been eradicated in 1980. The world had the opportunity, during the forthcoming eight months, to interrupt poliovirus transmission. Success depended on full technical and financial partnership between endemic and poliomyelitis-free areas.

The Committee noted the report.

Global strategy on diet, physical activity and health: Item 12.6 of the Agenda (Resolution EB113.R7; Document A57/9)

Dr MODESTE-CURWEN (representative of the Executive Board) said that at its 113th session the Board had considered the draft global strategy and had agreed to provide an additional period for comments by Member States, until 29 February 2004. It had also been agreed that the draft strategy would be amended after consideration of those comments. The resulting revised draft strategy had been sent to Member States and put on the WHO web site on 19 April 2004.

Dr Slater took the Chair.

Mrs BELLA ASSUMPTA (Cameroon) said that Africa was not spared the diseases linked to lifestyle and diet. She suggested amending subparagraph 2(4)(c) of the draft resolution to refer simply to "process and output indicators" (*indicateurs de processus et de résultats).*

Dr KIELY (Ireland), speaking on behalf of the 25 Member States of the European Union, the candidate countries Bulgaria, Romania and Turkey, and the countries of the Stabilisation and Association Process and potential candidate countries Albania, Bosnia and Herzegovina, Croatia, Serbia and Montenegro, and The former Yugoslav Republic of Macedonia, said that the draft global strategy on diet, physical activity and health would be a valuable resource to Member States in confronting the range of factors giving rise to noncommunicable diseases. The text, revised in the light of comments from Member States since the previous session of the Executive Board, offered a balance between the various viewpoints expressed. The role of industry, and especially that of transnational corporations, should be considered more closely. The European Union supported the draft resolution in resolution EB113.R7, and recommended that the Health Assembly should endorse the global strategy. The draft resolution should request the Director-General to report to the Fifty-ninth World Health Assembly on the implementation of the strategy.

Dr OTTO (Palau) supported the global strategy. Palau had a population of only 20 000 people, but nearly half the children aged 10 to 14 years were overweight or obese. Because six out of the 10 leading causes of death and disability were related to noncommunicable diseases patients were referred abroad for health-care services, at a cost of more than US$ 2 million a year.

He supported the draft resolution, subject to certain amendments to reflect the principle of accountability through a code of marketing; the protection of policymaking from undue influence; the need to preserve and protect healthy indigenous foods; and the need to ensure that all concerned with the implementation of the strategy were committed to its aims. In the sixth preambular paragraph, the words "in the global strategy on infant and young child feeding and the Framework Convention on Tobacco Control" should be inserted after "demonstrated". In paragraph 2(5), the words "engage them actively" should be replaced by "define their appropriate specified roles in keeping with the principles for avoidance and management of conflict of interest". In paragraph 3, the word "to" after "programmes" should be deleted. The words "join and support" should be replaced by "cooperate with", and the words "the promotion of" should be replaced by "to safeguard and uphold standards of". In paragraph 5(1), the words "including international marketing, including advertising of food" should be inserted after "support", and the words "when requested" should be deleted. In paragraph 5(4), the words "promoting healthy diet and physical activity" should be replaced by "to protect, preserve, promote and develop healthy sustainable indigenous and traditional food systems together with sustained physical activity throughout life". In paragraph 5(5), the words "committed to reducing" should be replaced by "in order to ensure their individual and collective commitment to the aims and objectives of the strategy and to reduce". He called on Member States to support the strategy and to implement it without delay.

Mr DA ROCHA PARANHOS (Brazil) expressed his support for the revised draft global strategy and the draft resolution. Although Brazil was aware of the possible trade implications of implementing the global strategy, paragraph 2(1) of the draft resolution adequately addressed that concern by referring to national circumstances, policies and programmes. There was still room for improvements in the text of the strategy, especially in paragraphs 10, 22, 47, 49 and 61. He proposed that it be further reviewed by an informal group composed of the main stakeholders, whose mandate would be to analyse suggested improvements to the strategy with a view to ensuring its adoption during the current Health Assembly.

The CHAIRMAN said that, in the absence of any comment, he took it that the Committee accepted that proposal.

Mr SEADAT (Islamic Republic of Iran) said that his country was committed to reducing the global health, human and economic burdens resulting from largely preventable noncommunicable diseases. Given the strong requirements of the multilateral process, a strategy that was comprehensive, balanced and flexible would enjoy wide support among Member States. There was room for compromise and for further improvement of the draft text, with more emphasis on undernutrition, infectious diseases and the socioeconomic implications of the strategy. The current draft acknowledged the need for a multidisciplinary and multisectoral approach. Such an approach should be followed in developing the strategy, not only when implementing it. Health was strongly influenced by the socioeconomic environment, but it should be recognized that interventions to improve health could also affect that environment. He welcomed the fact that the strategy offered a set of recommendations from among which Member States could choose their preferred option. He was aware that, although Members would decide on the strategies that were important for the health of their citizens, WHO's role would be crucial. His delegation would participate in the proposed working group.

Mr KAMARUZZAMAN (Indonesia) emphasized the role of the future global strategy in promoting human well-being and preventing noncommunicable diseases. His Government had introduced a nutrition programme intended to prevent, reduce and alleviate both undernutrition and overnutrition. The programme would be adapted in line with WHO's global strategy. His Government was committed to overcoming malnutrition by improving communication and education about nutrition and health throughout the community, and had enacted legislation for that purpose. The Ministry of Health had developed national policies and strategies for the prevention and control of noncommunicable diseases in line with the draft global strategy. One future priority would be to disseminate basic nutritional knowledge and the principles of a balanced diet. WHO, the United Nations and other international partners might support the development of such programmes in Member States, and provide technical assistance for them.

He urged developed countries to support efforts to improve the competitiveness of agricultural products, such as fruit, vegetables and legumes, which contributed to food security and to poverty alleviation. Developed countries should remove trade-distorting subsidies which threatened the growth of agro-industries and the welfare of small farmers in developing countries. He called upon all Member States to support the draft global strategy.

Mr LEPPO (Finland), speaking on behalf of the Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), underlined the importance of the proposed global strategy to public health. He commended the wide-ranging consultations on the strategy and the efforts to maintain transparency. According to *The world health report 2002*,[1] six of the eight leading causes of death were linked to

[1] *The world health report 2002. Reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

poor diet and physical inactivity. Compared with the cost of treatment, the promotion of a healthy diet, physical activity and a healthy lifestyle was a cost-effective public health measure. Good nutritional status helped to prevent infectious diseases. Since the mortality and morbidity caused by cardiovascular disease were largely due to health inequalities, the proposed global strategy could also help to bring about greater equity in health. The strategy was based on strong scientific evidence, consistent with the current Nordic recommendations on diet and physical activity. It made clear that governments and communities played a key role in preventing obesity and other major nutritional risk factors. Governments should provide the tools for individuals to make healthy choices.

He welcomed the linking of the strategy with the issues of undernutrition, overnutrition and unbalanced nutrition. Hunger, undernutrition and micronutrient deficiencies were still major challenges, and were connected with the broader issues of poverty, development and health.

Countries were free to adapt the draft strategy to local needs and situations. Over the past few decades, all the Nordic countries had taken action along the lines proposed. Finland had reduced mortality from cardiovascular disease; Norway had acquired considerable experience in nutrition policy, and was emphasizing physical activity; and Denmark had launched a national action plan against obesity in 2003. Nevertheless, more work was needed in all the Nordic countries, and international collaboration would be required, under the global leadership of WHO.

He appreciated the broad approach of the draft strategy and its emphasis on multidisciplinary and multisectoral collaboration and the creation of national and local partnerships. Following the lengthy process of consultation and the incorporation of final comments from Member States, the Nordic countries felt strongly that the text of the draft strategy should not be reopened for negotiation.

The adoption of the strategy would be only a first step. Its success would depend on implementation through regional and national strategies and action plans, for which, it was hoped, WHO would provide resources.

He proposed the addition of a new paragraph 5(6) to the draft resolution, to read: "to report on the implementation of the strategy at the Fifty-ninth World Health Assembly".

Dr RAMSAMMY (Guyana), speaking on behalf of member countries of the Caribbean Community, expressed gratitude for the work on the draft global strategy. In 2001, the governments of those countries had adopted the Nassau Declaration on Health, which listed prevention of chronic diseases as one of three key strategies for development. In most countries of the region, the burden of disease had shifted: infant mortality and deaths from communicable diseases had been reduced, although the decline in mortality from HIV/AIDS had only begun with the increasing availability of antiretroviral drugs. In contrast, premature morbidity and mortality due to chronic noncommunicable diseases, including cancer, were on the increase. The heads of government of the countries in the Community had, therefore, undertaken to define a regional strategy by 2005, with the support of PAHO/WHO. Regional programmes had been drawn up, including the Caribbean Lifestyle Initiative, modelled on existing programmes in Latin America and Europe. The Caribbean Food and Nutrition Institute, a PAHO agency dealing with the nutritional needs of people in the Caribbean, prepared dietary and exercise guidelines for the region consistent with the proposed global strategy. However, all those programmes would require more resources than regional governments alone could provide. He called on WHO, acting in concert with other stakeholders, to persuade the donor community to invest in the prevention of chronic diseases and the promotion of healthy lifestyles.

While endorsing the objective of the draft global strategy, he raised concerns that the revised version reflected too closely the report of the joint WHO/FAO Expert Consultation on diet, nutrition and the prevention of chronic diseases,[1] which some believed lacked scientific rigour. Despite the best efforts of the Secretariat, the link between the two documents persisted. Deleting the footnote to

[1] WHO Technical Report Series, No. 916, 2003.

paragraph 21 (document A57/9, Annex) would enable the members of the Caribbean Community to endorse the draft strategy.

Guyana and Jamaica were concerned that their sugar industries, which provided many jobs, might be threatened by an internationally-imposed ceiling on sugar imports aimed at curbing individual sugar consumption. Developing countries did not have the kind of safety-net available to societies in developed countries, and such a move might prove disastrous for wage-earners, peasant farmers and the economy as a whole. The revised draft strategy showed that endeavours had been made to tackle such concerns, and the flexible wording of the new version would enable many Member States to join a consensus to support it, subject to certain amendments. The revised draft recognized that it was for governments to formulate national implementation strategies in line with their own circumstances, objectives and timescale. States were responsible enough to implement the general tenets of the draft strategy.

He supported the broad principles underlying paragraph 47 of the draft strategy, relating to national food and agricultural policies, but WHO must not let its recommendations be used as a pretext for creating trade barriers. Paragraph 47(2), on fiscal policies, should be deleted.

He welcomed the continued efforts to monitor the available evidence base and to provide technical guidance to countries in the formulation of national programmes and plans of action. Intersectoral collaboration was needed at a national level, as well as collaboration with other organizations in the United Nations system, the World Bank and other development partners.

Given the amendments he had suggested, the draft strategy could be adopted by consensus. Otherwise, it would be prudent to allow more time for discussion. The draft strategy was an important weapon in the fight against chronic diseases. To avoid dissension, it would be better to remove those aspects that discomfited certain countries.

Mr JUGNAUTH (Mauritius) said that, as Minister of Health in his Government, he had tried to increase awareness of the problem of noncommunicable diseases, especially in developing countries. In Mauritius, the most recent quinquennial survey of noncommunicable diseases had shown that among people over 30 years of age 20% were diabetic and 30% suffered from hypertension; of the whole population 40% were overweight or obese and 70% did not engage in any physical activity; 50% of deaths were due to cardiovascular disease.

Noncommunicable diseases, which were on the increase because of changing lifestyles worldwide, imposed a huge economic burden and might, in the future, cause more deaths than HIV/AIDS. The measures proposed were consistent with the solutions adopted in Mauritius. However, it was not easy to encourage people to change their lifestyles, eating habits and patterns of physical activity.

He fully supported the draft global strategy but held reservations about the current text. The report of the joint WHO/FAO consultation on diet, nutrition and prevention of chronic diseases[1] was controversial and had been extensively criticized by the Executive Board and the FAO Committee on Agriculture. Its recommendation that sugar should comprise less than 10% of an individual's total energy intake was irrational and lacked any sound scientific basis. Sugar was acknowledged to be the cheapest source of energy; limiting its consumption would reduce the caloric intake of millions of people, resulting in low body weight and malnutrition. That recommendation did not appear explicitly in the new version of the draft strategy and he had been assured that the text, in particular paragraph 22 containing dietary recommendations, was not intended to reflect the content of the Technical Report. If that was the case, he had no objection to the text.

[1] WHO Technical Report Series, No.916, 2003.

His second reservation related to paragraph 47 of the draft strategy, especially the subparagraphs on fiscal and agricultural policies. As Minister of Health, he had no power to dictate those policies; nor did WHO have such powers. That paragraph should be amended.

His delegation was willing to participate in the proposed informal consultation group.

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

The meeting rose at 17:50.

FOURTH MEETING

Thursday, 20 May 2004, at 09:00

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)

1. FIRST REPORT OF COMMITTEE A (Document A57/39)

Mrs VAN BOLHUIS (Netherlands), Vice-Chairman, read out the draft first report of Committee A.

The report was adopted.[1]

2. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Global strategy on diet, physical activity and health: Item 12.6 of the Agenda (Resolution EB113.R7; Document A57/9) (continued from the third meeting)

The CHAIRMAN said that the complexity of the topic had been reflected in the informal discussions held the previous evening. He suggested that a drafting group chaired by the delegate of South Africa should meet after all the interventions to work on the draft resolution, which would be reconsidered the following day.

It was so agreed.

Mr SHARMA (India) said that in India lifestyle-related noncommunicable diseases were becoming increasingly prevalent, in both urban and rural areas. His Government was committed to reversing that trend through the adoption of a multisectoral strategy. It fully supported the objectives of the draft strategy and endorsed the text with its focus on providing information to promote lifestyle changes, subject to several observations. Strategies must be country-specific; there was no scope for developing any legally-binding convention such as the WHO Framework Convention on Tobacco Control. Malnutrition, endemic in developing and least-developed countries, was not taken into account in the draft, but must be addressed in national strategies. Countries should themselves designate appropriate intakes of sugar, salt and fat. It might not be feasible or appropriate to seek to influence diet through fiscal and market policies, or to tax foods consumed by poor people. Subsidies on food items might have implications for commitments made by Member States to WTO agreements. WHO and FAO should promote measures to encourage the consumption of healthy foods and to strengthen national capacities for implementing policies and programmes for that purpose.

Ms GILDERS (Canada) endorsed the revised draft global strategy, agreeing with the comments by the delegate of Finland at the previous meeting. The text was not prescriptive, offering instead a range of policy options that could be adapted to local requirements. She had noted the concerns expressed by various Member States, which should be dealt with in the resolution or through another mechanism. She called on Member States to endorse the strategy in its current form, and to undertake

---

[1] See page 238.

to develop national action plans to target unhealthy diet and physical inactivity in line with the policy options presented. Failure to act promptly on the strategy would result in an increased toll on human health and in mounting health costs, particularly for those countries least able to afford it.

Dr VIOLAKI-PARASKEVA (Greece) affirmed the importance of strengthening, expanding and reorienting nutrition programmes. Countries must set nutritional targets in accordance with WHO guidelines, and monitor and evaluate the effectiveness of the policies adopted in order to achieve them. Consumption of energy-dense, nutrient-poor foods rich in fat, sugar and salt posed an increasing risk of noncommunicable disease and adversely affected quality of life. That situation was compounded by the trend towards more sedentary lifestyles; indeed, in many countries the degree of physical inactivity was such that a diet adequate in micronutrients would inevitably lead to excessive body weight. Greece fully agreed with the guidelines set out in the draft global strategy, as the prevention of diet- and inactivity-related noncommunicable diseases was of vital importance in public health policy-making. She emphasized the need for a multisectoral approach involving all the government departments concerned, and for information campaigns to raise public awareness of healthy behaviour and dietary hazards. In 2002, Greece had set up a multisectoral National Committee on Dietary Policy; other countries might follow its example. Indeed the Greek or "Mediterranean" diet, based on olive oil and vegetables, might be considered the ideal.

Dr LOUMÉ (Senegal) welcomed the draft global strategy. A health policy to combat the increasing prevalence of diet-related noncommunicable diseases was a key element in developing the human resources required for economic and social development; good diet and physical activity were crucial to any health-improvement strategy. In the context of globalization, consideration should be given to ways of helping developing countries to improve their monitoring of foodstuffs, especially imported materials, and to strengthening of public-private partnerships in order to enable proper standards to be set for industrial and semi-industrial food products. The draft resolution should mention undernutrition, which was a major concern of countries like his. He proposed the insertion of two new paragraphs. The first, to follow the seventh preambular paragraph, would read: "Aware of the need to promote mutual support between this strategy and work under way in the area of undernutrition". The second, to follow the tenth preambular paragraph, would read: "Aware of the need for special attention to be paid to developing countries, particularly with regard to financial support for the implementation of the strategy".

Mr VOKÓ (Hungary) welcomed and supported the proposed global strategy, and commended WHO's preparatory work. Unhealthy diet and lack of physical activity caused serious health problems in his country. In April 2003 Hungary had launched a 10-year public health programme, one element of which dealt with healthy nutrition and food safety. Its three main areas of action were: raising the awareness of the general public and schoolchildren, and training persons working in mass catering; supporting the production and marketing of healthy foods; and improving food safety. A national policy on diet and physical activity was being prepared.

Mr GAO Qiang (China) commended the excellent work and endorsed the draft resolution. In view of the risks to health they posed, noncommunicable diseases must be controlled and prevented through diet and physical activity. China supported the draft global strategy. Some countries were experiencing problems related to poor diets, while others were confronting hunger; each country should adopt measures appropriate to its own circumstances.

Ms HALTON (Australia) expressed strong support for the revised draft strategy, which incorporated the diverse range of views expressed by more than 50 countries and many stakeholders, and commended it to other Member States. It constituted an evidence-based framework for action to bring about changes in dietary habits and patterns of physical activity, in order urgently and decisively to alleviate a largely avoidable disease burden. She acknowledged that scientific evidence was

constantly developing and that the strategy could evolve accordingly, but stressed the need to act immediately, before the problem became too great. Much of the responsibility for implementing strategies to combat obesity lay with the private sector rather than governments, and private industry could play a valuable role. Collaboration with the food industry, leading to changes to some fast-food and manufacturing practices, had already yielded tangible results in the form of healthier, affordable alternatives for consumers.

In order to reduce the risk and incidence of noncommunicable diseases associated with overweight and obesity, Australia had set up a national obesity task force, published a national agenda for tackling childhood obesity, and adopted national guidelines for physical activity and diet and clinical practice guidelines for general practitioners for the management of overweight and obesity. The dietary guidelines recommended the consumption of only moderate amounts of sugar.

Member States were expected to implement the strategy in a manner consistent with their national policies. Australia would commit funds to assist WHO with its implementation.

Dr SHRESTHA (Nepal) endorsed the draft global strategy, subject to several observations. Data from developing countries on noncommunicable diseases were limited, most existing data being generated from developed countries. It was important to study the effects of a high prevalence of those diseases in conditions of undernutrition and poverty, and he encouraged developing countries to attach high priority to gathering data on noncommunicable diseases. Secondly, intervention in the area of diet and physical activity must take into account local cultural factors. Thirdly, the high rate of urbanization in developing countries had lifestyle repercussions that must be taken into consideration. Fourthly, existing disparities between rich and poor, male and female, and urban and rural populations were matched by an information divide: only the privileged few in developing countries had access to up-to-date scientific knowledge, while the majority, especially poor and vulnerable groups, lacked even the most basic health information. A communication strategy must be developed in order to improve understanding of the issues of diet, physical activity and health.

Dr AMATHILA (Namibia) welcomed the draft global strategy and the draft resolution. In 1998 Namibia had developed nutrition guidelines that were widely used in the health, education and agriculture sectors. In 2003 a programme had been introduced on noncommunicable diseases, which were becoming increasingly prevalent, with the aim of drawing up a strategy for their prevention and control, within the framework of the WHO global strategy. Surveillance of noncommunicable diseases and their risk factors was an essential element in planning and evaluating the programme. The focus was on collecting the data required for monitoring their impact and predicting the future caseload. Such data were not yet available in Namibia, but a national survey would be carried out for that purpose in October 2004. Namibia was developing a comprehensive information, education and communication strategy to raise public awareness about noncommunicable diseases.

Dr MATIUR RAHMAN (Bangladesh) approved the draft global strategy, which was highly relevant to the prevention of noncommunicable diseases, and welcomed the change in emphasis from communicable diseases, particularly in relation to developing countries. In addition to the more obvious problems besetting developing countries such as infection, malnutrition and overpopulation, often compounded by superstition, ignorance, illiteracy and natural or man-made disasters, Bangladesh, like other countries, was witnessing increased prevalences of noncommunicable diseases, such as heart disease. In view of the difficulty of bringing about change in dietary habits, the global strategy was not so much a "prescription" for imposing change on countries as a broad-based initiative that would be multisectoral, multifaceted and adapted to the needs of individual countries. Bangladesh had taken several measures to control tobacco use, having recently ratified the WHO Framework Convention on Tobacco Control. In working towards the prevention of noncommunicable diseases, developing countries would need assistance from WHO and other multilateral agencies.

Dr PAPANTONIOU (Cyprus) expressed appreciation for the draft global strategy, which was particularly relevant to Cyprus. Like many countries that had recently made the transition from an agricultural economy to one based mainly on services and industry, Cyprus had lost in a few decades the benefits of healthy dietary habits and an active existence incorporating physical activity as part of the daily routine. Its healthy Mediterranean diet had been largely replaced by diets rich in energy, animal fat, and sugar and poor in fibre. That change had been accompanied by a major increase in noncommunicable diseases, which currently accounted for most mortality and morbidity in the country. High concentrations of cholesterol and obesity were becoming increasingly prevalent at ever younger ages, while a sedentary lifestyle, smoking and stress were further contributory factors.

In response, the Government had developed a multisectoral strategy designed to motivate Cypriots to adopt healthier lifestyles. A national committee on nutrition, bringing together all relevant governmental and nongovernmental sectors, was responsible for implementing the strategy, which took an integrated approach targeting the individual at all stages of life. Maternal and neonatal health was protected by high-quality care, including nutrition counselling, and breastfeeding was actively promoted, while in schools healthy nutrition was being promoted through campaigns and lectures. Programmes targeting children included an evaluation component and had revealed high levels of unhealthy eating habits, lack of exercise, obesity and high blood concentrations of cholesterol. Those findings would guide future activities for health promotion through structured programmes aimed at building the right attitudes and behaviour towards diet and physical exercise. The quality of school meals had also been improved.

The ministries of agriculture and health were implementing an education programme for women in rural areas that included promotion of healthy nutrition in the family. Programmes targeting the general population promoted the Mediterranean diet and consumption of fibre. An "Exercise for All" programme invited people to participate in physical exercise and healthy eating, but a more integrated and intersectoral approach was needed, which would, for instance, make urban transport more friendly to the physical environment and to pedestrians and cyclists.

The Ministry of Health was planning to redefine the present strategy for diet and physical activity on the basis of a holistic approach to a broad range of health determinants related to both communicable and noncommunicable diseases. The revised strategy would bring together and upgrade a whole range of existing strategic plans, including the plan for tobacco control, based on the WHO Framework Convention on Tobacco Control. Her country was grateful to WHO for its continuing guidance and support.

Dr ABIDIN (Brunei Darussalam) said that the leading causes of death in his country were noncommunicable diseases, namely cardiovascular disease, cancer, cerebrovascular disease and diabetes mellitus. The prevalence of obesity was high. According to the National Nutrition Status Survey (1997-1999), 32% of adults were overweight and 12% were obese, while 20% had high cholesterol levels, 5% had high sugar levels and 10% had high blood pressure. Among children aged 5 to 10 years, 6.9% were obese. In a 2001 survey of Primary 4 schoolchildren, 22% had been found to be obese, while in 2003 anthropometric screening of schoolchildren at Primary 1, 4 and 6 and Secondary 2 grades had found 11.5% to be obese. He therefore welcomed the draft global strategy. It should be country-specific and be adapted to local circumstances.

Ms BU FIGUEROA (Honduras) greatly appreciated the global strategy, since the problem of poor nutrition and lifestyle was reflected in morbidity from diabetes, high blood pressure and obesity. A multisectoral and multidisciplinary approach to policy formulation would work best in preventing risk factors and reducing rates of chronic noncommunicable disease among the Honduran population. However, the current draft text lacked detailed information on malnutrition and undernutrition while including irrelevant aspects such as labelling, fiscal policies and agricultural policies. At the implementation stage, the strategy would have to be considered in depth by other competent authorities, such as those responsible for trade, agriculture, and health. The draft did not take account

of the funding and international cooperation that would be needed for the strategy to be implemented in low-income countries.

Dr UĞURLU (Turkey) said that noncommunicable diseases were resulting in an increasing burden of mortality, disability and economic loss. Studies on early diagnosis, treatment and rehabilitation were important, but the promotion of healthy lifestyles, such as proper diet and physical exercise, was significant for reducing the emergence of those diseases. Turkey had drawn up a national food and nutrition plan, with the participation of all relevant sectors, which gave an important place to breastfeeding and child nutrition. There had been a considerable increase in breastfeeding as a result. Continuous training programmes on public nutrition had also been organized, and a project had been launched in 2001 to improve knowledge about diet and exercise in order to protect against heart disease and to measure behavioural change. His country appreciated the leadership provided by WHO, and supported the draft resolution.

Mrs NADAKUITAVUKI (Fiji) endorsed the global strategy and its policy framework, as outlined in resolution WHA55.23, and recalled resolutions WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, whose silent epidemic in Fiji claimed more lives each year than any other disease category. There was a need to identify risk factors in the population so as to ensure that effective control strategies were planned and implemented. She thanked WHO for its support in conducting the 2002 STEPwise survey in Fiji, which had helped to show how to proceed in controlling noncommunicable disease risk factors, and how to evaluate future efforts.

Iron-deficiency anaemia was common in Fiji, affecting 25% to 30% of the population. A Government initiative to fortify wheat flour with iron and other micronutrients would be launched nationally in June 2004 and should help to correct the problem and improve the dietary and nutrition status of the population. While the global strategy did mention micronutrient deficiencies, she recommended that it should specifically highlight iron-deficiency anaemia as the most predominant micronutrient deficiency disorder worldwide.

With regard to the four main objectives of the strategy, she proposed including a mention of "an enabling environment with appropriate national laws and regulations", alongside the existing statement on country policies and action plans. Fiji's recent experience, particularly with food safety and food standards laws, had shown that the fat or nutritional content of food, especially processed food, could not be controlled effectively if such laws and regulations did not exist or were out of date. Any formulation or revision of food standards must take into consideration the requirements and provisions of the Codex Alimentarius.

Dr CICOGNA (Italy) associated himself fully with the positive statement made at the previous meeting by Ireland on behalf of the European Union. He had some additional comments to make, however. The strategy must be considered in its original context of noncommunicable disease prevention, which was a top priority for all countries. With regard to the consultation process, he applauded the decision that had allowed two additional months for the submission of comments, their posting on the WHO web site and their careful review; the result was a well-balanced, comprehensive final text. The excellent process could serve as a model for other sectors and strategies.

There was no magic formula for a healthy diet, no good or bad foods, only good and bad diets. The Mediterranean diet certainly deserved thorough consideration. There was also a need to find and encourage the right balance between energy intake and expenditure. The draft global strategy was not prescriptive, but a valuable scientifically-sound reference source for the development of national plans and strategies, even though he disagreed with some of its content, for instance, the paragraph on fiscal policies. The Board's resolution was also excellent, reflecting open-ended discussions in the drafting group established at the 113th session, at which members had worked hard to arrive at a consensus. With regard to future drafting, he would prefer to see amendments submitted in writing, and he welcomed the proposed drafting group.

If endorsement of the strategy were to depend on a footnote in its text, he would appeal for deletion of such a footnote: anything that prevented or delayed endorsement of such a high-priority strategy would send a very negative message.

Mr BRUNET (France) observed that no human behaviour was more linked to culture and the economy than food habits. Even scientists had accepted such habits. Until recently, wide publicity had been given in France to the health benefits of drinking wine, as extolled by Louis Pasteur. That was no longer the case, however, as measures had been taken to regulate the consumption of a number of products of which the country was proud but whose over-consumption posed risks to public health. France was facing an epidemic rise in obesity, particularly among children; if current trends continued, within less than 15 years France would have the same obesity rate as the United States of America. A determined strategy was the only solution for preventing such a serious development. France had a national health programme that was largely consistent with the proposed global strategy, although not identical: the values used for reducing consumption of salt, sugar and fats were not the same, but the important thing was to agree on principles and a strategy, not on figures.

All Member States were aware of the need to finalize the drafting of the strategy. The proposed draft was acceptable, subject perhaps to some further minor amendments. Progress should not be held up by a footnote, however problematic; he understood the problem involved and was ready to discuss it in a spirit of flexibility in order to satisfy the legitimate concerns of other countries. He welcomed the working method proposed by the Chairman, which should make it possible to reach agreement and preserve a strategy that was adaptable to changing national circumstances.

Mrs LE THI THU HA (Viet Nam) observed that the comprehensive draft global strategy advocated an integrated public-health approach, bringing together the existing scientific data and evidence of the effects of poor diet, lack of exercise and tobacco consumption in causing noncommunicable diseases. Viet Nam faced a dual burden of communicable and noncommunicable diseases. According to 2002 statistics, cardiovascular disease was the leading cause of mortality and the sixth-ranking cause of morbidity. Hypertension had increased from 2% of the adult population in 1970 to 16.3% in 2002. A survey in Hanoi in 1999 had revealed a diabetes prevalence of 6%, five times higher than in 1991. There were estimated to be between 100 000 and 150 000 new cancer cases annually, and between 50 000 and 70 000 cancer deaths each year. The country's rapid economic growth over the past decade had been accompanied by a change in lifestyle, with smoking, alcohol and drug abuse, unhealthy diet and physical inactivity. The Government was committed to reversing that trend: it would shortly ratify the WHO Framework Convention on Tobacco Control and had recently adopted a national nutrition strategy for the period 2001-2010 and a programme for the prevention and control of noncommunicable diseases for the period 2002-2010. It had also developed food-based dietary guidelines to tackle both malnutrition and overeating.

She supported the draft global strategy and looked forward to WHO continuing to provide leadership and technical support to Member States in implementing it.

Dr DAYRIT (Philippines) fully supported the draft global strategy. Following the comments by the member for his country at the 113th session of the Executive Board, with particular reference to saturated and unsaturated fats, technical experts from WHO had held an exchange of scientific views with him on the issue. He was specifically concerned at the content of paragraph 22 of the strategy, which called for limiting energy intake from total fats and a shift from saturated to unsaturated fats. That sweeping prescription did not adequately differentiate between long-chain fatty acids, which were usually of animal origin and had been associated with cardiovascular disease, and medium-chain fatty acids, which were a main ingredient of coconut oil and had not been conclusively associated with cardiovascular disease. Coconut oil was a significant source of energy in the Philippines, where undernutrition was still a serious problem, yet there was no evidence of a particularly heavy burden of cardiovascular disease in the population. He cautioned against characterizing all saturated fats as bad and all unsaturated fats good. Some medium-chain fatty acids had antimicrobial properties; partially

hydrogenated unsaturated fats contained harmful *trans*-fatty acids. To avoid amending the global strategy, he would like to see that nuance reflected in the resolution, and would be prepared to participate in the work of the drafting group.

Dr MATHESON (New Zealand) strongly supported the draft global strategy and its recommendations. Obesity was a worldwide problem and, in many regions, was currently the biggest public health epidemic. In New Zealand, 40% of all deaths were attributable to nutrition-related risk factors, one third of the population was insufficiently active, half the adult population was overweight and 17% was obese. The strategy was based on sound evidence and considerable experience. Evidence of the size and impact of the problem was irrefutable, and the strategic approach of providing a menu of options allowed countries to adapt the strategy to their local conditions and populations, while further building the evidence base. The strategy would be a living document that evolved as global experience accumulated.

New Zealand had adopted a consistent approach, known as the "Healthy Eating Healthy Action" strategy, and was currently developing an implementation plan, with strong support from civil society, the media and industry.

The role of WHO was to provide global leadership on health, and the strategy was a tool to engage with society in improving global health. Member States must be unapologetic in their pursuit of better health, an objective that called for strong engagement with civil society and the private and public sectors. He endorsed the working method proposed by the Chairman and the reporting to the Fifty-ninth World Health Assembly on the implementation of the strategy.

Ms LAMBERT (South Africa) said that the draft global strategy was vitally important to public health, especially in developing countries. Her Government could scarcely afford the high cost of treating communicable diseases and would do its utmost to avoid the tremendous cost to its public-health budget of noncommunicable diseases and those caused by poverty and undernourishment. The strategy would provide impetus for that effort. Her Government recognized its strong scientific, evidence-based approach, and endorsed in particular the importance of a life-course perspective; the need for a broad, comprehensive and coordinated public-health effort, to include all aspects of nutrition, as listed in paragraph 29 of the draft strategy; the emphasis on considering the circumstances of the poorest people and communities; and the acknowledgement of the essential differences created by considerations of sex, culture, age and regional and local circumstances. Her Government also endorsed the strategy's broad approach, which left countries free to adapt it locally. Its adoption was only a first step and must be followed by the development and implementation of regional and national strategies and action plans. She therefore urged WHO to ensure that sufficient resources were made available to support such national and regional efforts, especially in developing countries. The strategy also emphasized the need for a multidisciplinary, multisectoral approach. While she appreciated the need to mobilize all stakeholders and create viable partnerships, guidelines would have to be drafted to prevent conflicts of interest and undue influence on the part of commercial concerns. Her Government looked forward to working nationally, regionally and internationally with the Secretariat and Member States on all aspects of nutrition, food security and healthy lifestyles.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) noted the clear identification of the lifestyle-related risk factors linked to cardiovascular disease, various types of cancer, type 2 diabetes, hypertension and other noncommunicable diseases. Given the scientific evidence of the contribution of poor diet and insufficient physical activity to mortality and morbidity from such diseases, the value of a global strategy on diet, physical activity and health was unquestionable. Because lifestyles were closely related to cultural values, however, implementation of the strategy and efforts to change eating habits must take account of cultural diversity, both between and within countries.

Although the report indicated that the draft strategy had taken into account suggestions from countries, it did not fully reflect the comments made by Cuba on the need for a more comprehensive and balanced strategy that also tackled hunger, undernutrition, micronutrient deficiencies, and access

to foods, problems also linked to noncommunicable diseases. In many developing countries they accounted for more years lived with disability and more potential years of life lost than did problems associated with overeating in developed countries. The strategy ought to take account of all aspects of the relationship between diet, physical activity and health, and the efforts and results of all WHO programmes on noncommunicable diseases should be linked.

The draft strategy included elements on which consensus had not been reached in other international forums, particularly some trade issues. It did not reflect the necessary encouragement of the industrialized countries to assist developing countries through both food aid and related research. Health-education strategies in the developed world needed to be strengthened, and education efforts should target children and young people, in particular, because it was in those generations that future changes in morbidity and mortality from noncommunicable diseases would be expressed. One of the most serious problems facing Cuba, for all its life expectancy at birth of 76 years, related to the consequences of poor diet and the lack of physical activity.

Cuba had supported the development of the strategy from the outset and remained committed to it. Cuba would be pleased to contribute its experience to the proposed drafting group.

Ms MOTSUMI (Botswana), affirming the focus of the draft strategy on the prevention of noncommunicable diseases, said that, like other developing countries, Botswana was experiencing a rise in those diseases and their risk factors, while marketing of unhealthy food products, especially fast foods with poor nutritional value and high levels of fat, was increasing. That situation was compounded by inadequate public information on nutrition and diet. Botswana was consequently developing a noncommunicable disease strategy targeting six major diseases, and formulating a health promotion and education strategy to encourage healthy lifestyles, including good diet and physical activity, although it needed WHO's support and technical advice in the further development and subsequent implementation of the latter strategy. The call in the draft resolution on the Director-General to provide technical support and build capacity to support countries in developing and updating national policies and strategies on diet, physical activity and health was welcome but that should be done in consultation with all relevant stakeholders. With those comments, Botswana supported the draft resolution.

Dr BELLO DE KEMPER (Dominican Republic) supported the idea that Member States should establish guidelines for framing national health policies on prevention of noncommunicable diseases. Her country had therefore suggested enhancing the educational component of the strategy to encourage healthy lifestyles, including a balanced diet based on natural, non-synthetic products. However, it continued to have some concerns about the joint WHO/FAO report[1] that formed the basis for the draft strategy, which stressed the need to reduce the intake of sugar but failed to put enough emphasis on undernutrition in developing countries or on the role played by individual and population risk factors.

She agreed with previous speakers that every effort should be made to avoid a scenario in which a single footnote or comment threatened the entire draft strategy, and expressed concern about the current wording of paragraphs 22 and 47. She looked forward to learning more about the proposal of Brazil with regard to the latter paragraph. She welcomed the proposed drafting group.

Mr VAZ (Uruguay) firmly supported the strategy and commended both its substance and its methodology. Uruguay also supported Brazil's proposal to establish a drafting group, one of whose main concerns should be to ensure consistency, both within the text and with other decisions, standards and principles agreed by the international community in other forums, particularly with

[1] WHO Technical Report Series, No. 916, 2003.

regard to trade matters. Similarly, any action taken pursuant to the strategy should be consistent with the policies and standards of UNICEF.

Dr KHAZAL (United Arab Emirates) said that Member States needed to take immediate action to implement the global strategy in order to address the rising rates of morbidity and mortality linked to unhealthy lifestyles. States had a duty to promote the health of individuals and society by recommending good dietary practices and other measures to prevent and control noncommunicable diseases. The United Arab Emirates therefore supported the draft strategy and resolution, and had taken steps towards adopting a national strategy to encourage physical activity and healthy diet. New mechanisms were needed to implement the strategy with the involvement of other sectors besides health, so as to make the best use of available resources. She attached particular importance to applying the strategy in the education sector, through schools and educational programmes. A special effort should be made to measure obesity and monitor diet among students. In that connection, the United Arab Emirates wished to encourage all students to avoid smoking and to take up sport.

Mr GRBEŠA (Croatia), endorsing the earlier statement by Ireland on behalf of the European Union, said that poor diet and lack of physical activity were indisputably contributing to an ever-increasing burden of morbidity from noncommunicable diseases. His country had adopted a policy to promote healthy diet some years earlier, and the Ministry of Health and Social Affairs was working on a national plan for the period 2005-2010 aimed at further improving dietary habits. Croatia supported the draft strategy and resolution, but considered that both texts should give more attention to children and adolescents, who should be targeted by health information programmes, starting in earliest childhood.

Dr STEIGER (United States of America), commending the current version of the strategy, said that he appreciated the time allotted for an additional round of review, which had enabled Member States to engage health, agricultural and other policy experts at the national level in the dialogue. The result was a much-improved strategy, which the United States was prepared to support.

His country had been strongly involved in the various evolutionary stages of the strategy since 2002. It recognized the seriousness of the problems of obesity, poor diet and lack of physical activity, which were far from being confined to the United States. Government leaders in all countries needed to encourage their citizens, and especially their young people, to move towards healthier lifestyles. The United States had just released a blueprint for action to reduce and prevent chronic diseases, which outlined steps for improving health. His delegation would be happy to provide others with copies of the document. The global strategy on diet, physical activity and health would be another possible blueprint for action available to all Member States.

The United States believed that the draft strategy and resolution could be used to give impetus for change. The strategy could serve as a relevant and practical tool for all countries in the development of national policies and programmes and as a guide for transparent and participatory processes that engaged a range of public and private stakeholders in identifying sustainable, evidence-based approaches for improving dietary choices and increasing physical activity among individuals, families, communities and nations as a whole. His Government remained committed to working with the Secretariat and all Member States to use the best possible science in the fight against the growing epidemic of obesity and the increasing global burden of noncommunicable disease.

Dr MOOSA (Maldives) also expressed appreciation for the broad consultative process. Maldives believed that, as a technical agency, WHO should provide strategic direction on all aspects of controlling noncommunicable diseases and improving health. Implementation of the strategy should be tailored to national contexts. To meet the challenge of noncommunicable diseases, countries must take action on the wider determinants of health. Accordingly, she welcomed the draft strategy's health-promotion approach that sought to create supportive environments facilitating healthy

behaviour and lifestyles. She also welcomed the reference in the draft strategy to multisectoral policies and the role of the private sector. She strongly endorsed the draft strategy and resolution.

Mr HARUN SIRAJ (Malaysia) said that, although Malaysia supported the proposals that would form the basis for developing national strategies, those strategies must take account of each country's specific situation, including economic, trade, social, cultural and culinary factors. Broad prescriptions should accommodate the sensitivities of individual countries. The socioeconomic implications of such strategies must also be examined. The structural adjustments in agriculture and food processing, together with research and development considerations, must be closely monitored and evaluated when the strategies were applied. Questions such as the role of saturated fatty acids in cardiovascular disease needed to be answered.

Immediate steps were needed to arrest the endemic problems of obesity and noncommunicable diseases. He questioned whether countries had the resources and political will to carry out the strategies adopted, which would require much international collaboration, technical assistance, teamwork and well-coordinated action. Monitoring and evaluation of the impact must be considered even before the strategies were implemented. That impact could be expected in four areas in particular: agriculture and food processing; food safety and multilateral efforts in the context of Codex Alimentarius committees; trade in agriculture and negotiations within WTO; and research and development to boost productivity and maximize value-added products.

Nations would have to review the health and nutritional aspects of the food they produced and consumed. International trade regimes should be supportive, as should enabling policies, whether fiscal policies nationally or trade policies internationally. Such policies could open up new trade opportunities for the agricultural products of developing countries. Cooperative research and development should examine how the curative and health-enhancing properties of agricultural products, including plants and herbs, could be further exploited.

Malaysia fully agreed with the draft strategy, which would provide a sound basis for future action. However, it advised that the interests of producers and manufacturers from developing countries should be safeguarded. International trade in relevant products must not be hampered by tariff and other barriers, since efforts to improve the health of populations required a healthy and conducive environment to produce, process and trade in such products. Such strategies, in short, held out fresh opportunities for trade and greater economic cooperation among nations.

Ms SHARP (United Kingdom of Great Britain and Northern Ireland) said that her country fully aligned itself with the statement made by Ireland on behalf of the European Union. It strongly supported the draft strategy and commended the extensive consultation that had resulted in an excellent text. The decision to extend the consultation period after the Executive Board session in January 2004 had provided all Member States with an additional opportunity to comment. The current draft presented a well-balanced compromise, and the draft resolution made it clear that Member States had a flexible set of options for developing their national policies and programmes, taking account of their national circumstances. She supported the draft resolution and recommended that the Health Assembly endorse the draft strategy as it stood. She welcomed the proposed drafting group to resolve differences raised by delegates, but urged Member States to deal with any concerns through the resolution, not the strategy. Agreeing on the global strategy would be the start of important action to achieve significant improvements in health worldwide.

Professor FIŠER (Czech Republic), recalling the extensive discussion by members of the Board on the draft resolution, said that the draft was a good compromise. He appreciated the preparation of the revised version of the global strategy. Deletion of the footnoted reference to document A57/9 and of subparagraphs 2 and 4 of paragraph 47 would assist in reaching a consensus. Rapid implementation of the global strategy in Member States was an important goal requiring close cooperation with the food industry, with success hingeing on public-private partnership.

Dr TANGI (Tonga), commending WHO's leadership, expressed full support for the draft global strategy and encouraged adoption of the proposed resolution with minimal changes. Like other developing countries, Tonga faced the costly prospect of a rising incidence of noncommunicable diseases caused by unhealthy diet and physical inactivity. A growing proportion of the population was either overweight or obese, and the prevalence of type 2 diabetes had more than doubled in 30 years. The global strategy would be a road map to help countries to formulate strategies according to their own needs. Tonga itself had recently prepared a national strategy to prevent and control noncommunicable diseases and was grateful for the assistance it had received from WHO and other partners. It had hosted the Fifth Meeting of Ministers of Health for the Pacific island countries (Nuku'alofa, 9-13 March 2003) on the theme of healthy lifestyles, and the ministers would be reporting back in 2005 on action taken. Defining the future for coming generations was essential for political will to be mustered. The time had come to act: adoption of the global strategy was a crucial first step.

Mr PIRA PÉREZ (Guatemala) supported the draft global strategy as an important instrument in assisting countries in the prevention and control of noncommunicable diseases, and urged its approval. However, his delegation shared the concerns of Brazil and believed that a drafting group could achieve a consensus on the final wording.

Dr FUKUDA (Japan) expressed support for the draft global strategy, which was based on principles shared by Japan's own programme to prevent lifestyle-related diseases by improving nutrition and diet. That programme had been initiated in 2000 following the setting in 1999 of a national standard for food intake.

Japan had several suggestions to make for carrying out the strategy, based on its own experience. First, implementation of the recommended actions should be based on regularly updated scientific evidence. Secondly, given the importance of communication by the government to the general public of the assessment and management of risk factors, the recognition of communication on risks should be reflected in the preambular paragraph of the draft resolution and sound implementation of risk communication should be reflected in the operative part addressed to Member States. Thirdly, given the diversity of target groups and specific national circumstances, the choice of options as to how to accommodate the recommended actions should be left to Member States. Fourthly, although the Millennium Development Goals offered a long-term objective, the direct impact of nutrition and diet in terms of the targets associated with those Goals was not always easily measurable, and countries should therefore allocate their resources having regard for a balance between the Goals and the recommended actions in the strategy.

Professor PAKDEE POTHISIRI (Thailand) supported the draft global strategy. Noting the concerns expressed by some Member States about the implications of the strategy for various economic sectors, notably trade in agricultural commodities and industrial practice that might induce undesirable patterns of consumption, he acknowledged the importance of agriculture and industry for economic development, but warned that such development should not proceed at the cost of health, which was the priority. Where health was concerned, market forces could not be given a free rein and government intervention was needed; health must come first. The proposed resolution should be adopted with the deletion of the square brackets around the first operative paragraph.

Dr VIZZOTTI (Argentina) said that, faced with the rising incidence of noncommunicable diseases caused, inter alia, by unhealthy diets and physical inactivity, strategic actions should be taken by governments to promote healthy diets. The public should be able to make informed choices, and intersectoral initiatives should be promoted. Ongoing efforts in Argentina included limiting the amounts of salt and saturated fats in existing products. Argentina supported the draft global strategy, as it did health-promotion measures for development as a means of reducing malnutrition and poverty. Although he understood the concerns expressed by some countries about the adverse effects of some

of the recommendations on the economic sector, he considered that the issue of diet must be tackled in order to reduce one of the risk factors for noncommunicable diseases. It would be worth pursuing talks at the current Health Assembly in order to reach agreement on those issues.

Mrs BARANAUSKIENE (Lithuania) said that her country looked forward to adoption of the global strategy at the current Health Assembly and to its effective implementation. The global strategy commendably tackled the major risk factors responsible for the growing level of noncommunicable diseases, and would be particularly important for the young population. In October 2003, her Government had adopted a national food and nutrition strategy and an action plan for 2003-2010, setting out measures to improve the nutrition of the population, including recommendations for children under the age of 12 and for increasing the level of physical activity. The problem of obesity in children should be solved through the common efforts of governmental and nongovernmental organizations and academic institutions worldwide.

Dr MUÑOZ PORRAS (Chile) endorsed the draft global strategy and resolution on a vital issue. The disturbing findings of a recent survey in Chile about prevalent diseases and risk factors, similar to those in many other countries, prompted the need for a change in lifestyles, especially among children and the poorer segments of the population. Any interventions to deal with those problems must be evidence-based. However, given the cultural and social differences between societies, support would be needed from WHO to enable countries to conduct their own assessments of the interventions needed to implement measures of proven effectiveness, especially for young people. It was necessary to introduce regulations on consumer information, in accordance with the Codex Guidelines on Nutrition Labelling. WHO should initiate a process of cooperation with countries in order to establish contacts with industry for implementing the recommended actions. It should publicize developed countries' regulations to enable the developing and, particularly, least developed countries to establish their own clear regulations in order to hold their own against the marketing strategies of the mass consumption food industry.

Chile was making available to WHO the results of specific low-cost, easily applicable nutritional interventions that had yielded excellent results, an example being a regulation passed in 1999 requiring flour producers to fortify wheat flour with folic acid, an action that had massively reduced the incidence of neural tube defects in the space of three years. Chile welcomed the emphasis on diet, physical activity and chronic diseases and requested the Director-General to persevere in his efforts to support countries' own initiatives.

Dr TOIKEUSSE (Côte d'Ivoire) said that countries such as his own were having to shoulder the double burden of the diseases typical of the developing countries and those of the developed countries. The preventive approach was essential in the global fight against poverty. In tackling noncommunicable diseases, public-private partnerships and stakeholder involvement were crucial. Programmes such as WHO's STEPwise approach to surveillance of risk factors for noncommunicable diseases had been of great assistance to his country.

Expressing support for the draft global strategy, he drew attention to crucial areas for attention: financing; communication and education for health; and infrastructure, especially for physical exercise. Another important aspect of any diet-related strategy was accessibility to and quality of water. He expressed concern about the massive influx of consumer water products into the markets of developing and, in particular, least developed countries. The draft global strategy was a good tool, which Côte d'Ivoire supported, but one that would evolve as requirements changed.

Dr ZAHER (Egypt) supported the draft global strategy in view of the rising incidence of noncommunicable diseases and their impact on public health. The strategy, which proposed a number of solutions, needed to be implemented in accordance with national policies so as to improve the overall health status of the population.

Mr SILBERSCHMIDT (Switzerland), supporting the draft global strategy and resolution as they stood, said that he was gratified to see diet and physical activity treated on an equal footing. The status of paragraphs 1 to 15 in document A57/9 should be clarified by removing the reference to them in paragraph 21 of the draft strategy. In order to meet the legitimate concerns expressed by some Member States about the economic impact of some recommendations, such as those in paragraph 47 of the draft strategy, he proposed that a provision be added to the draft resolution to the effect that the application of the global strategy was to be fully consistent with existing and future trade regimes and international obligations. In order to avoid reopening the draft global strategy for negotiation, malnutrition should be mentioned in the draft resolution along the lines proposed by Senegal.

Dr AL-HALWACHI (Bahrain) expressed support for the report. The role of diet and nutrition was essential for the continuing improvement of oral health. She drew attention to the importance of integrating oral disease prevention into noncommunicable disease prevention. The oral health profession was involved in diet counselling within the context of primary health care. Control of oral manifestations of HIV infection should also be strengthened.

Dr CHITUWO (Zambia), referring to the double burden of communicable and noncommunicable diseases on developing countries, expressed particular concern about the unhealthy diet and inactivity of young people. Zambia had developed programmes promoting healthy lifestyles as part of its National Health Strategic Plan. Further work and technical support were needed in order to strengthen the impact on the population, to balance meagre resources between communicable and noncommunicable diseases, to develop and sustain agricultural policies emphasizing indigenous foods, and to promote physical activities, especially in rural areas. He endorsed the proposal by the Chairman for further consultations. In implementing any strategy on diet and lifestyles, the cultural sensitivities of each society and country must be taken into account.

Dr AZIZ (Pakistan), acknowledging that, like many other developing countries, Pakistan was facing a double burden of communicable and noncommunicable diseases, welcomed WHO's efforts to create a framework for their integrated control and prevention. That and the WHO Framework Convention on Tobacco Control were landmark initiatives by WHO. Pakistan had created a successful tripartite model for the prevention and control of noncommunicable diseases in collaboration with a nongovernmental organization through the WHO country office, and would be happy to share its experience with other Member States. He fully endorsed the draft resolution.

Dr NEIRA GONZÁLEZ (Spain) joined previous speakers in welcoming the draft global strategy. In particular, she commended the broad-based consultative approach; the resulting text was sufficiently flexible to enable the remaining small differences to be resolved. She was confident that the drafting group, in which Spain was happy to participate, would ensure that the footnote did not impede progress. Successful adoption and implementation of the strategy would be of historic importance for future generations. She supported previous speakers by emphasizing that there was no such thing as good food or bad food, only a good diet and a poor diet. It was important to take account of cultural differences. A good diet was a balanced diet and she recommended the Mediterranean diet. In her country the ideal wife was slim; yet a sedentary lifestyle was common among children and young people. Much imagination and creativity would be needed to adapt the strategy to the realities of life.

Dr FAIHUN (Benin) said that some topics, such as oral hygiene, had not been given due prominence in the draft strategy. Furthermore, steps should be taken to step up the fight against the consequences of HIV infection. He proposed the inclusion of a statement along the following lines:

> "Recognizing and approving the findings of the World Oral Health Report 2003, WHO is encouraged to issue guidelines on further improving oral health in the twenty-first century,

emphasizing promotion of community care and prevention of oral diseases within primary health care, especially in the most disadvantaged countries and communities. The Health Assembly stresses the importance of addressing common risk factors, improving oral health through healthy lifestyles, prevention of oral diseases (which should be part of prevention of noncommunicable diseases) and reorientation of oral health services to prevention and prophylactic care."

Mr TEOKOTAI (Cook Islands) fully supported the draft strategy; its redrafting should not water down and/or delay its adoption. The Cook Islands had supported the work on the strategy both within the Western Pacific Region and at the Fifth Meeting of Ministers of Health for the Pacific island countries (Nuku'alofa, 9-13 March 2003). His country was carrying out a WHO-sponsored survey of the impact of noncommunicable diseases whose results would lay the basis for an action plan to counter the growth of such diseases – already a leading cause of death in the country. The survey would be repeated regularly. The problem in the Pacific area was too much food and too little activity. At the end of June 2004, with support from the private sector, a workshop on diabetes would be held in order to involve the wider community and spread the knowledge gained to date. The Cook Islands had just signed and ratified the WHO Framework Convention on Tobacco Control and he urged other Member States to do likewise. With the work under way in the Cook Islands, a start could be made on tackling tobacco-related diseases.

Mr EDWARDS (Marshall Islands) fully supported the draft strategy. The people of the Marshall Islands relied mostly on imported and processed food, which hastened the onset of the noncommunicable diseases from which about 20% of the population suffered. Less educated people ate food rich in fat and carbohydrates because they believed that size equated to health, while more educated young people, aware of the link between an unbalanced diet and those diseases, tended to eat more healthily.

Dr KIENENE (Kiribati) confirmed that his country, like many others, was suffering from the double burden of communicable and noncommunicable diseases. He congratulated the Director-General on the immense amount of work and consultation that had gone into drawing up the draft strategy, which he wholeheartedly supported.

Ms BIJOU (Haiti) supported the draft resolution contained in resolution EB113.R7 but shared the reservations expressed by some previous speakers. Haiti too was experiencing an increase in the incidence of noncommunicable diseases and was revising its strategic plan accordingly. She requested WHO's assistance in implementing the resolution and finding an appropriate response to the crisis.

Dr ENOSA (Samoa) endorsed the strategy. With the rapid worldwide increase in noncommunicable diseases the time was right to act, but any strategy had to be affordable, country-specific and culturally sensitive. Noncommunicable diseases were expensive to treat, especially in developing countries like his own. The people of the Pacific island countries loved their food, and obesity gave men a prosperous and chief-like appearance. Samoa appreciated WHO's help in conducting its survey to identify some of the risk factors.

Dr BENJAMIN (Federated States of Micronesia) said that Micronesia, with its small population of about 100 000, had often seen its health priorities ignored, especially at the global level. More than 50% of the population suffered from some form of illness (mostly diabetes) related to noncommunicable diseases, a proportion that was higher than in many other and larger countries. The impact of those diseases was expected to increase. More than half the country's total health budget had been used to treat patients with lifestyle-related diseases, leaving less than half for the treatment of other illnesses and for public health and preventive health services. He therefore fully supported the draft strategy. It would help to ensure that WHO continued to give noncommunicable diseases the

priority they deserved, and would serve to promote better services and resource allocation, especially at the country level, to prevent and treat them.

Dr SELUKA (Tuvalu) expressed his support for the draft global strategy. Combined with FAO's experience and knowledge of the composition of the food people ate and the fluids they drank, the strategy would be indispensable to health planners, families and individuals who cared about their own health and the health of their nation. There was much truth in the saying "You are what you eat"; a limited choice of food in his country forced the average family to consume whatever was available locally. Obesity was common among adults and an emerging problem among children, particularly in urban areas. Diabetes prevalence stood at 7%, and high blood pressure and urinary and heart conditions were contributing to mortality rates. Smoking and indifference to physical activity were widespread. The global strategy was needed to stimulate awareness that noncommunicable diseases killed.

Ms DE LA MATA (European Commission) said that the European Commission was aware that certain lifestyles, characterized by unbalanced diets and physical inactivity, were among the leading causes of obesity and major noncommunicable diseases. It also clearly recognized the importance of promoting a balanced diet and physical activity, not only for preventing disease, but also for enhancing quality of life in general. It therefore welcomed the timely elaboration by WHO of the draft global strategy, noted the evidence used to underpin the strategy and supported its general orientations. Nevertheless, certain issues relating to competition and world trade needed clarification. The Commission would therefore carefully analyse the recommendations made in the global strategy and examine their potential for contributing to the future development of policies at European Community level, taking into account the distribution of competences between the Community and its Member States, the prevailing socioeconomic and cultural realities in the Community, and new scientific developments. The Commission had called on Europe to tackle obesity.

Mr TONTISIRIN (FAO) said that FAO appreciated the broad consultative process that WHO had applied in developing the global strategy. That process had begun with review of the scientific evidence on the interactions between diet, physical activity and noncommunicable diseases, which had resulted in the Report of the Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases.[1] Through that and related joint activities, FAO and WHO had demonstrated their commitment to supporting countries in coping with the growing double burden of undernutrition and overnutrition. FAO was combating undernourishment, while tackling the growing burden of obesity and chronic diseases in developing countries. FAO supported WHO's work on the draft global strategy, while formulating its own short-, medium- and long-term responses to the growing need to improve diets and nutrition and to prevent chronic diseases. FAO considered that the recommendations of the Expert Consultation and the WHO global strategy would create new opportunities, targets and priorities for the food and agriculture sector. FAO would help developing countries to take advantage of new production and trade opportunities and to improve the nutritional quality and safety of the food supply. The FAO and WHO initiative to promote the production and consumption of fruit and vegetables was an example of their joint response to the need to prevent undernutrition, including micronutrient deficiencies, and noncommunicable diseases. FAO would assist governments in implementing policies and programmes to ensure that consumers had access to healthy and safe diets by providing new policy options and institutional measures to improve production, processing and marketing. In particular, it would tackle the needs of poor producers and poor consumers.

[1] WHO Technical Report Series, No. 916, 2003.

In February 2004 the FAO Committee on Agriculture, in a special session, had proposed that the recommendations in the report of the joint consultation[1] should be followed up, taking into consideration the WHO draft global strategy on diet, physical activity and health. Tackling malnutrition remained a top priority for FAO, but the Committee recognized the growing social and economic burden of noncommunicable diseases on all countries. The Technical Report was recognized as a useful resource for governments in considering nutritional recommendations to alleviate that burden. FAO would continue to work with WHO and provide Members with policy advice on nutrition and healthy diet and the prevention of noncommunicable diseases. Members had stressed the importance of nutrition education to enable individuals and families to make informed food choices. The Committee had agreed that the complex subject needed further national and regional studies. It had requested an assessment of the links between changing food-consumption patterns and noncommunicable diseases, and the possible effects of changes in demand on agricultural production systems, commodity trade and supply responses through diversification. Those assessments should take account of the specific conditions of each country and population group and of dietary patterns. FAO would follow up on those recommendations, which it deemed consistent with the aims and objectives of WHO's global strategy. That would provide opportunities to collaborate with WHO in addressing the challenges from a multisectoral and multidimensional perspective.

The meeting rose at 12:30.

FIFTH MEETING

Thursday, 20 May 2004, at 14:40

Chairman: Dr D. SLATER (Saint Vincent and the Grenadines)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Global strategy on diet, physical activity and health: Item 12.6 of the Agenda (Resolution EB113.R7; Document A57/9) (continued)

Dr PANDURANGI (Commonwealth Association for Mental Handicap and Developmental Disabilities), speaking at the invitation of the CHAIRMAN, said that in January 2003 his association had arranged a one-day workshop in Bangalore, India, on preventive health care among the urban poor, and, jointly with WHO, a global consultative workshop on population-based, cost-effective intervention strategies to prevent hypertension and diabetes. The two events had resulted in the formulation of a preventive health-care programme in Bangalore and, with technical support from WHO, the establishment of a Commonwealth centre for preventive cardiology. School health education and promotion of healthy lifestyles were integral components of the programme, which recognized that a healthy diet, normal body weight and adequate physical activity throughout the lifespan reduced the risk of numerous noncommunicable diseases. Increasing consumption of fruit and vegetables, and reducing the intake of fat and salt were key elements in the dietary prevention of cardiovascular diseases and cancer. Consumption of infant formula milk rather than breast milk in infancy had been shown to increase diastolic and mean arterial blood pressure in later life. Prevention of type 2 diabetes in infants and young children could be facilitated by the promotion of exclusive breastfeeding, avoidance of overweight and obesity, and promotion of optimum linear rate of growth. High levels of literacy, strong school health programmes and emphasis in the mass media on the need for healthy living and healthy policies could significantly improve the education of young people and adults alike, especially women. Community participation, through youth and women's groups for example, was essential. The Association would support the promotion of the proposed global strategy among poor people in urban areas.

Ms GIRARD (International Union against Cancer), speaking at the invitation of the CHAIRMAN, strongly endorsed the draft global strategy. Its implementation would decrease the global burden of cancer, which was currently expected to rise to 15 million new cases annually by 2020. In industrialized countries, an estimated 30% of cancers were attributed to an unhealthy diet and sedentary lifestyle, almost as many as to tobacco use. Moreover, high incidence rates of cancers, including cancers of the colon, breast, uterus and kidney, were associated with being overweight or obese, and excessive consumption of alcohol increased the risks of cancers of the oral cavity, pharynx, larynx, oesophagus, liver and breast.

Her organization stood ready to work with its members, in more than 80 countries, to promote a healthy diet and physical activity at the community level. The policy recommendations of the draft global strategy were crucial, because they provided the right context for efforts aimed at reducing the global cancer burden. She urged Member States to adopt the draft global strategy. The Union would support countries in implementing the strategy through recommendations to nongovernmental organizations of effective evidence-based strategies for improving dietary behaviour and increasing physical activity. Member States should be encouraged to include nongovernmental organizations involved in the fight against cancer and other health-related nongovernmental organizations in their multisectoral approaches.

Mr MISRA (International Organization of Consumers Unions), speaking at the invitation of the CHAIRMAN, said that the global strategy provided a vital opportunity for Member States to demonstrate their commitment to the health and welfare of their populations, and their support for consumers worldwide. At his organization's 2003 World Congress, delegates had voted unanimously to support WHO's global strategy as originally drafted. Since then, the text had been weakened, notably in the areas of health claims and clarity about the role of stakeholders. Member States should give guidance in those areas before it was too late. Despite the changes, the revised draft global strategy could provide Member States with a range of policy options; it also accorded with basic human rights as recognized by the United Nations. Food should be adequate in quantity and quality. It should also be safe: consumers should be protected from food of bad quality or that was unsafe to consume, including processed foods that were high in fat, sugar and salt. Consumers had a right to information about their food and should be protected from advertising, health claims and nutritional labelling that were misleading. His organization strongly opposed unregulated advertising and marketing targeted at children. All consumers had the right to choose and should have the choice of healthy foods. People also had the right to live in a safe and healthy environment with opportunities for physical exercise. The cost of illness and injury and their burden on health services would be substantially reduced through improved diet and physical activity.

Member States should not be taken in by misleading arguments put forward in the past by the tobacco industry and currently by the food and sugar industries. Industry should not be allowed to profit from marketing foods rich in fat, sugar, salt and unwanted chemical additives. The poorest consumers would benefit most from a healthier environment. He endorsed the comments on health interests prevailing over commercial interests, and urged Member States to support the draft global strategy and to provide guidance with regard to health claims and the role of stakeholders; his organization would support countries to ensure its implementation.

Professor JAMES (International Union of Nutritional Sciences), speaking at the invitation of the CHAIRMAN, said that the greatest causes of death and disability in babies, children, young adults and the elderly were nutritional in origin, as had been shown in recent world health reports. As Chairman of the United Nations Commission on the Nutritional Challenges of the 21st Century, he had reported to the United Nations some four years earlier on the double burden of disease facing developing countries. Many countries struggling with malnutrition and deficiency diseases also faced emerging epidemics of noncommunicable diseases, which affected poor people the most, with malnourished mothers producing a young generation sensitive to poor westernized diets. As there were no affordable medical solutions to meet the needs of entire populations, prevention was the only strategy that made sense, and must not be ignored, especially in the developing world.

Newly published scientific evidence confirmed the validity of the joint WHO/FAO report on diet, nutrition and the prevention of chronic diseases[1] as a sound basis for developing national action plans. Vested interests had encouraged confusion over the economic implications of the draft global strategy and a comprehensive economic analysis was needed. That should not be the reason for delay, however. Economic benefits would flow from improved health and the stimulus to agriculture which the strategy would provide. Fiscal and other measures, including subsidies, should therefore be reoriented to focus on improving capacities to deliver healthier diets.

The paramount importance of science and evidence in determining public policies had been clearly understood in relation to food safety and toxicology and the principle should be applied to the nutritional aspects of food. The private sector had opportunities and responsibilities in contributing to the successful implementation of the strategy. However, without a clear separation of public and private interests in that area of policy-making, global health was unlikely to improve. He urged the Health Assembly to support the draft global strategy without amendment.

[1] WHO Technical Report Series, No. 916, 2003.

Mr RIGBY (International Association for the Study of Obesity), speaking at the invitation of the CHAIRMAN, and also on behalf of the International Diabetes Federation, the International Pediatric Association, the International Union of Nutritional Sciences and the World Heart Federation, said that those organizations supported a strong global strategy on diet, physical activity and health, which was essential to tackle the mounting epidemic of noncommunicable diseases and ensure a more effective global culture of care and responsibility for the nutritional health of young children. A growing proportion of the population was overweight and obese, which were powerful determinants of type 2 diabetes and other noncommunicable diseases. Some 155 million schoolchildren faced sustained overweight problems before they reached adulthood and more than one quarter of them were obese. In the United States of America, one in three children would develop type 2 diabetes, and in many other countries the trends were similar. The United States Department of Agriculture had concluded that a big jump in average caloric intake between 1985 and 2000, without a corresponding increase in the level of physical activity, was the prime factor in the soaring rates of obesity and type 2 diabetes. Fats and sugars accounted for half the increase in caloric intake, and fruits and vegetables, increased consumption of which was recommended, only 8%. FAO had forecast a similarly large rise by 2003 in caloric intake in developing countries and countries with economies in transition. That situation could not be ignored.

"Diabetes and obesity" was the theme for World Diabetes Day on 14 November 2004. A new report on that topic, prepared by the International Diabetes Federation and the International Association for the Study of Obesity, recommended strong measures to improve diet and increase physical activity, including restrictions on marketing targeted at vulnerable children. Careful consideration should be given to the way in which public expenditure was used in order to switch the emphasis away from the dominance of fats and added sugars in the diet towards greater consumption of fruit and vegetables. Such a change would, as the World Bank had noted, provide a major boost for the economies of developing countries.

The draft global strategy was needed to enable Member States to address the challenges of poor diet and physical inactivity and provide the signposts to better diet, physical activity and health for all. Member States must take all necessary steps to attain that goal.

Ms MULVEY (Infact), speaking at the invitation of the CHAIRMAN, welcomed the draft global strategy and in particular its emphasis on provision of accurate information to consumers, the affirmation that pricing policies could encourage healthy nutrition and the recognition that food advertising affected food choices and dietary habits, especially in children. Encouraging Member States to curtail advertising of unhealthy food was consistent with the comprehensive ban on tobacco advertising, promotion and sponsorship in the WHO Framework Convention on Tobacco Control. Infact was concerned at the failure to protect the draft global strategy from potential conflicts of interest. Throughout the Framework Convention negotiating process, tobacco companies had been excluded on the ground that their aims ran counter to those of the treaty, and the final text obliged Parties to protect public health policies from commercial and other vested interests. In contrast, WHO had sought to engage global food corporations and their trade associations in the development of the proposed global strategy, despite the food industry's adoption of many of the tactics used by the tobacco industry to evade responsibility and fight international regulation. One of the world's largest food corporations was owned by the same group that owned a global tobacco company and the Chairman and Chief Executive of the group had taken advantage of the association with WHO for public relations purposes at the recent annual shareholders' meeting. However, association with such a company was inconsistent with resolution WHA54.18, which urged WHO and Member States to be alert to tobacco industry efforts to subvert health policy. The same two enterprises were prominent members of the Grocery Manufacturers of America (a member of the International Council of Grocery Manufacturers Associations), and the Confederation of the Food and Drink Industries of the EU, respectively, which with the International Council was seeking official relations with WHO, a status reserved for nongovernmental organizations concerned with health. WHO had saluted voluntary initiatives by the food industry to limit dangerous ingredients and portion sizes, but voluntary

standards could not replace external regulation. Member States should therefore amend the proposed draft resolution and strengthen the draft global strategy to emphasize the regulation of marketing, acknowledge the potential conflicts of interest between the food industry and others in the private sector and the strategy's goals and objectives, and protect implementation of its action plan from such conflicts.

Mrs VOÛTE (World Heart Federation), speaking at the invitation of the CHAIRMAN, said that the adoption by the current Health Assembly of the global strategy on diet, physical activity and health would be vital for the health of the existing population and future generations. The mission of her Federation, a nongovernmental organization bringing together cardiology societies and heart foundations from all over the world, was to prevent and control heart disease and strokes, especially in low- and middle-income countries, where 80% of the 17 million annual deaths from cardiovascular disease and 87% of cardiovascular-related disabilities occurred. Cardiovascular disease cut into the productive workforce of those countries to a degree not seen in industrialized nations, which meant that associated direct health costs in the developing world would inevitably rise as prevalence increased. It was therefore crucial to tackle the key risk factors immediately, since prevention was the only cost-effective strategy for all the countries concerned. The draft global strategy had set the stage for positive interaction with industry and had stimulated national programmes and activities for chronic disease prevention in the community. The Federation was already using the strategy as a framework for its activities. The Health Assembly should adopt the global strategy so as to ensure better health for all nations. Public health should take priority over every other objective, since a healthier population was the key to economic development. The strategy was an excellent first step towards a sustained, long-term commitment on the part of governments, the health community, industry, international organizations and nongovernmental organizations to join forces to curtail the chronic disease epidemic. The Federation was ready to support the strategy's implementation in at least 100 of the countries represented at the Health Assembly.

The CHAIRMAN noted that the Committee would return to the agenda item the following day when it would consider the draft resolution.

(For adoption of the revised draft resolution, see summary record of the eighth meeting, section 3.)

Implementation of resolutions (progress reports): Item 12.15 of the Agenda (Documents A57/18 and A57/18 Add.1) (continued from the third meeting)

- **Quality of care: patient safety** (Resolution WHA55.18; Document A57/18)

Sir Liam DONALDSON (United Kingdom of Great Britain and Northern Ireland) congratulated WHO for seizing a major opportunity to change international thinking on patient safety. The adoption of resolution WHA55.18 had demonstrated an awareness of the size of the challenge ahead. The enormity of the problem and the tremendous suffering caused to patients, carers and staff by the delivery of unsafe care had been discussed. WHO and its regional offices had made considerable progress in bringing together health experts to study that topic. Over the past two years, great international interest and commitment had been generated. The establishment of an international alliance for patient safety in the latter half of 2004 would be a major force for improvement, and would be fundamental in facilitating the development of patient safety policy and practice in all Member States through the setting and careful monitoring of key objectives each year. Those objectives would focus on cultural change, system development, technical advances and consumer involvement. His Government looked forward to working with the Secretariat and Member States to ensure the success of the alliance. The Health Assembly should request the Director-General to report

on progress in the implementation of the resolution and on the work of the alliance to the Fifty-ninth World Health Assembly in May 2006.

Mr YOSHIDA (Japan) welcomed the progress made and agreed that the Organization should tackle the different aspects of ensuring medical safety. With a view to preventing medical accidents and guaranteeing patient safety, his country had established a security measures committee and had enhanced its reporting system. WHO should continue to address the problem in earnest.

Dr MASSÉ (Canada) welcomed the action taken in response to resolution WHA55.18. The creation of the international alliance for patient safety was an excellent initiative, which should help to identify and assess best practices for the benefit of all Member States. In his country in 2001, the National Steering Committee on Patient Safety led by the Royal College of Surgeons and Physicians of Canada and other health stakeholders had been set up. Two years later the First Ministers' Accord on Health Care Research had asked health ministers to take the lead in implementing the recommendations of the National Steering Committee. Since then Can$ 10 million had been provided each year to help finance the Canadian Patient Safety Institute, whose board included representatives of not only health-care organizations, but also the public and provincial and territorial governments. International cooperation and information sharing in the field of patient safety should be accepted as essential elements of national health systems. An opportunity for such sharing would arise in the autumn of 2005, when his Government would host the 22nd International Conference of the International Society for Quality in Health Care. He supported the recommendation by the United Kingdom that a progress report be presented in two years' time.

Mrs KRISTENSEN (Denmark) said that reporting and learning systems were central to improving patient safety as a whole, since they made it possible to learn from adverse events or "near misses". In Denmark, a new Act on patient safety had entered into force on 1 January 2004, the first legislation in the world to set criteria for the establishment of a national reporting system for adverse events, including failures and unintentional incidents. Notification of adverse events was mandatory, but the health professionals submitting the reports could not be subjected to disciplinary investigations or measures by the employing or supervisory authorities, nor could penal sanctions be imposed on them for their report. Confidentiality was a prerequisite for the effectiveness and reliability of such a system. The reporting system would certainly be a useful tool in efforts to improve patient safety, as it would facilitate the gathering, analysis and dissemination of knowledge of the causes of various risk situations. Consequently the preparation of guidelines and identification of best practices for such systems by WHO was most welcome.

Dr GONZÁLEZ FERNÁNDEZ (Cuba) said that the international alliance for patient safety would be useful in encouraging the formulation of patient safety policies and helping Member States to evaluate patient safety programmes. He wondered, however, how Member States would gain access to such assistance and information in order to enhance the quality of care and patient safety.

Dr WANG Bin (China) said that her Government had done much to improve the quality of medical care and patient safety. Various Acts on management by doctors and nurses, and on drugs and medical technology and equipment had been passed. Standards and norms were being prepared for the management of medical technology and the Medical Society of China and other professional bodies had convened expert meetings to study and formulate norms and guidelines for clinical technology, operations and clinical diagnosis in order to establish standards of professional behaviour for medical personnel. Doctors and nurses were required to improve communication with patients and to respect their rights to be informed and to make choices about their care, as a means of improving safety. Peer reviews were to be instituted. Emphasis had likewise been placed on quality of care, effectiveness of treatment and information to the public. Medical care had improved as a result, although, as in many developing countries, there were still many challenges to be met, including the lack of technical

resources. Her Government was prepared to cooperate more closely with international organizations and other Member States and to exchange information with them and intended to participate actively in the international alliance for patient safety. WHO should be more prominent in providing technical guidance for Member States on patient safety and the training of medical personnel, and greater attention should be paid to achieving a balance between the cost of medical care and its quality and safety.

Mr VAN SCHOOTEN (Netherlands) said that the introduction of a blame-free reporting system was essential to the improvement of patient safety. Health professionals should be able to discuss adverse events in health care without being accused of mistakes or negligence. Blame-free reporting would eventually lead to better identification of and approach to risk factors, and merited serious discussion at the national level.

Mr FURGAL (Russian Federation) said that, while the report was informative, it would have gained from the inclusion of aspects dealing with the provision of information and support for countries. How in practice were WHO recommendations and findings passed on to Member States? How were the latter implementing them? What specific results had already been obtained and how was monitoring carried out? His Government was ready to play an active part in the international alliance and in all work on patient safety.

Ms MOTSUMI (Botswana) said that in her country strategies to prevent adverse events and improve patient safety and the quality of health care included performance-based reward systems designed to improve personal efficiency and the formulation of care standards for health professionals. HIV/AIDS programmes had been put in place and additional services set up to improve the safety and quality of health care of people living with HIV. Patient-monitoring programmes that enhanced safety by making medical records accessible had been put into operation, and staff emotional-support programmes had been extended to district and primary hospitals in an endeavour to offer a safer environment for patients. Policies and guidelines had been developed with a view to improving the quality of care. A patients' charter provided people with information on their rights and responsibilities so as to ensure greater feedback to the health-care delivery system, but more work was required on infection control, antibiotic policy and clinical research.

Dr SULEIMAN (Oman) thanked WHO for placing the subject of patient safety on the agenda. The issue had many aspects, including medical ethics, and concerned the entire health delivery system. It was vital to ensure that the procedures used were safely applied. In that respect, WHO should continue to play an active role, especially through training activities both at headquarters and in the regional offices. He welcomed the launching of the international alliance, and agreed that the results of its work should be available to the Fifty-ninth World Health Assembly in 2006.

Dr VIOLAKI-PARASKEVA (Greece), referring to paragraph 32 of document A57/18, asked how WHO would be working to standardize the taxonomy of medical errors and failures in health-care systems, and when the results of that work would be available.

Dr HUGHES (New Zealand) applauded the recognition of the issues that affected quality of care and patient safety. New Zealand had developed a multifaceted quality strategy covering both individual practitioners and organizational systems, and as part of that strategy had passed legislation that would ensure that all health professionals operated within the same quality assurance framework. Patient safety was included in that strategy's action plan, and efforts were being made to strengthen organizational systems in the field of health care.

She commended the report's recognition of the link between health-care workers and patient safety, and the mounting evidence of the close relationship between quality of staffing and patient outcomes. New Zealand had been fortunate to have been involved in research on the subject as part of

the five-country study. It was continuing to explore the links between nursing skills, organizational conditions and patient outcomes, and recognized the importance of investing in the professional skills of health-care staff.

Dr MAHJOUR (Morocco) said that patient safety was a major challenge facing national health-care systems, especially in developing countries where resources were scarce. The international alliance would provide an ideal forum for sharing information and exchanging experiences, especially in the poorer countries. He urged WHO to publish information on practical approaches for improving patient safety in order to help countries establish proper quality assurance systems.

Dr KAMUGISHA (Uganda), welcoming the continued concern about patient safety and quality of care, said that Uganda had a good record in that respect and had recently made significant efforts in two particular areas: injection safety and immunization safety. With routine immunization coverage currently exceeding 80%, it was important for the procedures used to be as safe as possible, especially in a country with a rampant HIV epidemic. The objective was to obtain injection equipment that was safe, affordable, cost-effective and disposable, for routine immunization and treatment in hospitals, and it was to be hoped that manufacturers would consider reducing the high price of such equipment.

Dr GARBOUJ (Tunisia) agreed that quality of care constituted a challenge for the future. In Tunisia, several activities had been launched to improve quality of care, ranging from awareness-raising for health professionals to training programmes. A strategy had been established, but the country still faced the problem of how to assess quality of care, and she urged WHO to provide information on evaluation methods.

Mr MERLEVEDE (International Federation of Hospital Engineering), speaking at the invitation of the CHAIRMAN, said that his organization had set up a task force for exchanging knowledge, ideas and advice on all aspects of health-care engineering, including the maintenance of installations and buildings. It was ready to share its experience in both developed and developing countries in the development of guidelines, standards and educational programmes connected with patient safety. It was also concerned with safety in other health-related fields such as waste management, operating theatres, sterilization units and in the use of electrical supplies and medical apparatus. It was ready to collaborate with WHO in those areas.

Dr EVANS (Assistant Director-General) said, in response to points raised, that the international alliance would publish international guidelines for reporting in October 2005 after an extensive consultation process. The taxonomy project, soon to be launched, would run for three years and would also include extensive consultations. Access to the alliance could be obtained through the WHO web site and Member States were invited to become actively involved. WHO was looking at ways of including patient safety in both training curricula and institutional or clinical settings. As the delegate of Denmark had observed, learning and reporting systems were important in dealing with medical errors: in that respect, good input was received through its technical programmes and the regional offices.

The international alliance for patient safety would be officially launched on 27 October 2004, and the progress would be reported to the Fifty-ninth World Health Assembly. He expressed his appreciation of the outstanding leadership shown by Sir Liam Donaldson in getting the alliance off the ground so quickly.

Road safety and health: Item 12.7 of the Agenda (Resolution EB113.R3; Documents A57/10 and A57/10 Add.1)

Dr AFRIYIE (representative of the Executive Board), reporting on the Board's discussion of road safety and health at its 113th session, said that the 21 Member States and two nongovernmental organizations that had spoken on the item had all noted that traffic accidents had become a major and growing cause of ill health. Many of them had produced statistics on the scale of the problem, which affected all age groups but especially young people. Board members had urged that work on road safety should focus on human behaviour, roads and vehicles. They had called for a multisectoral approach involving active contributions from the health sector, which should include, in addition to data collection, improved services for the survivors of accidents, the dissemination of information on the effectiveness of interventions, contributions to policy development, and advocacy. World Health Day 2004 with its theme of road safety was considered to provide an excellent opportunity to heighten political awareness of the problem. Members had also looked forward to the world report on road traffic injury prevention.

Professor AYDIN (Turkey) said that traffic accidents were a leading cause of early mortality and disability all over the world and welcomed the dedication of World Health Day 2004 to road safety. Because of the need for strong intersectoral cooperation, a traffic safety committee had been set up in his country in 1996 with participation by the sectors and nongovernmental organizations concerned. The Government considered early response to be important, and the goal was for services to reach traffic accidents in less than 10 minutes through the establishment of emergency aid stations on major highways; the target was a network of 112 stations by the end of 2004. In addition, 2004 had been declared Traffic Year, and a number of events and training programmes were being organized.

Mr VAN SCHOOTEN (Netherlands) commended the attention being given by WHO to road safety and supported all aspects of the approach proposed. Improvements were needed in many areas, including epidemiology and social cost accounting of road accidents. In view of the importance of the issue, WHO should explain how it intended to reach its objectives and provide more specific information on its planned activities and the human and financial resources needed to carry them out.

Mr CHEVIT (France) said that the excellent *World report on road traffic injury prevention*[1] jointly produced by WHO and the World Bank had highlighted the seriousness of the situation for both rich and poor countries. In France, too, awareness had been heightened; until recently it had had a much higher mortality rate than its neighbours, and the Government had therefore made road safety a top priority, with the focus on prevention of speeding and drink-driving. The results had been impressive: in 2003, injuries had decreased by 14.5% and serious injuries and deaths by more than 20% in comparison with the previous year. In the 1980s more than 12 000 persons had been killed on the roads each year, but there was reason to hope that the figure would be less than 5000 in 2004. France therefore welcomed the choice of road safety as the theme of World Health Day 2004 and was honoured by the Director-General's decision to celebrate the Day in Paris, which it saw as a recognition of France's efforts to promote road safety and an appeal to continue those efforts. Encouraged by the personal support of the Director-General and by the resolution[2] adopted on 14 April 2004 by the United Nations General Assembly, France intended to continue its campaign to improve road safety. He fully endorsed the draft resolution contained in resolution EB113.R3.

---

[1] Peden M et al. *World report on road traffic injury prevention*. Geneva, World Health Organization, 2004.

[2] Resolution 58/289.

Dr TSHERING (Bhutan) said that his country too endorsed that draft resolution, and thanked WHO for making road safety the theme of World Health Day 2004. The emphasis on a multisectoral approach to road safety was appropriate, as the task was too great for health ministries to tackle alone. Other stakeholders, such as nongovernmental organizations, ministries of transport, education and finance, the judiciary and the police, must be involved. He called on WHO and other organizations to help countries to enhance their capacity to reduce morbidity and mortality resulting from road traffic injuries.

Dr ZOMBRE (Burkina Faso) said that in celebrating World Health Day 2004 his country had taken the opportunity to stress the multisectoral nature of the issue. Ensuring road safety called for action by many different institutions, from ministries of transport and health to insurance companies. Road traffic accidents were responsible for an alarmingly high level of morbidity and mortality in his country: 78% of them were caused either by speeding, driving under the influence of alcohol or ignoring the rules of the road. A policy to improve medical care for victims of road traffic accidents, including trauma care, had been introduced. Following this, programmes to improve communication, raise awareness, monitor and penalize bad driving and improve traffic flow should be developed.

He supported the draft resolution contained in resolution EB113.R3, but proposed two amendments. One new subparagraph should be added to paragraph 3 recommending the establishment of a fund to finance road safety activities, particularly in the field of training, research and equipment, and another should be added to paragraph 4, calling upon the Director-General to arrange regular meetings of road safety professionals for consultations and exchanges of experience.

Dr WANG Bin (China), welcoming the reports and the *World report on road traffic injury prevention*, said that road traffic accidents were a serious public health issue in her country. In 2003, they had resulted in 104 000, a rate of 10.8 per 10 000 vehicles. Also in 2003, the Council of State had set up an interministerial mechanism to improve road safety, under which joint meetings and seminars were held in an effort to define the responsibilities of the various departments and ministries in that area. A new law had entered into force in May 2004, which defined road safety as a public health concern. A ministerial order had been issued for the management of road traffic accidents, which required emergency stations to be set up at regular intervals on major roads, and regulations on trauma care for the victims of road traffic accidents had also been issued. A network of rapid-intervention centres with its own emergency telephone number had been set up in an attempt to reduce emergency response times.

She called upon WHO to work towards implementation of its five-year strategy for road traffic injury prevention and to provide additional resources, perhaps in the form of a special fund, for technical assistance in that connection. WHO should coordinate the road safety activities of Member States and facilitate exchanges between specialists in trauma medicine.

Dr THAKSAPHON THAMARANGSI (Thailand) said that, according to a WHO study, road traffic injuries were the second most common cause of death in Thai men and the seventh most common in Thai women.[1] In 2002, the overall mortality rate from road traffic accidents had been 21.3 per 100 000 population, and one third of those killed had been teenagers. The most important risk factors were drink-driving and, for motorcyclists, not wearing a crash helmet. In Thailand, the ministries of health, transport and the interior, community organizations and nongovernmental organizations were all active partners in the promotion of road safety. 2004 had been declared "Road Safety Year", with campaigns aimed particularly at reducing drink-driving.

The draft resolution placed too much emphasis on the public health aspect, and neglected the key role played by other government agencies and nongovernmental partners, particularly civil

[1] *The global burden of disease*. Geneva, World Health Organization, 1996.

society. A successful road safety policy required active participation by all partners, and greater emphasis should be placed on specific interventions for major risk groups, such as teenagers and drinkers. He proposed that paragraph 1 should be amended to read: "... the public health sector, including other government and nongovernmental sectors, should actively participate ...". Paragraph 3(3) should be amended to read: "... including designating an effective mechanism according to the national context of road safety", and paragraph 3(4) should be amended to read: "... companies, including the community and civil society". Paragraph 3(6) should be amended to read: "... to revise as necessary traffic laws and regulations and promote effective law-enforcement, and to work ...", and in paragraph 4, a new subparagraph should be added, that would read: "to report progress made on road safety promotion and traffic injury prevention in Member States to the Sixtieth World Health Assembly in May 2007".

Dr FORSTER (Namibia) said that the publication of the *World report on road traffic injury prevention* and the designation of road safety as the theme for World Health Day 2004 were timely initiatives. Namibia's road network had expanded considerably over the previous 10 years with the construction of the TransKalahari and the TransCaprivi highways, which meant that the volume of traffic, especially heavy trucks, had greatly increased. Unfortunately, however, the morbidity and mortality resulting from road traffic accidents had increased as well, for four main reasons: excessive speed, driving under the influence of alcohol, failure to wear seat belts and failure to drive in a way appropriate to the state of the road. The Government had improved its methods of monitoring the occurrence of road traffic accidents: for instance, injuries resulting from such accidents were entered as a specific item in the country's health information system. Prevention programmes were being reinforced by educational activities in schools and the strengthening of programmes to prevent alcohol and drug misuse. However, there remained the challenge of changing the behaviour and attitude of some road users. It was important to mobilize all relevant partners: the private sector (which included major manufacturers of alcoholic beverages), disabled people's organizations and Alcoholics Anonymous, as well as relevant government departments.

He supported the draft resolution, as amended in document A57/10 Add.1.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Latin American and Caribbean Group, said that many activities had been organized in the region that year to increase public awareness of the enormous cost to the health of individuals and to society of road traffic injuries. WHO had reported that 1.2 million people per year died as a result of road traffic injuries throughout the world. Those deaths were principally due to drunken driving, excessive speed and failure to use seat belts. According to PAHO statistics, there had been about 130 000 deaths from road traffic accidents on the American continent in 2002, more than 44 500 of which were in the United States of America, where road traffic accidents were the leading cause of death in Hispanic-Americans under 34 years of age. To avoid a global public health crisis, concerted and multisectoral efforts were needed to draw up preventive measures, bearing in mind the fact that road safety was generally the responsibility of local, municipal and national authorities.

The Group was pleased that road safety had been chosen as the theme for World Health Day 2004, as that would help to increase awareness of the injuries caused by road traffic accidents, their serious effects and their enormous cost to developing countries. Road traffic injuries disproportionately affected poor people in those countries: most of the victims belonged to vulnerable groups such as pedestrians, children, cyclists, motorcyclists and public transport users. In a report prepared for the United Nations,[1] WHO had stated that the economic cost of road traffic injuries amounted to US$ 518 000 million per year, about US$ 100 000 million of which would be borne by developing countries. Deaths from all types of injury were expected to rise from 5.1 million in 1990 to

[1] United Nations General Assembly document A58/228.

8.4 million in 2020. WHO estimated that, by 2020, road traffic injuries would be the third most common cause of death, more common than malaria, tuberculosis or HIV/AIDS.

The Group supported the draft resolution, with the amendments proposed in document A57/10 Add.1.

Dr MASSÉ (Canada) said that in his country, as in many others, mortality and morbidity due to road traffic accidents had been significantly reduced by means of intervention programmes and intersectoral prevention activities. In Quebec, for example, the number of deaths had almost halved over the previous 12 years. Nevertheless, the human and economic burden of road traffic injuries still gave cause for alarm.

Road safety and the prevention of road traffic injuries were multisectoral issues. The transport and health sectors obviously had a vital role to play, but the support of industry, the justice and law-enforcement systems, education and many other sectors was also important.

He welcomed the report and supported the draft resolution contained in resolution EB113.R3.

Mr GINTER (Belgium) welcomed the reports and the initiatives undertaken for World Health Day 2004. The number of deaths and serious injuries resulting from road traffic accidents in Belgium had decreased since 1980, but much remained to be done. The ministries of health and transport had emphasized the contribution to road traffic accidents of high-risk behaviour, such as lack of sleep and the consumption of alcohol, illegal drugs or sedatives. The Belgian Road Safety Institute had invented a device that would warn a driver who was becoming drowsy at the wheel. The total economic cost of road traffic accidents in Belgium, including medical costs, loss of production and damage to property, amounted to about 4600 million euros per year, to say nothing of the human cost. Road traffic accidents were a major public health problem and a major expense for the social security system.

He supported the draft resolution and pledged his country's support in its implementation.

Dr AL-LAMAKI (Oman) welcomed the focus on road safety and its adoption as the theme for World Health Day 2004. In his country, road traffic accidents were a major cause of death and most of those deaths were in people aged 15–40 years. His Government, demonstrating the priority it attached to the problem, had launched several campaigns to raise awareness of the dangers of driving. His country approved the *World report on road traffic injury prevention*.

It would be useful if some mechanism could be found to categorize the different types of injury, in order to facilitate the comparison of statistics between countries or regions.

Dr MATIUR RAHMAN (Bangladesh) expressed his country's appreciation of the initiative taken by WHO and fully endorsed the report. World Health Day 2004 had provided an opportunity to draw attention worldwide to a serious and rapidly-growing public health problem. Instead of being regarded, as in the past, as a transport-related problem, road safety was rightly being considered as a public health issue, with massive implications: if present trends continued, road traffic accidents were projected to be the third biggest burden on health systems by the year 2020. The momentum generated by World Health Day 2004 should be maintained, possibly by the designation of an annual Road Safety Day.

His Government had introduced many programmes designed to improve road safety, including the designation of a National Safe Road Day to raise public awareness, but coordinated regional and global efforts were needed. He fully supported a multisectoral approach and the complementing of national efforts by international financial and technical assistance, particularly for developing countries, where deaths resulting from road traffic accidents were highest.

Professor AKOSA (Ghana) said that his country was fully committed to tackling the problem of road traffic accidents, which were the fourth cause of death nationally and constituted a major public health issue. The principal focus had been on prevention, using a multisectoral approach whereby not only ministries but also nongovernmental organizations and private transport operators were involved

in the organization of frequent road safety and anti-drink-driving campaigns. Road safety activities were coordinated by a national road safety commission and steps had been taken to make vehicle and driver licensing more stringent, enhance police powers, and provide a fully-equipped national ambulance service. Programmes had been set up to train all health professionals in essential trauma care and it was planned to open centres to treat and rehabilitate the injured.

He fully supported the draft resolution contained in resolution EB113.R3.

Mrs MATSAU (South Africa) welcomed the initiative of raising the profile of road safety and making it the theme of World Health Day 2004, because road safety was a priority for her country. National statistics revealed that road traffic accidents involved primarily men, and in particular those aged between 15 and 44. The economic and social impact of such accidents was clear. Alcohol was often a factor, among both drivers and pedestrians.

Her Government's objectives for the prevention of road traffic injury coincided with those set out by WHO and it supported the recommendations of United Nations General Assembly resolution 58/289. It aimed to improve the national injury mortality surveillance system, to step up multisectoral collaboration for road accident prevention, and to strengthen the national strategy on road traffic injury and deaths, taking as a framework the *World report on traffic injury prevention*. In addition, there were plans to strengthen the emergency medical services, and an anti-drink-driving campaign was under way. She was aware, however, that much more still needed to be done, and called for support from WHO and other agencies in formulating suitable strategies. She supported the draft resolution.

Dr AGARWAL (India) was grateful for the attention drawn to road safety by its adoption as the theme for World Health Day 2004. Road traffic accidents killed 100 000 people each year in his country, most of them young, and the health infrastructure had to bear the burden. The causes of road accidents were multiple and called for a multisectoral approach, in which the health sector should take the lead and assume the coordinating role. In the meantime, the Government had set up an ambitious project to provide health centres along highways across the country. Surveillance was another priority for his Government and it had decided to include data on road traffic injuries as part of its disease surveillance programme.

Mr EINARSSON (Iceland), speaking on behalf of the Nordic countries, welcomed the reports, which highlighted the importance of incorporating prevention into a broad range of activities. Road traffic injuries, which were set to increase unless action was taken, constituted a major public health issue in all Member States and called for a multisectoral approach. The health sector had an important role to play in prevention through surveillance, data collection and research on risk factors. Particular attention needed to be devoted to driving under the influence of alcohol and drugs and the public had to be made aware of the consequences of such behaviour. The situation of victims of road traffic accidents needed to be improved as a matter of urgency and had to be given a higher priority by all Member States.

He welcomed the proposed additions to the draft resolution contained in document A57/10 Add.1.

Dr AL-KHAFAJI (Iraq) said that road traffic accidents represented a real public health issue in her country, and the Ministry of Health gave it priority because they were avoidable. A multidisciplinary body had been set up involving several ministries with a view to establishing public policy. A national road safety policy based on WHO recommendations was currently under preparation.

She supported the draft resolution contained in resolution EB113.R3.

Mr SOLANO-ORTIZ (Costa Rica), supporting the statement on behalf of the Latin American and Caribbean Group, welcomed both the draft resolution and the additions to it proposed in document

A57/10 Add.1. Road safety was an item that ought to feature permanently on the Health Assembly's agenda, because in addition to the human costs of death and injury on the roads, there was the financial cost of treatment and rehabilitation, which constituted a heavy burden for developing countries. The problem called for action by diverse agents, including the education, health and transport sectors. It was essential that countries establish national plans for prevention, but international support and cooperation were also vital.

His country had adopted a series of measures relating to road infrastructure, the condition of vehicles, use of seat belts, driving while under the influence of alcohol, and police controls. Such measures, and others in the pipeline, should help to maintain the reduction in the death rate achieved in recent years.

It was to be hoped that experience gained to date would serve as a solid base for national and international action to increase road safety.

Dr ASSI GBONON (Côte d'Ivoire) praised the work to prevent road traffic accidents and limit their social, health and economic consequences. In her country, a substantial proportion of victims of road traffic accidents were pedestrians, many of them children. Her Government favoured a multisectoral approach to the problem and had improved inter- and intra-sector cooperation. In order to prevent accidents, it was necessary to apply WHO's five-year strategy, which required a surveillance mechanism to be in place. Road traffic accident prevention should be included in public health programmes, and structures to support victims both medically and psychologically should be reinforced. She too supported the draft resolution.

The meeting rose at 16:50.

SIXTH MEETING

Friday, 21 May 2004, at 09:30

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)
later: Mrs A. VAN BOLHUIS (Netherlands)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Road safety and health: Item 12.7 of the Agenda (Resolution EB113.R3; Documents A57/10 and A57/10 Add.1) (continued)

Professor SZCZERBAN (Poland), welcoming the inclusion of the subject on the agenda, expressed his support for the draft resolution. Although the number of road traffic injuries and fatalities had been steadily decreasing in Poland, despite an increased volume of traffic, the number of such deaths was still too high: 15 per 100 000 population. The main causes included: failure to adjust speed to road conditions; failure to respect right of way; failure of pedestrians to respect traffic regulations; and driving under the influence of alcohol, although some progress had been made in that last area.

Since 1999 Poland had been implementing an integrated medical rescue programme to speed up and improve the quality of services in emergencies such as road traffic accidents. The number of medical-rescue units had doubled and emergency facilities had been provided with modern, well-equipped ambulances. Rescue notification centres were linked to the fire brigade and used modern computer/telecommunications systems, which enabled the efficient dissemination of information and immediate dispatch of rescue teams, including airborne units, to the scene. Such an efficient medical-rescue service had an important role to play in reducing road traffic-accident-related deaths and injuries, as part of a broader programme including development of the transport network, with better roads; improvement of drivers' skills; and promotion of public awareness of the importance of road traffic safety.

Mrs Van Bolhuis took the Chair.

Mr VOKÓ (Hungary) stated that in Hungary, as in other countries, about half those who died in accidents were young adult men, mainly owing to excessive speed, driving under the influence of alcohol, and not wearing the mandatory seat belt. As the problem concerned mainly the active age group it was not only a medical but also an economic issue. The other group at risk was children. His Government had therefore welcomed the opportunity presented by World Health Day 2004 and, under the leadership of the Ministry of Health, Social and Family Affairs, had organized a multisectoral event in Budapest involving also the Ministries of Interior Affairs, Economics and Transport, the Hungarian Automobile Club and several nongovernmental organizations. The various activities had included the Automobile Club's launch of a road safety campaign, and a conference on road traffic injuries covering aspects related to road traffic organizers; police; ambulance personnel; and traumatization and post-traumatic rehabilitation. Similar events had been held in all counties with a view to preventing road traffic accidents by drawing attention to their main causes in a context of multisectoral cooperation and media support. He fully supported the draft resolution.

Dr ACHARYA (Nepal), welcoming the reports, said that a survey in 2003 had revealed that road traffic accidents in Nepal had increased by 9% in a year. For road traffic injuries the most vulnerable groups were people with visual or hearing defects; the mentally disturbed; and those

driving under the influence of alcohol. Nepal was taking strategic measures to reduce the increasing number of road traffic injuries, for example, by strictly enforcing traffic rules and regulations.

Dr MISORE (Kenya) stated that road-traffic-related injuries were a major problem in Kenya and had accounted for about seven deaths per day in recent years. Most road traffic accidents involved public transport vehicles and were mainly due to excessive speed; overloading of public transport vehicles; unsound mechanical state of vehicles; poor condition of roads; and driving under the influence of alcohol. The non-wearing of seat belts also contributed to injuries and deaths. In order to reduce the disease burden related to road traffic injuries the Government had adopted a multisectoral approach, involving the health, transport and communication sectors, and had elaborated strategies, including the adoption of a new law requiring all public transport vehicles to be fitted with safety belts and speed governors and prohibiting vehicles from carrying standing passengers. That law had come into effect in January 2004. Since then, road traffic injuries had decreased by more than 30%, and it was hoped that the continued implementation of such strategies would markedly reduce morbidity and mortality rates related to road traffic injuries in the coming years. He fully supported the draft resolution.

Dr GARBOUJ (Tunisia) welcomed the attention paid to developing countries in the reports. It was important for those countries to implement a strategy for road safety and health, and for individuals to take responsibility for protecting their own life and that of other road users. She fully supported the draft resolution, which would assist countries in introducing strategies to reduce the growing number of road traffic injuries. In view of the high number of road traffic injuries and fatalities in Tunisia, new legislation was being drawn up on road safety, involving several government agencies. Action was also being taken to improve infrastructure and the care provided to accident victims.

Dr VIOLAKI-PARASKEVA (Greece) said that, coming from a country with a high rate of road accidents, she endorsed the need for a multilateral approach to the prevention of road traffic injuries, with public health playing an important role. Recognizing that the use of alcohol and other psychotropic drugs was a significant factor in many road traffic accidents, with the possible addition of the use of mobile phones, she looked to WHO to provide guidance and technical support for efforts to improve road traffic safety. She supported the draft resolution, proposing the addition (in no particular order) of three new subparagraphs to paragraph 3: "to ensure knowledge and surveillance of risk factors with particular effects of alcohol consumption and psychoactive drugs"; "to integrate traffic injuries prevention into public health programmes"; and "to strengthen emergency and rehabilitation services".

Dr FUKUDA (Japan) commended the decision to make road safety and health the theme of World Health Day 2004 and recommended that Member States discuss the issue on a continuing basis. Japan had one of the highest rates of road traffic injury and death among high-income countries. The situation had been at its worst in the 1970s, coinciding with a period of high economic growth, and had resulted in heavy loss of life. In response, the public and private sectors had continuously undertaken various traffic safety promotion activities, particularly targeted at schoolchildren, which had contributed to a decrease in the rate of traffic accidents. He expressed his support for a multisectoral approach, recommending that the matter be discussed further, and said that such an approach, under the strong leadership of the National Police Agency, had contributed to the success of Japan's traffic accident prevention policy. In view of the current situation of limited resources, he invited discussion of how best to use those resources, for example, through WHO leadership in cooperation with the health agencies of Member States. What would be the role of the health sector? WHO should provide guidance and promote capacity building within the health sector in the area of traffic safety.

Mr FURGAL (Russian Federation) said that the road safety and health situation was rapidly becoming a global crisis with great socioeconomic and human repercussions. All aspects of the problem, including technical issues, needed to be addressed by competent players from both the State sector and civil society. Coordination of activities could be provided by Working Group 1 of the United Nations Economic Commission for Europe, which had 50 years' experience and had established international agreements and conventions in the area of road safety. WHO should be acting to achieve effective results in health-related areas: for example, demonstrating the dire consequences of road injuries; focusing on prevention, which was cheaper and more effective than cure; and drawing up the optimal approach for training medical personnel to help victims of road accidents. Criteria might be established for health-sector action with regard to road traffic injuries and recommendations made to increase the effectiveness of medical care given to road traffic accident victims. Also, special guidance was needed for all social services involved in order to eliminate the negative consequences of road traffic injuries.

Dr ZAHER (Egypt) stated that WHO's five-year strategy on prevention of road traffic injury had been adopted in Egypt. The health ministry in Egypt was working on several fronts to ensure road safety, through the provision of special rescue teams and medically equipped emergency points for road accidents on highways and desert roads, supported by various types of ambulances including mobile intensive-care and surgery vehicles. Led by the Ministry of Health and Population, and in close cooperation with the Ministry of the Interior, various ministries were establishing measures to reduce road traffic accidents, which included identifying drivers who used drugs and monitoring of pharmacies to deter the sale of narcotics or tranquilizers. In 2004 World Health Day activities had included lectures on the provision of first aid to victims and the training of ambulance drivers. He supported the draft resolution.

Dr RAZAFIMAHEFA (Madagascar) said that Madagascar had adopted a multisectoral approach to prevention of road traffic injury, bringing together the different ministries involved, nongovernmental organizations and sectors of civil society, such as transport, public works and town planning. Several measures had been adopted to prevent, and mitigate the consequences of, road traffic accidents. For example, regulations had been drawn up, or reinforced, for obtaining a driving licence; mandatory wearing of seat belts by drivers and passengers; wearing of helmets by motorcyclists and passengers; a ban on the use of mobile phones when driving; stricter vehicle testing; and breathalyser tests. Similarly, measures had been taken to improve road infrastructure and to reinforce the provision of hospital care for victims of road traffic accidents. However, she affirmed the need for the cooperation and support of Member States, organizations belonging to the United Nations system and nongovernmental organizations in providing a more positive response in the area of road safety and health. She thanked the Government of France in particular for support to her country for the introduction of breathalyser tests, which had reinforced prevention aspects. She urged WHO to call for reinforced cooperation of that kind on a greater scale. Referring to the draft resolution, she proposed the addition of the following words at the end of paragraph 3(9): "and to ban the use of mobile phones when driving".

Ms BOLORMAA (Mongolia) stated that injuries and accidents were the third leading cause of mortality in Mongolia and particularly affected young people and those at their most productive age, resulting in human suffering and economic loss. In 2002 her Government had adopted a national programme for road traffic injury prevention. Celebration of World Health Day in 2004, with its theme of road safety, had further reinforced her country's efforts. World Health Day would be celebrated as a national event each year, demonstrating her Government's high political commitment to WHO's initiatives. She expressed her full support for the draft resolution.

Mr WEEKES (Barbados) said that road traffic accidents particularly among the 15- to 44-year age group were a serious concern in Barbados. That group had accounted for 66% of all injuries from

such accidents during the period 1994-2001. Road traffic accidents cost the Government of Barbados an estimated 1% to 2% of gross national product annually. An intersectoral approach to the prevention of accidents and injuries was needed. Several measures had been introduced, including a major highway improvement programme, adoption of seatbelt legislation, and the requirement for motorcyclists to wear helmets. The Ministry of Public Works and the Caribbean Academy of Driving Excellence, a nongovernmental organization, had initiated a structured programme to sensitize children, youth and adults to road safety measures.

The growing demand for rehabilitation services for road traffic accident victims had resulted in a plan to establish a state-of-the-art rehabilitation centre and to decentralize ambulance services, and a training programme for emergency medical technicians, which would strengthen pre-hospital and trauma care. The Government recognized the need for national road safety strategies and plans of action, as recommended in the *World report on road traffic injury prevention*, and for regional and international cooperation, resources and information sharing. Barbados supported the draft resolution.

Dr KAMUGISHA (Uganda) observed that the preceding comments clearly showed accidents to be a global problem requiring priority intervention by all Member States. In Uganda, deaths from road traffic accidents had more than doubled in the previous 10 years to reach the highest road accident fatality rate in the East Africa region, seriously affecting the most productive age group – those aged 15 to 44 years. The Government had reacted by establishing a multisectoral road safety council under which the Ministry of Health carried out mass education on road safety and ensured that health facilities had the necessary competence to handle trauma cases. Also, casualty units were being established in all highway hospitals. Other sectors had designed programmes to reduce road traffic accidents, for example, through discouraging driving while under the influence of alcohol. The heavy burden of road traffic accidents left no doubt about the need to support the draft resolution.

Professor MAJORI (Italy) said that, considering the wide range of risk factors, a multisectoral approach to prevention was essential, and the public health sector had a crucial role to play in that effort. Italy was engaged in various such prevention programmes. He thanked WHO for raising awareness of the issue and putting it high on the global public health agenda. Italy fully supported the draft resolution.

Dr AKBARI (Islamic Republic of Iran) stated that traffic accidents were the second leading cause of death in the general population and the leading cause of mortality among children and young people. They also accounted for the greatest proportion of years of potential life lost. A multisectoral approach was needed; the Ministry of Health and Medical Education had sought to increase awareness of the problem, ensure high-level political commitment and strengthen intersectoral coordination and cooperation for the prevention and control of traffic injuries. He encouraged WHO to organize international summits with other stakeholders, globally and regionally, involving a range of high-level officials from Member States, including ministers of health, education, interior, transport and others. He fully supported the draft resolution.

Mr GRBEŠA (Croatia) said that traffic accidents were a leading cause of death in Croatia. Most victims were young people aged between 15 and 25 years, an alarming figure from a demographic standpoint, given the country's falling birth rate. Croatia was endeavouring to reverse that trend with the introduction of a new law on road safety that would include strengthened prevention measures and much more stringent driving standards. He fully supported the draft resolution and suggested that road safety should be a topic of ongoing concern for the Health Assembly.

Mrs CHERQAOUI (Morocco) noted that, as in other countries, traffic accidents had taken a heavy toll in Morocco. The country was working to strengthen competency and skills in order to improve health care and outcomes for accident victims. Her delegation supported the draft resolution.

Ms MOTSUMI (Botswana) said that the evidence on the linkage between road safety and health was of particular significance to Botswana. Accidents and injuries, including road traffic accidents, were currently the second leading cause of death, after HIV/AIDS. Some 76% of traffic fatalities occurred in the 1- to 39-year age group. National activities in the context of World Health Day 2004 had provided a good opportunity for strengthening multisectoral partnerships and fostering an integrated approach towards the planning and delivery of programmes relating to road safety, and for raising public awareness. The national launch of the *World report on road traffic injury prevention*, planned for later in the year, was expected to be a strong advocacy tool for further heightening public awareness of the importance of road safety. Botswana supported the draft resolution.

Professor DUSHIMIMANA (Rwanda) affirmed that traffic accidents, which took many lives each year, were largely preventable. In Rwanda, the most frequent causes included excessive speed; driver distraction, resulting, for example, from answering mobile phones while driving; failure to obey road signs; insufficient technical control of the vehicle; and driving while under the influence of alcohol – all of which could be avoided. Drivers must take responsibility for their actions. The activities carried out in connection with World Health Day 2004 had helped to mobilize numerous stakeholders in Rwanda, including the police, transport companies and various ministries. Her delegation fully supported the draft resolution on road safety and health.

Dr TSHABALALA-MSIMANG (South Africa) said that road traffic injuries had accounted for 27% of all deaths from injuries in South Africa in 2002. Many of those who died from traffic-related accidents were young men, further increasing the economic and social impact of such deaths. A burden of disease study had ranked traffic accidents as the fourth leading cause of premature mortality in the country. The theme for World Health Day 2004 had been "Stop road carnage now". A special unit had recently been created to deal with road traffic accidents, functioning as part of a multisectoral system focusing on prevention of risk factors for road accidents, advocacy and epidemiology. The legislative framework for improving road safety was in place, covering seat belt use, vehicle safety, alcohol use and speed. The country faced the challenge of enforcement of the laws. South Africa's objectives were in line with those of WHO. Her Government supported the draft resolution.

Dr ABREU CATALÁ (Venezuela) said that her Government had enacted a law in 2001 creating a permanent programme of education, at all levels, on issues relating to transport and road safety. The Ministry of Health and Social Development was currently working on the following aspects of road safety: enlistment of the mass media in prevention and education programmes; involvement of young people in such programmes, especially those who drove vehicles that had been modified without technical specifications; dissemination of written and audiovisual information to promote prevention of accidents; and information on risk factors such as use of alcohol; proper vehicle use and maintenance; participation in major prevention events organized by other institutions; and identification of road safety measures for mass transit systems, which were widely used by Venezuelans. Her delegation supported the draft resolution.

Mr MANGUELE (Mozambique) described the incidence of road traffic accidents in his country as an epidemic, accounting for more than 40% of deaths from non-natural causes between 1990 and 2000 and badly affecting children and working-age adults. He supported the draft resolution. Mozambique had welcomed WHO's choice of road safety as the theme for World Health Day 2004, and had worked to boost multisectoral collaboration for the prevention of road accidents and injuries. One of the Government's main priorities was to raise awareness through public health education carried out by the health sector in collaboration with schools, the police, the mass media, transport, and other sectors. A national multisectoral board had been created to coordinate all prevention activities. While Mozambique had accomplished a great deal, much remained to be done, and it still needed WHO's support and guidance.

Mr CAPEL FERRER (United Nations Economic Commission for Europe) welcomed WHO's involvement in road safety, which called for a multisectoral approach, with the health sector having a key role. That had been well understood by the General Assembly of the United Nations, which had, through resolution 58/289, invited WHO to act as a coordinator on road safety issues within the United Nations system, working in close collaboration with the United Nations regional commissions. Road safety had been a major objective for the governments of the Member States of the Commission since its creation in 1947. The Commission had created a working party on road traffic safety, composed of experts from its Member States. In close cooperation with the relevant intergovernmental and nongovernmental organizations, the working party had developed and updated internationally agreed road safety rules, regulations, norms and standards on all the main risk factors for road accidents. Many of them had evolved into legally binding agreements and conventions, including rules for road design and construction, active and passive safety requirements for the construction of safe vehicles, and the rules of the road for safe road traffic contained in the Vienna Conventions on Road Traffic and on Road Signs and Signals, which formed the basis for national legislation in many countries. The Commission believed that accession to, and implementation of, those conventions and norms by more governments would significantly help to reduce the number and severity of road accidents. Participation in the working party would increase countries' capacity to address road safety problems. In that regard, he recalled that all countries that were Members of the United Nations but not of the Commission were still entitled to attend its meetings in a consultative capacity and could accede to most of the legal instruments administered by the Commission. It looked forward to continued collaboration with WHO and all other interested partners in the common endeavour of improving global road safety.

Mr MUKELABAI (UNICEF) recalled that, among the about 1.3 million road traffic accident deaths occurring annually, most of those killed were children under 15 years of age, especially those who lived in poor communities. In many countries road traffic accidents accounted for more than 12% of morbidity in children. Contributing factors included overcrowded and poorly planned cities, with insufficient space allocated as playgrounds for children. As a result, children often played in the middle of busy streets and were vulnerable to traffic accidents. UNICEF pledged to work with all partners to support governments and communities in their enforcement of road traffic regulations in order to improve road safety, strengthening road safety education, including road safety as part of health promotion and disease prevention activities, and encouraging local governments and city councils to allocate sufficient playground space and to construct pedestrian paths, particularly for children. UNICEF was a member of the United Nations Steering Committee for Global Road Safety, and had participated in the United Nations General Assembly debate on global road safety in April 2004. UNICEF strongly supported the draft resolution on road safety and health.

Mr LAMB (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, commended the choice of road safety as the theme for World Health Day 2004 and the active participation of many Member States in the issue. The Federation supported a multisectoral approach worldwide and emphasized not just health aspects but also disaster preparedness and relief, post-disaster and trauma counselling, economic aspects and, above all, education. The Federation supported the principle of partnership. It was a member of and host for the Global Road Safety Partnership, other members of which included WHO, the World Bank and private sector partners, such as vehicle manufacturers. It was also heavily engaged at the regional level. Many countries were using a good practice guide on road safety and first aid prepared recently by a group of 26 European national Red Cross and Red Crescent Societies. The guide, which had been launched on World Health Day, was available on the Internet and had already been translated into 13 languages.

The Federation would be inviting national societies to contact their host governments with a view to making further progress in the area of road safety.

Dr KRUG (Injuries and Violence Prevention) thanked delegates for their constructive comments, and all those who had collaborated in arranging the hundreds of World Health Day 2004 events across the world, which had significantly raised awareness of road safety issues.

Delegates had asked about future activities and resource needs. The efforts made in recent months would all be in vain without concrete actions in countries. First, a meeting was to be organized with the United Nations regional commissions to discuss coordination of activities and define roles. Subsequently, discussions would be held with national governments at the highest political level regarding implementation of the recommendations contained in the *World report on road traffic injury prevention*, with particular emphasis on certain risk factors – drinking alcohol and driving, excessive speed, and failure to use safety belts and wear motorcycle crash helmets. A WHO programme would support public health schools in training on trauma prevention. WHO was also finalizing two documents to support first aid at accidents. Further efforts would be needed to mobilize additional extrabudgetary funding and develop partnerships within the United Nations and with governments, civil society and the private sector. The establishment of a specific fund was already being examined with certain partners, in particular the World Bank. Exchange of expertise was another important task and had been one of the aims of the *World report on road traffic injury prevention*. Opportunities to exchange information between experts would be afforded by the Seventh and Eighth World Conferences on Injury Prevention and Safety Promotion, for which WHO was a cosponsor, to be held in Vienna (6-9 June 2004) and South Africa in 2006, respectively, and by other planned meetings on road safety, including one with civil society.

The recent World Health Day and the Committee's debate should be considered as first steps. Most road accidents could be avoided – the solutions were already available. A redoubling of efforts was needed, however, to build on the progress made so far.

The CHAIRMAN invited the Committee to consider the draft resolution recommended in resolution EB113.R3 with the additional preambular and operative paragraphs set out in paragraph 4 of document A57/10 Add.1 and the amendments proposed during the discussion.

Dr HOLCK (Secretary) read out the proposed amendments. The delegate of Thailand had proposed that in paragraph 1, "and other sectors, government and civil society alike," should be inserted after "the public health sector". The delegate of Greece had proposed the insertion of a new paragraph 3(1) to read "to integrate traffic injuries prevention into public health programmes". Existing paragraphs 3(1) and 3(2) should be renumbered accordingly. The delegate of Thailand had proposed that the words "or through another effective mechanism according to the national context" should be added at the end of existing paragraph 3(3) and that "communities and civil society" should be added at the end of existing paragraph 3(4). Three further subparagraphs had been proposed for insertion in paragraph 3. The delegate of Greece had suggested two subparagraphs reading: "to strengthen emergency and rehabilitation services" and "to ensure knowledge of risk factors with particular effects of alcohol consumption, psychoactive drugs and the use of mobile phones while driving", the mention of mobile phones having been proposed by the delegate of Madagascar. The delegate of Burkina Faso had suggested addition of: "to explore the possibilities to increase funding for road safety, including through the creation of a fund". The delegate of Burkina Faso had requested the insertion of an additional paragraph 4(7) to read: "to organize regular meetings of experts to exchange information and build capacity;" and the delegate of Thailand had proposed an additional paragraph 4(8), reading: "to report on progress made in the promotion of road safety and traffic injury prevention in Member States to the Sixtieth World Health Assembly in May 2007".

In reply to a question from Mr HOHMAN (United States of America) regarding the budgetary implications of the proposal that WHO should organize regular meetings of experts to exchange information and build capacity, Dr KRUG (Injuries and Violence Prevention) said that those activities could be part of ongoing and planned WHO meetings and would not have major budgetary implications.

Mr HOHMAN (United States of America) suggested that in the proposed amendment to paragraph 3 referring to risk factors, "to ensure knowledge of risk factors with particular effects of alcohol consumption" should be replaced by "to raise awareness about risk factors with particular effects of alcohol abuse".

Dr HOLCK (Secretary) offered the following alternative wording: "to raise awareness about risk factors, in particular the effects of alcohol abuse, psychoactive drugs and the use of mobile phones while driving".

It was so agreed.

The CHAIRMAN invited the Committee to approve the draft resolution as amended, noting that circulation of the amended text in writing would entail a further delay.

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

Health promotion and healthy lifestyles: Item 12.8 of the Agenda (Resolution EB113.R2; Document A57/11)

The CHAIRMAN, mindful of the lengthy debate on the related agenda item on the draft global strategy on diet, physical activity and health, urged delegates to restrict their comments to the draft resolution recommended in resolution EB113.R2.

Ms AREEKUL AMORNSRIWATANAKUL (Thailand), speaking also on behalf of Australia, Belgium, Canada, Germany, Hungary and Switzerland, welcomed WHO's recognition of the need to strengthen policies and human and financial resources for health promotion in Member States, and to devise innovative means of financing to ensure the effectiveness and sustainability. Such policies and mechanisms should be appropriate to the health systems and political context of each country. Some countries derived funding for health promotion from dedicated tax revenues or national social and health insurance contributions. Thailand earmarked 2% of income from taxes on tobacco and alcohol sales, which had amounted to about US$ 15 million in 2003.

She proposed the insertion of a new third preambular paragraph in the draft resolution, to read, "Recognizing that the overriding efforts in health promotion should be geared towards reducing health inequalities by comprehensively tackling the determinant chain from societal structures, environmental factors and lifestyles". She further proposed the insertion of a new subparagraph 1(2) to read "to set up appropriate mechanisms to collect, monitor and analyse national experiences in order to strengthen the evidence base for the effectiveness of health promotion interventions as an integral part of health systems to achieve effective societal and lifestyle changes", with renumbering of subsequent subparagraphs. A new paragraph 1(5) should be added to read, "to actively consider where necessary and appropriate the adoption of innovative, adequate and sustainable financing mechanisms for health promotion and establish a firm institutional base for health promotion". She also proposed the insertion of a new paragraph 2(4) to read, "to proactively support Member States where necessary and appropriate in their attempts to establish an innovative financing mechanism with a firm institutional base to effectively coordinate and systematically monitor their health promotion efforts".

She invited delegates to attend the Sixth Global Conference on Health Promotion to be held in Bangkok from 7 to 11 August 2005, which would provide the best forum in which to report progress

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA57.10.

made in Member States and exchange views and experiences with a view to strengthening health promotion strategies in the context of rapid globalization.

Dr VIOLAKI-PARASKEVA (Greece) proposed that the words "and the WHO Framework Convention on Tobacco Control" should be added at the end of the first preambular paragraph of the draft resolution. She further proposed the insertion of an additional preambular paragraph to read: "Noting that mental health promotion constitutes an important component of overall health promotion".

Dr SMITH (Denmark), speaking on behalf of the five Nordic countries, Denmark, Finland, Iceland, Norway and Sweden, endorsed the high priority given by WHO to health promotion and healthy lifestyles and welcomed the planned Sixth Global Conference on Health Promotion. She stressed the importance of linking endeavours in the area of health promotion and healthy lifestyles to implementation of the global strategy on diet, physical activity and health.

Health promotion was a major advocacy tool to tackle wider health determinants, and thus to narrow health gaps. She strongly supported the "Move for health" initiative as such a tool at the global level. It was imperative that healthy lifestyle initiatives and interventions gave priority to children and adolescents. In view of the ageing population, the elderly as a group and healthy ageing should also constitute a focus, especially in the light of WHO's mandate in respect of the recommendations of the Second World Assembly on Ageing (Madrid, 2002). The alarming increase worldwide in physical inactivity and obesity caused mainly by unhealthy diets and excessive eating called for strong vigilance and concerted action. Strong documented scientific evidence showed that physical activity improved the body's defences against several diseases and disorders associated with a poor lifestyle. The "global burden of disease" study had shown that harmful use of alcohol was a major contributor to death and disability in the world, and it was imperative that WHO take the leadership role in reducing the harm done by alcohol. The Nordic countries looked forward to the report due to be issued in 2005 on the Organization's future work on alcohol consumption.

The CHAIRMAN, intervening, reminded the delegate of Denmark that speakers had been requested to confine their remarks to the draft resolution.

Dr SMITH (Denmark), concluding her remarks, said that the five Nordic countries were very much in favour of WHO assuming a leading role in developing evidence-based tools to counter the alarming trend in noncommunicable diseases and ill-health. They fully supported the draft resolution.

Mr ASLAM (Pakistan) expressed his support for the draft resolution.

Ms LABORA (Cuba) pointed out that most countries lacked the policies, human and economic resources and institutional capacity needed to promote health. She expressed her support for the draft resolution.

Mrs CHERQAOUI (Morocco) also supported the draft resolution. She proposed that the strategy should include the setting up of mechanisms to help smokers and drug users to give up their unhealthy habits.

Ms WIGZELL (Sweden), referring to the amendment proposed by the delegate of Thailand, suggested that for the sake of consistency the same language should be used in new paragraphs 1(5) and 2(4).

The CHAIRMAN suggested that, in view of the number and length of the amendments proposed, the agenda item should remain open until the following morning, when a new version of the draft resolution would be issued. If sufficient time remained after all the draft resolutions had been approved, the Committee could return to the general debate on the item.

It was so decided.

(For adoption of the resolution see summary record of the eighth meeting, section 3.)

Family and health in the context of the tenth anniversary of the International Year of the Family: Item 12.9 of the Agenda (Resolution EB113.R12; Document A57/12)

Reproductive health: Item 12.10 of the Agenda (Resolution EB113.R11; Document A57/13)

The CHAIRMAN said that the draft resolutions pertaining to agenda items 12.9 and 12.10 had been considered together by the Executive Board at its 113th session in January 2004, as the issues were closely related, and she proposed that the Committee should do so too in order to try to reach a swift consensus. She further proposed that the Committee should, as under the preceding item, consider the draft resolutions first.

It was so agreed.

Dr MODESTE-CURWEN (representative of the Executive Board) explained that the report on WHO's activities relating to family and health submitted to the Executive Board at its 113th session had confirmed the Organization's commitment to safeguarding and promoting family health.[1] The Board had adopted resolution EB113.R12 on family and health in the context of the tenth anniversary of the International Year of the Family.

Turning to reproductive health, she recalled that by resolution WHA55.19 the Health Assembly had requested the Director-General to develop a strategy for accelerating progress towards attainment of international development goals and targets relating to reproductive health. The draft strategy had been submitted to the Executive Board at its 113th session, and its endorsement by the Health Assembly was recommended in a draft resolution sponsored by several Member States. The Board had welcomed the draft strategy, and many members had commended it highly, stressing its usefulness in assisting countries to reach the Millennium Development Goals and targets and in reinforcing the consensus reached at the United Nations Conference on Population and Development (Cairo, 1994) and at the Fourth World Conference on Women (Beijing, 1995). The Board had emphasized the central importance of human resources and in particular the need for skilled birth attendants and hoped that the reports on implementation of the strategy would focus particularly on maternal and neonatal health. Some members had highlighted the importance of appropriate financing mechanisms to ensure sustainability of the actions proposed, and others had mentioned the importance of the role of the family in raising awareness of the importance of sexual and reproductive health. Other specific aspects on which members had commented included Member States' obligations under international human rights law and legal and policy barriers to people's access to services. Some speakers had asked for slight modifications, while others had expressed the wish to see the strategy forwarded to the Health Assembly for endorsement without change. The Board had adopted resolution EB113.R11 recommending inter alia that the Fifty-seventh World Health Assembly endorse the reproductive health strategy.

Mr ASLAM (Pakistan), referring to resolution EB113.R11, said that, when the draft strategy on reproductive health had been presented to the Executive Board in January 2004, his delegation had expressed reservations about paragraph 32 and proposed that the first and third bracketed texts should be deleted. Noting with surprise that the paragraph had remained unchanged, he requested again that those parenthetic texts be removed, since they were at odds with the tenets of certain countries, especially in the Muslim world.

---

[1] Document EB113/45.

The CHAIRMAN invited comments on the draft resolution contained in resolution EB113.R12.

Dr ABREU CATALÁ (Venezuela) said that her delegation proposed that in the eighth preambular paragraph of the draft resolution the words "the right to health and to" be inserted after the words "access to", and the words "and violence in all its forms, especially" after "child abuse, neglect".

Dr AGARWAL (India) proposed the addition of a new paragraph stating that initiatives focusing on family and health must take into account the role of schools in educating children, especially girls, about the importance of the family. The crucial role of family in the care and support of the increasing elderly population needed to be stressed. He requested suitable wording along those lines. His delegation supported the draft resolution.

Dr LEWIS BELL (Jamaica), speaking on behalf of member countries of the Caribbean Community, expressed support for the draft resolution. She proposed the inclusion of a new subparagraph under paragraph 2, to read as follows: "to support Member States in their efforts to establish or strengthen programmes on parenting through relevant research and international forums for sharing country experiences", and that in paragraph 2(4) the words "with special emphasis on men and the elderly" should be inserted between "members" and "in".

Ms MORENO ANAYA (Spain), expressing support for the draft resolution, said that it was entirely in line with her country's own policies in the area. Spain would support any type of initiative aimed at achieving universal welfare cover.

Dr QUANSAH-ASARE (Ghana) expressed her support for the draft resolution. She stressed the importance of highlighting issues relating to the elderly, particularly the neglected elderly, and the disabled. She therefore proposed inserting the phrase "particularly of members with disability and older persons" at the end of paragraph 1(3), between "neglect" and "occur".

HIV/AIDS and its impact on families, which were mentioned in document A57/12, should be reflected in the draft resolution as well.

Miss CHA-AIM PACHANEE (Thailand) recommended that WHO should integrate family health and strengthen gender-sensitive health policies in all its health programmes. She supported the draft resolution.

Mrs PHUMAPHI (Assistant Director-General) asked delegates to submit their proposed amendments in writing. Responding to the comment by Pakistan concerning paragraph 32 of the draft reproductive health strategy contained in document A57/13, she said that, depending on the response from other delegations, consideration would be given to removal of the text in brackets.

The CHAIRMAN invited comments on the draft resolution contained in resolution EB113.R11.

Dr LEWIS BELL (Jamaica), speaking on behalf of member countries of the Caribbean Community, supported the draft resolution. She proposed that in paragraph 2(3) the phrase "those countries where related mortality and morbidity are highest" should be replaced by "all countries".

Dr RUIZ (Mexico) proposed that in paragraph 2(3) an explicit reference should be made to the need to strengthen the capacity of health systems "with the participation of the community and nongovernmental groups".

Dr QUANSAH-ASARE (Ghana) supported the draft strategy and resolution, in paragraph 2(4) of which she proposed that the words "including adolescents and men" should be inserted after "other marginalized groups". A new subparagraph should be added to paragraph 3 reading "to assist in ensuring reproductive health commodity security among Member States".

Mr KIFLEYESUS (Eritrea) supported the draft strategy and the emphasis on reproductive health in achieving the Millennium Development Goals. He recommended that a reference to security in reproductive health commodities and the use of country commodity managers to improve logistics management information on reproductive health commodities should be added.

Dr SIRIPON KANSHANA (Thailand) proposed that references should be added in paragraphs 2(3) and 2(5) to the need for attention to adolescent reproductive health as an important foundation for later years.

Mr GUZMÁN VALENCIA (Colombia), supporting the draft resolution and strategy, said that WHO's initiative was largely consistent with his Government's policy on sexual and reproductive health and was based on the same principles of social and gender equity, analysis of demand, targeting and quality of services.

Dr RAKOTOELINA (Madagascar) expressed support for the draft resolution and thanked WHO, UNFPA, UNICEF and the World Bank for their joint statement on emergency obstetric and neonatal care to reduce maternal mortality.[1] In order for the proposed strategy to be effective, all multisectoral partners, civil society communities and health systems at all levels would have to be involved. She asked that wording to that effect be included in the draft resolution.

Mrs LE THI THU HA (Viet Nam) said that the draft resolution and strategy fully reflected the principles expressed at the International Conference on Population and Development and in the Millennium Development Goals. They also reflected the essential needs of the Vietnamese people, giving high priority to women and children and disadvantaged individuals and communities.

Ms KOLOLA (Malawi), supporting the draft strategy, said that reproductive health services were crucial to alleviating poverty and achieving the Millennium Development Goals.

The CHAIRMAN said that the various amendments proposed would be incorporated, with a view to discussion of both draft resolutions at the following meeting. She invited general comments on items 12.9 and 12.10.

Dr SONGANE (Mozambique) noted that the issue of reproductive health was being forgotten and deserved renewed emphasis in view of its contribution to the Millennium Development Goals for maternal and child health and its role in the strengthening of health care systems.

Experience in Mozambique indicated that health carers other than doctors could provide emergency care at the first referral level. In countries such as his, where there was only one doctor for every 38 000 inhabitants, assistant medical officers and nurse obstetricians could perform such functions effectively, but funding would be required to provide training and equipment. The strategy should encourage the various partners to help to ensure that that approach was pursued.

Dr ABREU CATALÁ (Venezuela) recapitulated the steps taken in her country on the family and social rights. The current Government had fully recognized gender equity, sexual and reproductive

---

[1] *Reduction of maternal mortality*. A joint WHO/UNFPA/UNICEF/World Bank statement, WHO, 1999.

rights, and full citizenship rights for children and adolescents. The drafting of a new Constitution in 1999 that enshrined equal opportunities for men and women and corrected gender inequities had begun a process of transformation designed to build human and social capital, in which the individual, the citizen, the family and the community were the focus of social policy in a people-centred State. The Constitution established equality before the law, without discrimination on grounds of sex, belief or social status, and with regard to employment. Housework was recognized as an economic activity that created added value and produced wealth and social well-being, housewives were entitled to social security, and the right to work was guaranteed without discrimination. The employment of adolescents in work that was detrimental to their overall development was prohibited; there was equal pay for equal work and free, compulsory and democratic education. A national plan for women had been drawn up, a national institute for women has been created within the Ministry of Health and Social Development, and a women's bank had been established to provide credit for women's micro-business cooperatives. Women in the most disadvantaged sectors were being empowered through credit, training and information, self-help, culture and sexual and reproductive health. A national office for the defence of women's rights had been set up, and a national equal opportunities plan had been developed. Progress had been made in drafting a comprehensive health policy with the provision of free, universal access to health services, and a comprehensive health care model was being implemented in cooperation with Cuba, under which 80% of individuals previously excluded from the country's development programmes and plans received health care; doctors made home visits to the most disadvantaged communities. The primary health care sector had been overhauled with the provision of people's clinics, outpatient care and hospitals. Comprehensive care for boys, girls and adolescents was being provided in a strengthened child health programme, as well as comprehensive care to combat childhood diseases and prevent infant and maternal mortality.

Dr YEVIDE (Benin), speaking on behalf of the Member States of the African Region, said that the conditions prevailing in developing countries, where there was limited access to basic services, and a lack of qualified staff, including midwives, resulted in high rates of maternal and infant mortality. A firm commitment must therefore be made to promote reproductive health. The draft strategy would be important in achieving the Millennium Development Goals. The countries of the African Region reiterated their commitment to mobilize the financial resources needed to strengthen the capacity of their health systems, in order to achieve universal access to reproductive health care, with particular emphasis on maternal and neonatal health. They called on the Director-General to mobilize additional financial resources for strengthening their reproductive health programmes and services; provide them with technical support in implementing their strategies while taking account of their sociocultural context; cooperate with other United Nations agencies to ensure the coordinated support of the United Nations system for improving reproductive health; and support countries in monitoring progress towards the Millennium Development Goals.

Dr CONNOLLY (Ireland), speaking on behalf of the European Union, the candidate countries Bulgaria, Romania and Turkey and the countries of the Stabilization and Association Process and potential European Union candidates Albania, Bosnia and Herzegovina, Croatia, The former Yugoslav Republic of Macedonia, and Serbia and Montenegro, said that the European Union had always been committed to the principles of the Cairo Programme of Action. The draft reproductive health strategy would contribute to achieving the Millennium Development Goals and to preventing HIV/AIDS, and would accelerate the so far uneven progress in meeting the goals of the Cairo Programme of Action.

Health services could not deal with all the social and economic factors that affected population size. The joint WHO/UNICEF report[1] showed that antenatal care was heavily influenced by factors

[1] *Antenatal care in developing countries: promises, achievements and missed opportunities.* Geneva, World Health Organization, 2004.

such as wealth and education: women with secondary schooling were two to three times more likely to receive antenatal care than those with no education. Implementation of the Programme of Action depended not only on the reproductive and health sector but also on the social sector, including education, issues related to gender equality and the protection of minority and vulnerable groups, democracy and good governance. Intersectoral links would permit an integrated approach to meeting sexual and reproductive health needs. Only through progress in those key areas could the environment necessary for full realization of sexual and reproductive health and rights be built. Cooperation and collaboration within the United Nation system was a prerequisite.

The European Union supported the draft resolution, endorsed the proposed strategy and encouraged the Director-General to work closely with appropriate partners to support Member States in implementing the strategy and reaching related development targets.

Dr RUIZ (Mexico) welcomed the reports on the family and on reproductive health, with their bases in equity and respect for human rights. Mexico's strategy for ensuring that everyone had an equal start in life recognized that infant mortality and life expectancy varied considerably among Mexico's regions. The country's programme was based on four fundamental strategies, namely to ensure healthy pregnancy, clean and safe childbirth, healthy neonates and fit children, involving broad participation by the community, local authorities and various nongovernmental organizations. It rested on both a social network, with midwives and the community, which sought to ensure that women in rural communities were able to receive health care or were referred on a timely basis to health-care units, and a broad network of services, guided by the philosophy that no woman should be turned away by a clinic or hospital. The programme was based also on proper training of health personnel and the availability of equipment and materials. Applauding the strategy's focus, not only on maternal and infant mortality but also on family planning, with emphasis on adolescents and women, he fully supported the proposed strategy.

The meeting rose at 12:30.

SEVENTH MEETING

Friday, 21 May 2004, at 14:40

Chairman: Mrs A. VAN BOLHUIS (Netherlands)

TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Family and health in the context of the tenth anniversary of the International Year of the Family: Item 12.9 of the Agenda (Resolution EB113.R12; Document A57/12) (continued)

Reproductive health: Item 12.10 of the Agenda (Resolution EB113.R11; Document A57/13) (continued)

Dr YOOSUF (Maldives) said that the reproductive health needs of women and adolescents, particularly in developing countries where the pregnancy-related morbidity and mortality rates were high, should be met by the provision of appropriate, user-friendly health services that were acceptable to the community. The draft strategy provided a comprehensive platform for achieving international development goals and the draft resolution complemented the Programme of Action of the International Conference on Population and Development (Cairo, 1994). His Government therefore strongly endorsed the strategy.

Dr QUANSAH-ASARE (Ghana) said that the concept and definition of reproductive health used in her country's national health service policy and standards document had been revised in 2003 to include gender-based violence and other emerging issues. Since 1996, reproductive health priorities had included essential and emergency obstetric care, family planning, adolescent health, cervical cancer and HIV/AIDS. Despite action on contraceptive security and two national campaigns on family planning and safe motherhood, the national maternal mortality rate was still high, at 214 per 100 000 live births, with wide regional variations. The contraceptive prevalence rate was 13%. Although there had been an increase in antenatal care coverage, supervised delivery rates were low. Strategies had been adopted to deal with inequalities within the country and funding had been increased to the five regions with the worst maternal and child health indicators. Free supervised delivery had been instituted in four regions. As part of a community-based health planning strategy, which was being implemented incrementally, multipurpose community health nurses/midwives were employed to deliver local health care, and tractor ambulances were being used to attend obstetric emergencies in remote agricultural areas. Adolescent reproductive health was also a priority. Good progress was being made in securing the participation of men in reproductive health care.

WHO's sound and comprehensive draft strategy fitted in well with other strategies and initiatives, in particular with its consideration of population groups that were generally underserved and marginalized. It would help to redirect priorities and support achievement of development goals. It should nevertheless pay explicit attention to men's sexual and reproductive health and do more to address the issue of unsafe abortions. WHO should emphasize the potential benefits of family planning, be more proactive in reproductive health commodity security and ensure the prompt and extensive dissemination of scientific information (including technical assistance for countries with few Internet resources) on family planning methods, breastfeeding and HIV/AIDS. Her Government endorsed the draft strategy.

Dr SOLOMON (Kenya) said that reproductive health was high on the list of his Government's priorities, on account of the country's high pregnancy-related mortality and morbidity rates. Currently, in Kenya, 90% of deaths due to complications during pregnancy were preventable; the maternal

mortality rate was 590 per 100 000 live births and only 42% of births were attended by skilled attendants. Kenya was implementing a national reproductive health strategic plan, under which a full range of services would be available in the private and public sectors, and which covered safe motherhood and child survival, family planning, the reproductive health of adolescents and young people, sexually transmitted diseases, HIV/AIDS, gender and reproductive rights, infertility treatment and reproductive tract cancers. Services would be integrated to improve the quality of care, research would be carried out, resources would be mobilized, and monitoring and evaluation systems introduced. The provision of reproductive health services needed to overcome the acute shortage of medical staff and inadequate equipment and supplies.

In the field of family health, policies had been formulated on adolescent and youth health and development, and on infant feeding. The integrated management of childhood illnesses was being strengthened and guidelines on health promotion were in preparation. Mental health policy included a family health component. Harmful cultural practices were being tackled and post-rape management guidelines were being drawn up. An infertility working group had been started. Infant feeding choices needed to be clarified, and sociocultural beliefs that discouraged medical consultation and difficulty in reaching young people had to be overcome.

He supported the draft resolutions on reproductive health and family health.

Dr VON VOSS (Germany) fully endorsed the draft strategy on reproductive health, stressing the importance of providing age-appropriate sex education for children and young people. The importance of a well-functioning health system could not be overestimated in that context, as it played a decisive role in reducing morbidity and mortality and facilitated effective preventive strategies and health education. Reproductive health must become a cross-cutting issue for marginalized and impoverished sections of the population to be reached. In Germany, family planning and sex education strategies were being developed as part of a government programme for disadvantaged neighbourhoods which would entail a comprehensive interdisciplinary and intersectoral community effort. Evaluation must also form an integral part of national and international programmes. In Germany, two institutions had been designated as WHO collaborating centres.

Mr YOSHIDA (Japan) said that the family structure in many countries had so altered owing to an ageing society and the increase in the number of working women that the community could no longer ignore the acute need for professional support. In 2000, his Government had launched a national action programme aimed at building capacity to improve the health of parents and children in the 21st century. It covered the psychological health of parents-to-be, parents and children, and adolescent health, focusing on sexual behaviour, drug abuse, eating disorders, social maladjustment, unwanted pregnancy, HIV/AIDS and other sexually transmitted diseases. Emphasis was also placed on a life-course approach that promoted the health and development of children and adolescents by recording their progress in a mother and child health notebook. Other countries had taken up that idea and his Government was keen to pursue international cooperation that drew on that experience.

For reproductive health, the reduction of maternal mortality was particularly important. A safe birth programme that had been launched as part of a bilateral technical cooperation programme aimed at training birth attendants to provide basic services. Assistance was also being provided to countries with a maternal mortality rate of 100-200 per 100 000 live births in an effort to improve the quality of care. To help to prevent mother-to-child transmission of HIV Japan was likewise promoting public-private partnerships and collaborating with other organizations to expand the provision of basic health services. Although the social, cultural and other aspects of reproductive health complicated achieving the Millennium Development Goals, experience had shown that the provision of basic health services was the best way to reduce the maternal mortality rate. He strongly supported the draft resolution.

Dr WANG Bin (China) favoured adoption of the draft strategy in order to accelerate progress towards the attainment of international development goals and targets in relation to reproductive health. Over the past decade, understanding of the issues involved in reproductive health had deepened

and in most countries it had become an important factor in safeguarding women's health rights. The guidance offered by the international community had had a far-reaching impact on reproductive health in her country. The protection of women's reproductive health rights had been integrated into national policy. Central and local government had allocated substantial resources for reducing the high maternal mortality rate in poor areas. Experience had shown that good results could be obtained with the right policy and inputs. Her country had obtained much assistance from WHO and other international bodies in recent years, which had resulted in innovation and improved management and technology. Given the size of its population and its efforts to achieve the targets of the Programme of Action of the International Conference on Population and Development, it trusted that further help would be forthcoming. Although the proposed draft strategy was comprehensive and specific, regional and national differences would have to be taken into account in implementation. Interministerial cooperation would be essential.

Dr TARUS (Republic of Moldova) fully supported the draft strategy, since cooperation with WHO, UNFPA and UNICEF had enabled her country to adopt several practical measures in reproductive health, perinatal care and family planning. The Republic of Moldova had been selected as a pilot country for the Making Pregnancy Safer initiative. The medical services being provided in youth centres had resulted in a sharp reduction in maternal and child mortality and in the number of abortions. The global strategy would help her Government cope with the challenges that lay ahead.

Mr KIFLEYESUS (Eritrea) said that his Government's efforts to improve the health of the country's population had had the support of United Nations agencies and of bilateral and international partners. Priority had been given to providing good, accessible, fully-integrated health services. The number of facilities had been increased and staff had been trained. Policy guidelines on sexual and reproductive health, as part of primary health care, had been formulated. The next task was to ensure universal access to those services in governmental and nongovernmental facilities, to reduce the high maternal mortality rate, improve the quality of antenatal care and increase the availability and use of family planning. Women would be empowered to take greater control of their reproductive and sexual lives, and disadvantaged populations and communities would be involved in planning, implementing, monitoring and evaluating their own reproductive health programmes.

He suggested that a reproductive health commodity security programme should be mentioned in the draft strategy under the section on family planning, and further that developing countries should use the country commodity manager to improve their logistics management information systems. Having strongly supported the Programme of Action of the International Conference on Population and Development, his Government endorsed the draft strategy.

Dr HERMIYANTI (Indonesia) said that Indonesia's 2002/2003 health survey had shown a high maternal mortality rate owing to delays in referring women with obstetric complications, a lack of qualified antenatal care and absence of skilled assistance during childbirth. On the other hand, family planning had reduced the total fertility rate and increased contraceptive use. Unsafe abortions and infertility remained problems and the number of cases of HIV/AIDS was increasing each year. The problems encountered among adolescents were unwanted pregnancies, drug use, anaemia and limited health information and services. As with gender-based violence and gynaecological conditions, however, the data available were limited. Progress had been made: Indonesia had adopted the reproductive health and sexual health definitions and had launched a reproductive health programme. A national committee on reproductive health had been established, and policies and strategies had been adapted to accelerate the progress of the reproductive health programme. Indonesia strongly supported the draft resolutions.

Mr HOHMAN (United States of America) said that his country remained committed to the key goals of the Programme of Action adopted at the International Conference on Population and

Development in Cairo. It was the largest bilateral contributor to programmes in developing countries on reproductive health, voluntary family planning and maternal morbidity and mortality reduction.

Given the urgency, range and depth of women's health issues around the world, WHO's draft strategy should have provided a framework for practical action and leadership, but it fell far short of that goal. Although the draft was an improvement on earlier versions, its shortcomings made it unacceptable. It cited internationally agreed human rights instruments as a guiding principle, yet not all instruments had been universally accepted, and they did not impose obligations on States that were not Party to them. In more than one place, the document referred to sexual health rights, but the international community had never defined any such rights as human rights. His country could not accept the numerous references to "reproductive health and sexual health services" as that expression could be interpreted as promoting abortion services or the use of abortifacients. It was also troubled by the focus on "unsafe" abortions, since that implied that "safe" abortions were acceptable; it did, however, recognize the humanitarian necessity of providing care for women suffering from the consequences of an abortion. It also objected to the suggestions that urgent action could include providing abortion services at the primary health care level and that the issue of violence against women could be tackled by the provision of abortion. There was inadequate recognition of the rights and responsibilities of parents, legal guardians or other caregivers, which had been a central focus of the World Summit for Children (New York, 1990). The characterization of all recommended actions as "necessary" was unacceptable. The document should clearly reflect its non-binding nature: whether an action was "necessary" was a decision for Member States. No evidence or data were provided to back many of the draft's assertions. For those and other reasons, his delegation believed that further work should have been done on the strategy before it was submitted to the Health Assembly.

Dr MATIUR RAHMAN (Bangladesh) said that, in developing countries like Bangladesh, women were disadvantaged economically and socially as well as in health, unlike most countries where economic growth had led to a decline in overall mortality. Although infant mortality for females was lower than for males, the survival rate of women beyond the age of 30 was significantly lower, with unacceptably wide disparities between rural and urban populations. Improvement of women's health and reduction of maternal mortality should be given the highest priority by government policy-makers and civil society. An alliance of all interested groups had been forged in Bangladesh through stakeholder consultations at every level to develop the country's poverty reduction strategy paper for achievement of the Millennium Development Goals. That paper included strategies that emphasized improvements in women's health and education and reduction of maternal mortality. In Bangladesh many girls married early and became pregnant as adolescents; with maternal mortality some two to three times higher than for adults, coordinated social and legislative action was needed as well as better access to antenatal care, skilled birth attendants, and access to essential obstetric care in the event of complications. A maternal health strategy had been developed to reduce maternal mortality rates. However, various obstacles, such as long distances, financial barriers and poor quality services, prevented women from making use of available care. Efforts were being made to improve facilities at upazilla (subdistrict) level, including a maternal health voucher scheme in 21 upazillas for the poorest pregnant women. Bangladesh was deeply committed at the highest political level to women's development. Several programmes coordinated by the Ministry of Women and Children Affairs were being implemented and girls were being encouraged to complete primary school and embark on secondary education. There was intensive training for female health assistants and female welfare assistants, who were recognized as skilled birth attendants in place of midwives. For that reason, he proposed adding in paragraph 32 of the draft strategy after "(e.g. preventing midwives ..." the words "or skilled birth attendants ...)".

Dr DONNAY (UNFPA), speaking at the invitation of the CHAIRMAN, applauded the strategy and the attention given to reproductive health. The strategy was fully compatible with the Programme of Action adopted at the International Conference on Population and Development and reaffirmed by the United Nations General Assembly special session on children in 1999. Its integrated approach was

the most cost-effective way of providing reproductive health services. Together with WHO, UNFPA worked to ensure that young people had access to lifesaving information and care in a culturally appropriate manner. Strengthening linkages between reproductive health and HIV prevention and care programmes could have significant impact.

Services such as family planning and antenatal care provided excellent opportunities to reach women for HIV prevention and treatment. Since more than 75% of HIV infections were sexually transmitted, interventions focused on behavioural change, safe delivery practices for mothers and neonates and treatment of sexually transmitted infections were effective entry points for HIV prevention and care. WHO and UNFPA had organized an expert consultation in December 2003 to identify indicators for measuring progress towards the goal of universal access to reproductive health, a target essential for achievement of the Millennium Development Goals by 2015. UNFPA collaborated fully with WHO on all core aspects of reproductive and sexual health. Within maternal health, skilled care in childbirth and emergency obstetric care to manage complications should be given due consideration. The prevention of unwanted pregnancies also played a major role in reducing maternal deaths and childbirth injuries. Despite the massive increase in contraceptive use in developing countries, there was still a great demand for family planning services; ensuring commodity security and improving the quality of service were important in responding to needs.

Effective application of the strategy's human rights approach would promote social inclusion and help to alleviate poverty. More resources were nevertheless needed to fulfil the promise of a world of freedom, solidarity, tolerance and shared accountability.

Dr MORINIÈRE (International Federation of Red Cross and Red Crescent Societies), speaking at the invitation of the CHAIRMAN, said that his organization was committed to assisting in enhancing family health and reducing global mortality from malaria, especially for pregnant women and children under five years of age. The Federation and its member societies recognized the severe burden imposed by the disease on children and mothers, its impact on economic and social development, the need for cost-effective treatment and prevention and the commitment of the Roll Back Malaria initiative to mobilize resources towards achieving the Millennium Development Goals and the 2005 targets set by the African Summit on Roll Back Malaria (Abuja, 2000). Those objectives were in keeping with the Federation's mission to help the most vulnerable and its capacity to mobilize thousands of community volunteers for that purpose. The International Federation at the global level and national societies at country level were actively combating major public health problems in cooperation with national governments, WHO, UNICEF and other partners. In addition to their traditional role in responding to disasters, its volunteers had been increasingly involved in ongoing programmes to control diseases such as HIV/AIDS, tuberculosis and poliomyelitis. Their active participation since 2001 in vaccination campaigns against measles, in which, by the end of 2005, more than 200 million African children would have been vaccinated, had offered opportunities to accelerate other important interventions, such as the mass distribution of mosquito nets for malaria prevention among young children and pregnant women. After successful demonstrations in Ghana in 2002 and in Zambia in 2003, a campaign of measles vaccination and mosquito net distribution would start in Togo in December 2004 with the participation of its volunteers. The joint WHO/UNICEF statement of January 2004 calling for combined malaria control and immunization activities was welcomed by the Federation, which looked forward to working with governments, WHO and other partners to implement the comprehensive strategies for measles mortality reduction and the expansion of malaria control activities. It supported the call for stronger partnerships at the global, regional and national levels. A broader involvement of nongovernmental organizations as partners of governments was crucial to better family health. The mobilization of civil society and the involvement of the communities and families concerned lay at the heart of the Federation's work of helping communities to improve the health of the most vulnerable populations and advance the Millennium Development Goals.

Mrs KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, supported WHO's drive to accelerate action for reproductive health. It was deplorable that maternal mortality rates had not fallen in the past 10 years, despite the knowledge that most deaths could be prevented by access to effective, appropriate and affordable health services and to high-quality education. She updated the statistics in the draft strategy: 13 million children each year became mothers, and 70 000 of those died from pregnancy-related complications; 1 million children born to those children would die before their first birthday, and, if the girl-mothers were under 14, their chances of death or disability were more than doubled; and health services did not reach the 50% of those who were married. She urged WHO to explore ways of providing reproductive health services in situations of conflict. With regard to adolescents (paragraph 25 of the draft strategy), priority needed to be given to reducing social, economic and cultural barriers to health care. Her organization had used primary health care principles to develop draft guidelines ("Agenda for change and making change happen") which were currently being used in Bangladesh and the Russian Federation for improving access to health services by adolescents. Member States should request those draft guidelines to support the development of national adolescent health strategies that would include parents, adolescents and other stakeholders. The "3 by 5" initiative should support the integration of quality of care and primary health care principles into the programmes for strengthening health systems. Health workers needed to be given the resources, support, supervision and training required to provide adolescent-friendly services. In connection with paragraph 32 of the draft strategy, she urged Member States to legislate against early marriage so as to protect girls from a life of restricted choices and poverty. In relation to paragraphs 26, 27 and 30, she urged Member States to abolish user fees, as Uganda had done and Ghana had begun to do. She was grateful that WHO had persisted with the rights-based strategy and looked forward to more rights-based programming and strategy implementation, especially in relation to children's health.

Mrs HAUPTER (International Alliance of Women), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baccalaureate Organization and the International Federation of Business and Professional Women, said that, although 20% more women in developing countries were receiving antenatal care than in 1990, the rise of only 4% in sub-Saharan Africa, probably due to the strain on national health budgets of high rates of population growth, was alarming. Many more women and adolescents needed to understand the benefits of smaller families and have access to means of birth spacing. The recent restricting of policies on contraception was worrying. Since financial security was essential for effective reproductive health programmes, relevant United Nations agencies and donors should step up their efforts, particularly with respect to sub-Saharan countries. Information, education and communication were vital, and services, including family planning, needed to be available, affordable and adequate. The Millennium Development Goal of reducing maternal mortality appeared to be in jeopardy. In 2000, more than 500 000 women had died of complications during pregnancy and childbirth and at least 13% of those deaths had been caused by unsafe abortions. She appealed to governments to revise the existing restrictive legislation. The organizations she represented were committed to working for women's equal rights and empowerment. They were convinced that better status for women, especially in developing countries, would improve the whole spectrum of reproductive health.

Mrs HASLEGRAVE (Global Forum for Health Research), speaking at the invitation of the CHAIRMAN, said that much remained to be done to attain the targets of the Programme of Action of the International Conference on Population and Development and the Millennium Development Goals. Political commitment and resources would be required to fund the necessary research. So far, efforts to reduce maternal mortality and morbidity had failed to reach agreed targets, as had the methods adopted to reduce the prevalence of sexually transmitted infections, particularly among teenagers, a major cause of the current high levels of secondary infertility. Women still lacked a method of avoiding such infections that was under their own control, yet funding for research into a safe, reliable and affordable microbicide was inadequate. There was also a growing need for contraception for the

increasing number of women entering their childbearing years and for sexually active adolescents. New responses were needed if the agreed targets were to be met. What was required was broad-based comprehensive research into the determinants of reproductive and sexual ill-health and methods of preventing and treating it. The Global Forum urged governments to support research into health policies and systems, the social and behavioural factors involved and their consequences, and operational research.

Mrs KINGMA (International Confederation of Midwives and International Council of Nurses), speaking at the invitation of the CHAIRMAN, stressed the importance of adopting the draft strategy to accelerate progress towards the attainment of international goals and targets. An unacceptably large proportion of women in the world's poorest regions gave birth without the help of a skilled birth attendant. In sub-Saharan Africa, the proportion had not changed in the past decade. Even though the crucial role of skilled birth attendants and the availability of emergency obstetric care were emphasized in the strategy, midwives and nurses were often limited by certain policies and regulations, such as those preventing performance of life-saving procedures against postpartum haemorrhage, the major cause of maternal mortality. The strategy also indicated that the main barrier to the expansion of comprehensive reproductive and sexual health services and better quality of care was the shortage of human resources. She particularly welcomed the founding of the draft strategy on internationally agreed human rights treaties and global consensus, but the action required to meet reproductive health targets depended on the political will to strengthen the health sector, especially in the poorest countries. The two organizations she represented would continue to work with national member associations to support national and global reproductive and sexual health agendas.

Dr HOLCK (Secretary) read out the proposed amendments to the draft resolution contained in resolution EB113.R11. Paragraph 2(3) should be amended to read "... health systems, with the participation of community and nongovernmental groups, to achieve universal access...," and "those countries" should be replaced by "all countries." Paragraph 2(4) should be amended to read "... marginalized groups, including adolescents and men, and that ..." Paragraph 2(5) should be amended to read "... inter alia, adolescent reproductive health and maternal and neonatal health ..." A new subparagraph should be added to paragraph 3, reading "to assist in ensuring reproductive health commodity security among Member States."

Responding to questions from Ms de HOZ (Argentina) and Mr HOHMAN (United States of America), Dr VAN LOOK (Reproductive health and research) explained that the term "reproductive health commodity security" meant ensuring that essential products for reproductive health were available when people visited family planning clinics or when women were admitted to hospital suffering from obstetric or gynaecological complications. Commodity security was mainly the responsibility of UNFPA; WHO ensured that essential reproductive health commodities were included on countries' essential medicines lists and helped Member States to make high-quality products available in sufficient quantities at the point of delivery.

Mr HOHMAN (United States of America) suggested the wording "to assist Member States in ensuring reproductive health commodity security."

Dr HOLCK (Secretary) read out the proposed amendments to the draft resolution contained in resolution EB113.R12. The eighth preambular paragraph should be amended to read "... neglect, violence in all its forms, especially spousal and domestic violence, alcohol ...". Paragraph 1(3) should be amended to read "... members, such as those families in which child abuse, violence in general, domestic violence or neglect, including of members with disabilities and older persons, occur."

A new paragraph 2(3) should be inserted, reading "to support Member States in their efforts to establish or strengthen programmes on parenting through relevant research and international forums for sharing country experiences." Original paragraph 2(4) should be amended to read "to pay due attention to the care and support issues related to the health of family members, including men and the elderly, in relevant ... and ensure that initiatives focusing on family and health take into account the role of the school in educating children, especially the girl child".

The draft resolutions, as amended, were approved.[1]

Mr HOHMAN (United States of America) said that his delegation had not wished to block consensus approval of the draft resolution contained in resolution EB113.R11. However, he wished it to be placed on record that his Government did not endorse the draft strategy relating to reproductive health.

Genomics and world health: report of the Advisory Committee on Health Research: Item 12.13 of the Agenda (Resolution EB113.R4; Document A57/16)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB113.R4.

Dr LARIVIÈRE (Canada), welcoming the report,[2] said that genomics offered high promise to make a beneficial contribution to health care. WHO's call for the development of national policies and strategies and for the establishment of health technology assessment mechanisms and a proper regulatory system for safety, as well as ethical review procedures, was consistent with his own country's initiatives. Efforts must be made to ensure that genomics served to reduce, rather than exacerbate, health inequities. The benefits of advances in technology and science must not be confined to those who could afford to pay the full price for them. He supported the draft resolution.

Dr AGARWAL (India) said that India had encouraged research and development in genomics and health biotechnology since the 1980s. In 1999, the Indian Council for Medical Research had set up a task force on human genetics. The Council had worked on microbial and vector genomics, disease-susceptibility genes, prenatal diagnosis of thalassaemia, genetic epidemiology, diagnostics, therapeutics and vaccine development. It had drawn up draft guidelines on stem cell research and regulation; it had prepared a regulatory framework for the use of genetically modified foods and discussed related ethical issues. Countries must develop appropriate policies and regulations for genomics research and strengthen their capacity in that area, while bearing in mind the ethical implications of their work. It was to be hoped that WHO would earmark funding for research and capacity-building in genomics.

Dr NISHIJIMA (Japan) supported the draft resolution. Genomics research had the potential to improve people's health and well-being and to promote the development of new industries. However, it might widen the health care gap between countries, and there were other concerns about its safety and ethics. Genomics research must be promoted with respect for human dignity and rights. His country had adopted ethical guidelines for genomics research in 2002, and a law on the protection of personal information had entered into force in 2003. The Ministry of Health and Welfare had

---

[1] Transmitted to the Health Assembly in the committee's second report and adopted as resolutions WHA57.12 and WHA57.11, respectively.

[2] *Genomics and world health: report of the Advisory Committee on Health Research.* Geneva, World Health Organization, 2002.

recommended that genomics research should be aimed at improving human health, not merely advancing knowledge.

Dr FERDINAND (Barbados), speaking on behalf of member countries of the Caribbean Community, said that the sequencing of the human genome would contribute to the clinical and therapeutic management of diseases, especially hereditary diseases, but warned that the cost of the technology required might be beyond the means of those who needed it most. The sophisticated infrastructure required would place an added burden on health services.

Genomics research carried potential risks, such as the possibility of exacerbating global health inequalities, and might raise complex ethical issues. Bioethicists and legal professionals would have to exercise strict controls in order to ensure that the technology was not abused or exploited for profit. Conventions and other legislation were required in order to end the patenting of genes and ensure access to technology. The early diagnosis of inherited conditions caused by defective genes might increase the demand for other interventions which had legal and moral implications. The manipulation of genes might cause mutations or new diseases. Genomics research could be used to improve health, especially in the developing world, but more public education, awareness and debate were needed.

She supported the draft resolution and the call for a WHO strategy to ensure that the benefits of genomics were applied to health improvement in developing countries.

Mr ASLAM (Pakistan), supporting the draft resolution, said that genomics research had improved the diagnosis, prevention and, to some extent, management of common inherited diseases caused by a single defective gene, and made likely the availability of new diagnostic agents, vaccines and therapeutic agents for communicable diseases. Decisions were needed on how recombinant DNA technology and its benefits could be fairly distributed, so that the gap in health care between rich and poor countries did not widen. The patenting of genes had already aroused considerable concern in poor countries. A coherent policy framework was urgently required.

All forms of recombinant DNA technology raised important safety issues and required careful monitoring and control, and the potential risks must never be underestimated. Effective regulatory systems should be established in countries in which genomics research had not yet begun, or was in its early stages.

Dr NSIAH-ASARE (Ghana) said that genomics could bring long-term benefits for the prevention, diagnosis and management of many diseases, but recombinant DNA technology and its potential clinical benefits must be distributed equitably, so that the already yawning gap in health care between rich and poor countries did not grow even wider. A coherent policy framework was needed to ensure that DNA patenting would stimulate scientific and economic progress in the application of medical technology to the health problems of developing countries. He too supported the formulation of a WHO policy to ensure that the benefits of genomics were applied to health improvement in developing countries.

Dr VIOLAKI-PARASKEVA (Greece) said that the Advisory Committee's recommendations formed a useful basis for biomedical programmes and could contribute significantly to public health, although genomics research in the field of human cloning must be subject to ethical constraints. Information of a high scientific standard showing the potential benefits must be made available to public health officials, governments and the general public, and WHO must ensure collaboration and coordination with other United Nations bodies.

She supported the draft resolution, but proposed a new preambular paragraph after the sixth preambular paragraph, to read "Recognizing that genomics have a significant contribution to make in the area of public health." A footnote should be added citing document A57/16, and in paragraph 5(2) "and also in drug development" should be added after "genomics research".

Dr THAKSAPHON THAMARANGSI (Thailand), acknowledging the comprehensive report, said that her country was seriously concerned about the potential for inequity between Member States owing to differences in the knowledge and benefits they gained from genomics research. Intersectoral sharing of the advances of genomics research equitably would never happen unless an effective mechanism was set up.

She suggested that, in the draft resolution, the sixth preambular paragraph should be amended to read "... benefits that accrue to human beings". In paragraph 5(1) "and regulatory systems, particularly with regard to safety and the need for public awareness" should be added after "health problems."

Dr CUI Gang (China) endorsed the main points of the Advisory Committee's report. Genomics research was a two-edged sword, with enormous potential benefits but also potentially harmful safety, ethical, legal, social and economic consequences. The research capacity of different Member States already varied widely: if the current practice of gene patenting were not changed, a few countries would enjoy a monopoly over gene resources, leading to further inequalities in health care. Application of genomics research must be based on universal ethical principles. China firmly opposed reproductive human cloning, although it allowed therapeutic cloning in strictly regulated conditions. In that regard, Member States should encourage multilateral cooperation and seek innovative forms of action, observing the principles of equity and mutual benefit.

Dr STEIGER (United States of America), commending the quality of the Advisory Committee's report, said that, although it was likely that all countries would benefit greatly from genetic research and genetic medicine, the need to link research results more directly to health care delivery was becoming increasingly clear worldwide. His country shared the concerns expressed about potential ethical risks, and would work with the international community to tackle them. WHO had a role to play in facilitating dialogue, but would need to work closely with other agencies such as WIPO and UNESCO, which had competencies in related areas.

The report could provide a useful basis on which to work, although its recommendations would have to be adapted to the specific characteristics of each country. WHO would provide a scientific and evidence-based framework for comprehensive debate on issues such as the health impact of genetic research and the need for regulatory measures to safeguard against the hazards of that research and its applications. It could also facilitate capacity building and training for such research, particularly in developing countries. His country was unable, however, to agree with all the report's conclusions, in particular those relating to human cloning. It considered that both reproductive and therapeutic cloning should be banned.

Dr MOETI (Botswana) agreed that the complete sequencing of the human genome and other genomic research had opened up tremendous opportunities for benefits to human health. However, such research was expensive and could not be undertaken by most developing countries, which lacked the necessary technical expertise and resources. WHO should make it a priority to ensure that the benefits were accessible to all, so that present imbalances in access to health care were not exacerbated.

The complex ethical, legal and social implications of the technologies concerned and the globalization of health research made it essential for developing countries to gain the technical expertise necessary to enable them to benefit from innovative developments, and to protect themselves from inherent risks. He therefore welcomed the draft resolution, in particular the call on the Director-General to support strengthening capacity in Member States. WHO should also ensure that commercial ownership of the results of genomic research did not deny developing countries access to the associated health benefits.

Dr TSHABALALA-MSIMANG (South Africa), also supporting the draft resolution, said that her country was contributing to the global debate on the ethical, environmental, economic, legal and social issues. Its scientists had been part of an international consortium that had produced a detailed

functional map of more than 20 000 human genes, and other work would map the gene profile of the population and elucidate the molecular basis of diseases common to South Africa. The most urgent priority for her country's health sector was the development of a safe, effective HIV vaccine through the South African AIDS Vaccine Initiative. She urged governments of developing countries to be aware of the need to formulate policies on genomics.

Ms STROHMAYER (Austria), commending the report, recalled that it was to have been followed by a report on biotechnology in food production. Austria fully supported the draft resolution, but urged WHO to explore the ethical aspects of biotechnology, food production and intellectual property rights, with a view to facilitating discussion leading to international harmonization. The forthcoming WHO study on modern food biotechnology, human health and development could provide a useful basis for that discussion.

Dr AL-MAZROU (Saudi Arabia), also supporting the draft resolution, proposed the addition of a new subparagraph in paragraph 3 reading "to ensure coordination in this field between developed and developing countries in order to provide for manpower training in developing countries and to promote national and regional research related to different population groups".

Mr HUR (Republic of Korea) emphasized the urgent need for collaboration among all stakeholders to ensure the equitable, ethical and equal distribution of the benefits of genomics research and for assessing its benefits and risks. WHO had a vital role to play in ensuring that such benefits were fairly distributed at low cost, in particular to those most in need, and the Republic of Korea strongly supported WHO's efforts in that connection. It would be an active participant in the Forum for Ethical Review Committees in Asia and the Western Pacific, and was willing to collaborate with, and support, Member States in expanding their genome research capacity. He supported the draft resolution.

The CHAIRMAN suggested that, in order to allow the proposed amendments to be collated, consideration of the draft resolution should be deferred until after discussion of item 12.14, Human organ and tissue transplantation.

It was so agreed.

(For resumption and approval of the resolution, see page 116.)

Human organ and tissue transplantation: Item 12.14 of the Agenda (Resolution EB113.R5; Document A57/17)

The CHAIRMAN drew attention to the draft resolution contained in resolution EB113.R5.

Dr UĞURLU (Turkey) said that WHO's strong leadership would be welcome in strengthening international cooperation in order to protect poor and vulnerable groups with regard to "transplant tourism" and the selling of tissue and organs.

Mr YOSHIDA (Japan) supported the draft resolution. The commercialization of organs and tissue was illegal in his country; WHO should formulate guidelines to harmonize global practice in the procurement and transplantation of human organs and tissue and collect data on regional ethics and systems. The procurement of organs and tissues for transplantation should take account of local ethical concerns, and appropriate studies should be undertaken so that guidelines could be developed.

Although a law on human organ transplantation had been in force in Japan since 1997, the expected increase in the number of organ transplants had not materialized. The issues relating to transplantation had to be reconsidered in the light of changing national and international

circumstances, and he urged WHO to gather data on global trends and the safety of allogeneic transplantation. Liver transplant survival rates in Japan were higher than in the rest of the world. The effective follow-up system for donors and recipients could provide scientific evidence on safety and efficacy.

Dr VIOLAKI-PARASKEVA (Greece), commending the report, said that legal frameworks for donation and transplantation procedures varied from one region to another, and the subject raised complex medical, ethical, economic, legal and psychological issues. She urged WHO to be active in fostering international cooperation and coordination in order to produce a uniform global policy.

She supported the draft resolution, but proposed that in the sixth preambular paragraph, before "Mindful of the risk associated ..", the words "Recognizing that transplantation encompassed not only medical but also legal, ethical aspects and economic and psychological issues, and ..." should be inserted. In section I, paragraph 1(3), the words "by giving attention to the wider problem of international traffic in human organs and tissues" should be added, and in section II, paragraph 1(3) the words "and coordination" should be added after "international collaboration".

Mr CHEVIT (France) supported the draft resolution. France favoured transplantation provided that it was done within a strict legal framework covering both ethical and technical aspects. Priority should be given to the most cost-effective transplantation procedures.

Dr VON VOSS (Germany) endorsed the draft resolution. An important issue raised was whether genetic relationship was necessary for allogeneic living donation. He wholeheartedly supported amending the text to give protection against organ tourism and commercialization.

To deal with xenotransplantation and allogeneic organ transplantation together was not appropriate, because the argument for considering the former as an alternative to the latter was not yet medically validated. Despite his reservations, he supported the substance of the draft resolution, but proposed that in section II, paragraph 1(2), the words "including protective measures in accordance with internationally accepted scientific standards to prevent the risk of potential secondary transmission of any xenogeneic infectious agent" should be inserted after the words "global practices". In section II, paragraph 2(1), the word "facilitate" should be substituted for "to provide leadership through the promotion and facilitation of," and in paragraph 2(3) the words "including policy-making and oversight by national authorities" should be deleted.

Mrs ALONSO CUESTA (Spain) welcomed the proposal for the creation of a multidisciplinary working group to study the various aspects of transplantation. Close cooperation at international level was essential, as it would permit the exchange of experience and knowledge or even organs and tissues between neighbouring countries. It was important to deal with traceability and the accreditation of transplantation services, and to improve training, communication and raising public awareness. An ethical framework was needed to cover, for example, international cooperation on such important and sensitive issues as the commercialization of human body parts. As in all fields of medical science, respect for human rights was vital, and equal access to treatment had to be promoted.

Transplantation from living donors was increasingly being used as an option, but was just one of a range of possibilities when other options had been exhausted. It was hazardous for the donor and might lead to claims for financial recompense, which should be avoided or at least strictly controlled.

In recent years, closely cooperating within the European Union, Spain had developed quality and safety standards for cell and tissue transplantation, and had been involved in setting up a global register of data on donations and transplants. It had provided training for health professionals in donation and transplantation procedures in the Americas and in other regions.

WHO was the ideal framework within which to implement the strategies set out in the report. The draft resolution should be approved and become the first step in a fruitful programme.

Ms MOTSUMI (Botswana) said that in developing countries the lack of transplantation services posed ethical dilemmas and challenges. Botswana had neither the technical expertise nor the resources to provide allogeneic transplantation services, although feasibility studies were under way. Regional cooperation could be a means of improving access to such services, and she welcomed the call for technical support and for the sharing of experiences between Member States with successful transplantation programmes and developing countries. She too supported the draft resolution.

Professor SZCZERBAN (Poland) identified safety and quality, compliance with procedural standards, and transparency in transplant procedures as some of the major challenges in contemporary transplant medicine. The European Parliament, in discussing a proposed directive, had emphasized quality and standards. Particularly important were the ethical implications of that form of therapy, as had been evident at the WHO Consultation on Ethics, Access and Safety in Tissue and Organ Transplantation (Madrid, 6-9 October 2003). Endorsing the comments made by the delegate of Germany, he proposed the insertion of an additional subparagraph under section I, paragraph 1, urging Member States to set up ethics commissions to oversee the ethical aspects of organ, cell and tissue transplantation.

Dr AZIZ (Pakistan) said that, in view of the growing practice of organ and tissue transplantation, both allogeneic and xenogeneic, and associated concerns, she fully endorsed the draft resolution. WHO should, in particular, provide technical support to Member States for strengthening capacity, policy-making and oversight by national regulatory authorities, and develop guidelines to harmonize global practices in the procurement and transplantation of human cells, tissues and organs. Xenotransplantation should only be allowed when effective regulatory control and surveillance by national health authorities were in place. Protocols must be developed to prevent the potential secondary transmission of any xenogeneic pathogen that might infect recipients of xenotransplants. The Ministry of Health of Pakistan had drafted legislation to control the practice of human organ and tissue transplantation.

Dr CUI Gang (China) affirmed that organ and tissue transplantation had legal, ethical, social, economic and psychological as well as medical implications. Discussion of all those issues at the Health Assembly would certainly have a positive impact on the regulation of organ transplantation in Member States. China supported the draft resolution.

The purpose of human organ and tissue transplantation must be to treat disease and save lives. Recognized ethical principles must be observed and proper care given to providers and recipients of organ transplantations. Legislation was required, as was rigorous management based on such legislation, and administrative institutions must be strengthened. All aspects of organ transplantation, from sources of organs, principles and procedures for donations, to organ collection and donation, must be regulated and implemented in accordance with legal and ethical standards and socially acceptable practices.

Ms RØINE (Norway) noted with appreciation that the problem of organ trafficking was mentioned in the draft resolution. During the current Norwegian chairmanship of the Council of Europe, Norway had strongly supported the adoption of Recommendation 1611, "Trafficking in organs in Europe". Globally, organ trafficking and transplant tourism resulted mainly from the long waiting lists for transplantation. Two measures had proved effective in Norway: the recent adoption of the "Spanish model" of organ donation, with a focus on hospitals where specially designated doctors had particular responsibility for donations and donors; and the practice of living kidney donations from close relatives, which had reduced the demand for dialysis treatment, was cost-saving and gave the patient a better quality of life. She proposed the inclusion in section I of an additional subparagraph 1(4) urging Member States "to extend the use of living kidney donations when possible".

Dr AGARWAL (India), recalling India's Transplantation of Human Organs Act of 1994, said that the transplantation of organs from non-related living donors was regulated through a committee in each hospital. India was attempting to meet its insufficient supply of cells, tissues and organs from deceased donors through organ retrieval and banking organizations. He called for international cooperation against transplant tourism, and particularly welcomed the appeal to Member States to take measures to protect the poorest and most vulnerable groups from such exploitation. Research should be carried out to establish the safety of xenotransplantation, and adequate regulatory systems should be in place before it could safely be introduced. India supported the draft resolution.

Dr NSIAH-ASARE (Ghana) said that his country, which did not as yet have the resources to introduce organ and tissue transplantation into its health services, welcomed the establishment of the group of experts and endorsed its findings and recommendations. Member States should continue to give attention to providing effective oversight (from procurement and distribution of human materials for transplantation to follow-up of recipients and donors), ensuring accountability for such materials and introducing safeguards against the risks posed by xenotransplantation. Severe acute respiratory syndrome (SARS) and avian influenza exemplified the need to take extreme care to detect transmission of xenogeneic infectious agents. WHO should continue to facilitate communication and collaboration among Member States for controlling the international circulation of transplant material in order to prevent exploitation of poor, vulnerable donors. WHO should set minimum standards for safety, quality and efficacy of transplantation. He supported the draft resolution.

Dr TSHABALALA-MSIMANG (South Africa) said that her country, which had participated in the WHO Consultation on Ethics, Access and Safety in Tissue and Organ Transplantation (Madrid 2003), supported the expert group's recommendations and was finalizing a policy on organ transplantation. One of its objectives was to ensure rational use of scarce organs and equitable access to transplantation through the establishment of a national organization that would manage procedure and distribution. South Africa had witnessed an influx of foreign nationals seeking to use its scarce resources, including organs and facilities, and was therefore setting criteria for cooperation and seeking international and regional cooperation on transplantation programmes. It had instituted measures to exclude coercion in organ donation and to ban trade in organs. She supported the draft resolution.

Dr KRIT PONGPIRUL (Thailand) said that the country's regulatory framework for transplantation, in place since the early 1990s, had been more strongly enforced after a scandal of illegal kidney transplantation in 1999. The measures did not, however, apply to xenogeneic transplantation, and in particular did not cover emerging infectious agents.

He urged consistency in the vocabulary used in the draft resolution. Either "allogeneic transplantation" and "xenogeneic transplantation" or "allotransplantation" and "xenotransplantation" should be used throughout, and also in section II, paragraph 2, an additional subparagraph should be inserted, reading "to proactively provide technical issues related to emerging infectious agents".

Mrs KRISTENSEN (Denmark) said that, because of its alarming increase, organ trafficking should be placed high on WHO's agenda, not least because it affected the poorest and most vulnerable groups of the population. The Recommendation on organ trafficking adopted recently by the Council of Europe gave guidelines to Member States on how to minimize that risk. The problem should be tackled globally and not be overshadowed by other aspects of organ, tissue and cell transplantation. She proposed the addition of a new subparagraph to section I, paragraph 2 of the draft resolution, requesting the Director-General "to provide support for Member States in their endeavours to prevent organ trafficking, including drawing up guidelines to protect the poorest and most vulnerable groups from being victims of organ trafficking". She supported the amendments proposed by Greece and Norway.

Dr ZAHER (Egypt), commending the report, drew attention to the dangers of commercialization of organs and exploitation of poor, vulnerable donors. She stressed the importance of the ethical implications of organ transplantation, which must not conflict with national traditions and religious beliefs. Cooperation was needed with medical associations internationally on the ethical issues associated with transplantation so that rules and guidelines could be drawn up. Also, international cooperation should be stepped up in the supervision and control of organ trafficking and of practices that exploited the poor and vulnerable. Safeguards for cross-species transplants should be established.

Ms BLACKWOOD (United States of America) said that the report was an effective instrument for raising international awareness of important ethical and safety issues in organ and tissue transplantation, and praised WHO and the Government of Spain for their leadership. Safe and effective transplantation of human organs, tissues and cells should be available to alleviate disease worldwide, but currently demand exceeded supply, reinforcing the need for ethical and safe procurement and allocation of human transplant materials. Although living organ donation offered substantial health benefits to recipients, it had entailed serious human rights abuses; when an altruistic reason was ascertained, living donation was acceptable. Member States would benefit from a comprehensive study of the practices and ethical issues surrounding living donation globally, as there was growing reliance on living donor transplantation, with potential donors and recipients often crossing international borders for that purpose.

Condemned prisoners should not be accepted as organ donors, given the risk of transmitting infectious diseases and that free and voluntary consent was not guaranteed. Member States should be encouraged to cease such ethically unacceptable practices and to prevent their citizens receiving organs from such sources.

In order to minimize the risk of transmission of infectious agents, and believing that human tissues could be safely recovered, processed and distributed with appropriate regulatory oversight, the United States was devising a regulatory framework for the use of human cells and tissues that involved registration of establishments, product listing, donor eligibility and good tissue practice. It had long been concerned about the potential infectious disease risks inherent in xenotransplantation; swine influenza virus, HIV and the SARS coronavirus were among the serious pathogens documented as being transmitted from animals to human beings. She commended WHO for taking on work on standard-setting, including urging stringent national regulations for xenotransplantation and discouraging the practice in countries in which appropriate oversight and monitoring were not in place. WHO could also provide leadership for international surveillance of infectious disease outbreaks resulting from xenotransplantation, and to inhibit the spread of such disease.

Expressing support for the draft resolution, she proposed that a final paragraph should be added requesting the Director-General to report back to the Health Assembly on further action taken. Some of the amendments proposed by earlier speakers required further consideration: for instance, she felt that it was premature to propose the establishment of an ethics commission at that time.

Ms DE LA MATA (European Commission) said that a new European Union directive setting quality and safety requirements for human tissues and cells intended for human application, which had entered into force in April 2004, included provisions for the donation, procurement, testing, processing, preservation, storage and distribution of human tissues and cells as well as requirements for authorization of tissue establishments, to ensure that patients treated with such materials could be confident about their safety and good quality.

Dr LEITNER (Assistant Director-General) said that the recent establishment of the Department of Ethics, trade, human rights and health law attested to the importance attached by WHO to the ethical and other implications facing Member States in many areas, including human organ and tissue transplantation. Given the shortage of material for transplantation, equity management was of the utmost importance. Guidance should be given to Member States and appropriate standards set for

procurement, and limits placed on the commercialization of organs and tissue. Other crucial issues were safety and quality. Aware as it was that those issues transcended borders, WHO acknowledged the need to work towards internationally harmonized regulatory systems. She had noted Member States' calls for technical cooperation and support at the country level. Those concerns would be reflected in the updating of the 1991 Guiding Principles on Human Organ Transplantation, which would be available as soon as possible after an extensive consultation process. Under a harmonized system and with the use of the Guiding Principles, the undesirable side-effects of transplantation, such as "transplant tourism", should be avoided.

(For adoption of the resolution, see summary record of the eighth meeting, section 3.)

Genomics and world health: report of the Advisory Committee on Health Research: Item 12.13 of the Agenda (Resolution EB113.R4; Document A57/16) (resumed)

The CHAIRMAN invited the Secretary to read out the amendments made earlier to the draft resolution contained in resolution EB113.R4.

Dr HOLCK (Secretary) said that in the sixth preambular paragraph, the words "human beings" should be substituted for "countries". A further preambular paragraph should be added, to read: "Recognizing that genomics have a significant contribution to make in the area of public health". In paragraph 5(1) the words "and regulatory systems, particularly with regard to safety and the need for public awareness" should be added. A new paragraph 5(3) should be added, to read: "to facilitate exchange between developed and developing countries in the use and application of genomic technology to tackle both local and region-specific problems through, for example, training and technical support activities".

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

HIV/AIDS: Item 12.1 of the Agenda (Document A57/4) (continued from the first meeting, section 3)

The CHAIRMAN drew the Committee's attention to a draft resolution prepared by the informal working group, which read as follows:

> The Fifty-seventh World Health Assembly,
>
> Having considered the report on HIV/AIDS;[2]
>
> Noting with great concern that by the end of 2003 about 40 million people were living with HIV/AIDS, the pandemic had claimed an estimated three million lives in 2003, and that HIV/AIDS affects women and children with particular severity;
>
> Also concerned that, although about six million people in developing countries need antiretroviral treatment, only 440 000 currently receive it;
>
> Noting with concern that other health conditions also cause high morbidity and mortality in developing countries;
>
> Acknowledging that antiretroviral therapy has reduced mortality and prolonged healthy lives and that the feasibility of delivering antiretroviral treatment has been demonstrated in several resource-constrained settings;
>
> Recognizing that treatment and access to medication for those infected and affected by HIV/AIDS, as well as prevention, care and support are inseparable elements of a comprehensive

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA57.13.

[2] Document A57/4.

health-sector response at the national level, and require adequate financial support from States and other donors;

[Recognizing that social stigma, discrimination, lack of affordability of ARV medicines, economic constraints, limitations in health care capacity and human resources are some of the major impediments to access to treatment and care for people living with HIV/AIDS;

Also recognizing the need to further reduce the costs of ARV medicines;]

Recalling the Declaration of Commitment on HIV/AIDS adopted at the United Nations General Assembly special session on HIV/AIDS (27 June 2001), which acknowledges that prevention of HIV infection must be the mainstay of national, regional and international responses to the epidemic and calls for significant progress, by 2005, in implementing comprehensive care strategies, including for access to antiretroviral drugs;

Recalling also resolution WHA55.12 on the contribution of WHO to the follow-up of the United Nations General Assembly special session on HIV/AIDS, resolution WHA55.14 on ensuring accessibility of essential medicines, resolution WHA56.27 on intellectual property rights, innovation and public health, and resolution WHA56.30 on the global health-sector strategy for HIV/AIDS;

Recalling and recognizing the Programme of Action adopted at the International Conference on Population and Development (Cairo, 1994), commitments made at the World Summit for Social Development (Copenhagen, 1995) and the World Summit for Children (New York, 1990), the Beijing Declaration and Platform for Action (1995), the Declaration on the Elimination of Violence against Women (1993), and the Millennium Declaration (2000), their recommendations and respective follow-ups and reports;

Noting with satisfaction the agreement of 25 April 2004 among development partners to improve coordination and harmonization in the response to HIV/AIDS at country level, through the "Three Ones" principle, namely, one agreed HIV/AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multisectoral mandate; and one agreed country-level monitoring and evaluation system;

Recognizing the central role of the health sector in the response to HIV/AIDS and the need to strengthen health systems and human capacity development so that countries and communities may contribute fully to realization of the global targets set out in the Declaration of Commitment on HIV/AIDS and to develop public health systems with a view to minimizing the emergence of drug resistance;

Underlining the importance of WHO's work, including through the WHO-initiated procurement, quality and sourcing project, to facilitate access by developing countries to safe, effective and affordable antiretroviral drugs and diagnostics at the best price;

Recalling the Declaration on the TRIPS Agreement and Public Health adopted at the WTO Ministerial Conference (Doha, November 2001), and welcoming the decision taken by the General Council of WTO on 30 August 2003 on the implementation of paragraph 6 in that Declaration;[1]

Acknowledging WHO's special role within the United Nations system to combat and mitigate the effects of HIV/AIDS, its responsibility in the follow-up of the Declaration of Commitment on HIV/AIDS and, as a cosponsor of UNAIDS, in leading United Nations efforts in relation to treatment and care for HIV/AIDS;

Welcoming the progress made by many Member States in beginning to scale up treatment for HIV/AIDS in their countries;

Welcoming also the increased support of Member States for programmes to combat HIV/AIDS,

---

[1] Document WT/L/540, available at http://docsonline.wto.org.

1. WELCOMES the Director-General's "3 by 5" strategy to support developing countries, as part of WHO's follow-up to the comprehensive global health-sector strategy for HIV/AIDS, in securing access to antiretroviral treatment for three million people living with HIV/AIDS by the end of 2005, and notes the importance of mobilizing financial resources from States and other donors including for WHO to achieve this target;

2. URGES Member States, as a matter of priority:

(1) to establish or strengthen national health and social infrastructure and health systems, with the assistance of the international community as necessary, in order to assure their capacity to deliver effectively HIV/AIDS prevention, treatment, care and support services;

(2) to plan and deliver HIV/AIDS prevention, treatment, care and support services within the context of the overall national health strategy, ensuring an appropriate balance between services for HIV/AIDS and all other essential health services;

(3) to pursue policies and practices that promote:

(a) sufficient and adequately trained human resources with the appropriate skill mix to invoke a scaled-up response;

(b) human rights, equity, and gender equality in access to treatment;

(c) affordability and availability, in sufficient quantities, of pharmaceutical products of good quality, including antiretroviral medicines and medical technologies used to treat, diagnose and manage HIV/AIDS;

(d) accessible and affordable treatment, testing and counselling with informed consent, prevention and care services for all, without discrimination, including the most vulnerable or socially disadvantaged groups of the population;

(e) good quality and scientific and medical appropriateness of pharmaceutical products or medical technologies for treatment and management of HIV/AIDS, irrespective of their sources and countries of origin, inter alia by making the best use of WHO's list of prequalified drugs that meet international quality standards;

(f) further investments in medicines, including microbicides, diagnostics and vaccine research, and in social science and health systems research, in order to improve effective interventions;

(g) development of health systems designed to promote access to antiretroviral medicines and to facilitate adherence to treatment regimens with a view to minimizing drug resistance;

(4) to consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights;

(5) to apply the "Three Ones" principle with a view to improving coordination and harmonization in the response to HIV/AIDS;

3. REQUESTS the Director-General:

(1) to strengthen the key role of WHO in providing technical leadership, direction and support to health systems' response to HIV/AIDS, within the United Nations system-wide response, as a cosponsor of UNAIDS;

(2) to take action within the framework of the "Three Ones" principle:

(a) to provide support to countries in order to maximize opportunities for the delivery of all relevant interventions for prevention, care, support and treatment of HIV/AIDS and related conditions, including tuberculosis;

(b) to support, mobilize and facilitate efforts of developing countries to scale up antiretroviral treatment in a manner that focuses on poverty, gender equality, and the most vulnerable groups, within the context of strengthening national health

systems while maintaining a proper balance of investment between prevention, care and treatment;

(c) to provide guidance on accelerating prevention in the context of scaled-up treatment, in line with the global health-sector strategy for HIV/AIDS;

(3) to take measures to improve access of developing countries to pharmaceutical and diagnostic products to diagnose, treat and manage HIV/AIDS, including by strengthening WHO's prequalification project;

(4) [to ensure that the prequalification review process and the results of inspection and assessment reports of the listed products, aside from proprietary and confidential information, are made publicly available;]

(5) to support developing countries in improving management of the supply chain and procurement of good-quality AIDS medicines and diagnostics, inter alia through WHO's AIDS medicines and diagnostics service;

(6) to provide a progress report on implementation of this resolution to the Fifty-eighth World Health Assembly, through the Executive Board.

Dr LARIVIÈRE (Canada) noted that the consensus meant that the square brackets around the seventh and eighth preambular paragraphs and around paragraph 3(4) could be removed.

Ms STAVÅS (Sweden) proposed a few minor amendments. In the seventh preambular paragraph, the words "and social support" should be added after "treatment and care". In the sixteenth preambular paragraph, the words "and playing a strong role in prevention" should be added after "care for HIV/AIDS". In subparagraph 2(2), the words "to plan and" should be replaced by "to strengthen national planning, monitoring and evaluation systems in order to ...". In subparagraph 2(3)(b) the words "and care" should be added after "treatment".

Mr ZEPEDA BERMUDEZ (Brazil) fully supported the draft resolution. The text, however, had been further discussed by countries of the Latin American and Caribbean Group and the Region of the Americas, which had proposed adding a subparagraph after paragraph 2(5), to read: "to encourage that bilateral trade agreements take into account the flexibilities contained in the WTO TRIPS Agreement and recognized by the Doha Ministerial Declaration on the TRIPS Agreement and Public Health;". It had also been proposed that the words "inter alia through WHO's AIDS medicines and diagnostics service" at the end of paragraph 3(5) be deleted, in order to allow for the possibility that WHO might mobilize more than one service.

Mr HOHMAN (United States of America) said that his country wished to be added to the list of sponsors of the draft resolution.

Dr AMMAR (Lebanon) expressed support for the "3 by 5" strategy. The draft resolution covered the main requirements for the implementation of that strategy by respecting the "Three Ones" principle, but he drew attention to the importance of strengthening health systems to ensure the smooth application of the strategy and the sustainability of anti-AIDS action. Other aspects of crucial importance to a sustainable response to AIDS should be mentioned, such as the sound management of funds assigned to the programme and the strengthening of the capacities of health professionals, especially nurses, by involving them in prevention, care, support and the development of AIDS policies and strategies at WHO and in their countries. The capacity to generate the necessary information for decision-making, monitoring and evaluation was also important.

The worst-affected countries also needed the institutional capacity to cope simultaneously with other priorities. HIV/AIDS, which required long-term efforts, would be impossible to tackle with a defective health-care system and nonexistent or badly organized care in the home. Strengthening health-care systems should be integrated with the fight against AIDS and he therefore proposed a new subparagraph to follow paragraph 3(5), to read: "to provide support to countries to embed the scale-up

of the response to HIV/AIDS into a broad effort to strengthen national health systems, with special reference to human resources development and health infrastructure, health system financing and health information;".

Dr TSHABALALA-MSIMANG (South Africa) supported the draft resolution in general but proposed that three additional areas should be covered in order to ensure a coordinated and comprehensive response to HIV/AIDS. First, nutritional aspects were not sufficiently well articulated. Secondly, in the African Region, more than 90% of people consulted traditional healers, yet there was little knowledge about potential interactions between antiretroviral drugs and traditional remedies. Research on traditional medicines for the treatment of HIV/AIDS was needed. Thirdly, WHO should be proactive in disseminating information on counterfeit and substandard medicines to enable countries to respond rapidly and protect their populations.

Dr OTTO (Palau) said that greater emphasis should be given to mother-to-child transmission of HIV. He therefore proposed the addition of a new subparagraph 2(3)(h) to read, "breastfeeding in light of the United Nations Framework for Priority Action on HIV and Infant Feeding and the new WHO/UNICEF guidelines for policy-makers and health-care managers".

Dr HOLCK (Secretary) re-read the proposed amendments to the draft resolution.

Dr ABREU CATALÁ (Venezuela) said that the proposed new paragraph 2(6) should refer to regional rather than bilateral trade agreements. Referring to the amendment proposed by Palau, she said that in Venezuela milk banks had been established to enable infants born to HIV-positive mothers to receive breast milk from other mothers. She therefore suggested that the proposed text should be amended to refer to access to breast milk.

In reply, Dr HOLCK (Secretary) said that it was her understanding that access to milk banks was covered by the United Nations Framework for Priority Action on HIV and Infant Feeding and was therefore already covered in the draft resolution.

Mrs TSENILOVA (Ukraine) said that Ukraine, too, wished to be included as a sponsor of the draft resolution.

Dr CHOW (Assistant Director-General), in reply to the point made by South Africa on the need for research on alternative medicines, said that work was under way in several institutions on medicines for palliative care.

Dr LEPAKHIN (Assistant Director-General) added that WHO had a special project on counterfeit drugs, which covered drugs for the treatment of HIV/AIDS. It was important to strengthen national drug regulatory authorities to enable them to combat counterfeiting.

Dr TSHABALALA-MSIMANG (South Africa) said that her concern was not about traditional medicines for palliative care, but the potential for interaction between traditional medicines and antiretroviral drugs, and the need for research in that area. She had received no reply to her proposal for a mention of nutrition. She requested that all three of the concerns she had expressed should be reflected in the draft resolution.

The CHAIRMAN said that a little time would be required to draft appropriate amendments to cover those points.

Ms MOTSUMI (Botswana) suggested that reference to research on traditional medicines could be included in paragraph 2(3)(f), which already mentioned research.

Dr TSHABALALA-MSIMANG (South Africa) accepted that suggestion, but wondered whether paragraph 2(3)(f) would also reflect the need for nutrition to be integrated into the comprehensive and coordinated response to HIV/AIDS, as she had suggested.

Mr AITKEN (Director of the Office of the Director-General) suggested that that concept be included in a new paragraph 2(3)(i) which would read "integration of nutrition into a comprehensive approach to HIV/AIDS."

Ms MOTSUMI (Botswana) and Dr TSHABALALA-MSIMANG (South Africa) fully supported that suggestion.

Mr ESPINOSA SALAS (Ecuador), Mr KONCHELLA (Kenya) and DR ABREU CATALÁ (Venezuela) requested that their countries be added to the list of sponsors of the resolution.

The CHAIRMAN announced that Croatia, too, had expressed the wish to be added to the list of sponsors.

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

Dr SEIGNON (Benin), speaking on behalf of Member States in the African Region, recalled that HIV/AIDS was its leading cause of mortality (2.3 million deaths a year) and one of their highest priorities. It caused untold suffering, exacerbated the Region's severe human capacity problems and endangered its socioeconomic development. Prevention remained the cornerstone of their response, with programmes targeting vulnerable groups and promoting a range of behaviours including abstinence, delayed sexual initiation, fidelity, reduction of the number of sexual partners and condom use. Member States had welcomed the "3 by 5" initiative as a step towards universal access to antiretroviral therapy, and had indicated their willingness to work with international development partners to increase access to treatment and care in the countries of the Region. To date, assessment missions had been carried out in 16 countries and technical support had been provided for the implementation of care and treatment programmes and for preparing proposals for the fourth round of applications to the Global Fund to Fight AIDS, Tuberculosis and Malaria.

The African Member States urged the Director-General, inter alia, to support them in expanding their HIV/AIDS prevention and treatment interventions and to request national decision-makers and international partners to increase financial resources so as to ensure long-term treatment and regular supplies of antiretroviral medicines; to work closely with international development partners, including the Global Fund, to simplify mechanisms for rapid disbursement of funds; to ensure a unified United Nations response to the HIV/AIDS epidemic in the Region; to support the strengthening of health systems, particularly in the area of human resources, and to devise management systems to improve treatment and care services; to support Member States in integrating nutrition into the treatment and care of HIV/AIDS patients; and to exchange experiences and lessons learnt in the scaling-up of treatment and care services, with a view to their rapid incorporation into national strategies. They also called on WHO and donors to provide additional resources for research into traditional medicine in relation to HIV/AIDS, to extend the pre-qualification system and to support quality-control laboratories. They also urged development partners to support relevant national processes through the "Three Ones" principle.

Mrs TSENILOVA (Ukraine) observed that, although state funding of HIV/AIDS treatment in Ukraine was increasing each year, the health system could not afford the cost of antiretroviral drugs

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA57.14.

for all who needed them or of the preventive measures that were also required. Ukraine needed assistance in tackling its HIV/AIDS problem, in the form of financial resources. However, the lack of a mechanism for coordinating donors' programmes and their resulting fragmentation were threatening the success of all the activities being undertaken. The resolution just approved was therefore extremely important, particularly in its emphasis on the "Three Ones" principle. In that connection WHO and UNAIDS should have the major coordinating role.

Dr OTTO (Palau) said that the Pacific island States greatly appreciated the "3 by 5" initiative, making antiretroviral therapy available to those who needed it, and he expressed support for the call for strengthening preventive measures.

Referring to *The world health report 2004*, he pointed out that in Chapter 1, in the section on preventing infection in infants and children, while the statement on HIV transmission during breastfeeding correctly reflected current United Nations policy, it fell short of indicating that exclusive breastfeeding might have a potential for reducing postpartum transmission of HIV. Research into that possibility might indicate that exclusive breastfeeding was the most effective intervention to advocate. The statement also failed to warn against the dangers of mixed feeding and it would have been helpful if reference had been made to the United Nations HIV and Infant Feeding Framework for Priority Action, and the WHO/UNICEF/UNAIDS guidelines for policy-makers and health-care managers on HIV and infant feeding. In the section on preventing transmission of HIV from mother to child, the reference to resource-poor countries gave the impression that the strategy was based primarily on economic and epidemiological indicators rather than on the agreed rights-based approach that facilitated informed decision-making on the part of the mother. He requested that Palau be added to the list of sponsors of the resolution.

Dr GIZAW (International Federation of Red Cross and Red Crescent Societies) said that in collaboration with many other international organizations the Federation had long been advocating increased access to care and antiretroviral therapy, and treatment for opportunistic infections. It was greatly encouraged by the global momentum towards that goal in resource-poor countries, and by the commitment and leadership of some developing country governments in that regard. The Federation had renewed its commitment to support that global effort.

Effective provision of antiretroviral therapy required coordinated action at the community, household and medical service levels to promote a continuum of care and treatment and to enhance synergy. Communities must be educated and prepared for antiretroviral therapy. Stigmatization and discrimination must be minimized, and persons living with HIV/AIDS and family members must be educated about adherence to treatment and given proper nutritional and counselling support. In many badly affected countries, the Federation was already providing such services through its home-based care and support programmes, and could therefore contribute significantly to increasing demand and promoting uptake of and adherence to treatment. It was also working to support collaborating medical institutions through provision of antiretroviral medicines, drugs for opportunistic infections and diagnostic reagents. The Federation strongly supported the "3 by 5" initiative, and pledged its continuing help and support.

Mr DE LAY (UNAIDS) said that progress towards UNAIDS major targets, with the exception of those relating to policy improvement, had been disappointing. The most disturbing figure was the low number of people with access to antiretroviral therapy: only one in every 100 eligible people in sub-Saharan Africa received treatment ("eligible" people being those likely to die within one to two years without treatment). UNAIDS fully supported the "3 by 5" initiative and was the second highest provider of funding. Although many challenges remained, the international community would undoubtedly look back on 2004 as a major turning-point in the fight against AIDS.

Ms GUNASEKERA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of Health Action International, supported the Director-General's call for greater

investment in WHO's prequalification programme, which had contributed to both the availability of medicines and the simplification of drug regimens through the prequalification of fixed-dose combinations for the management of HIV/AIDS. She urged Member States to incorporate the prequalification project into the WHO essential drugs programme on a permanent basis. Her organization would continue to provide accurate information to give the public a better understanding of health systems.

Dr NOEHRENBERG (International Federation of Pharmaceutical Manufacturers Associations), speaking at the invitation of the CHAIRMAN, said that the Accelerating Access Initiative, a partnership between WHO, other multilateral organizations and the pharmaceutical industry, had provided antiretroviral treatment for more than 150 000 patients in Africa alone by December 2003. That figure represented a 16-fold increase since May 2000; the number of patients reached had doubled in the last six months of 2003, demonstrating the potential for scaling-up the programme. Those patients were almost the only ones receiving high-quality triple therapy in Africa: they were able to live healthier lives, continue to work and stay active in their communities and families.

In order to expand access to treatment, several pharmaceutical companies had announced their intention to develop new fixed-dose combination therapies and co-packaged therapies. All new therapies must be developed according to rigorous regulatory standards in order to ensure their quality, safety and efficacy. Double standards in HIV/AIDS treatment, which might adversely affect HIV/AIDS patients in developing countries and eventually lead to an epidemic of drug-resistant HIV infection, were unacceptable to the industry. His organization welcomed the recent announcement by the Secretary of Health and Human Services of the United States of America that that country's Food and Drug Administration would expedite the regulatory review of fixed-dose combination drugs to treat HIV/AIDS. It looked forward to working with WHO to guarantee high-quality treatment for all.

Mrs HERZOG (International Council of Women), speaking at the invitation of the CHAIRMAN, noted that almost half the estimated 5.3 million people who had been infected with HIV in 2000 were women. Older women were the mainstay of families in crisis, taking care of their sick adult children and of children orphaned by AIDS. The issue of women and AIDS was closely linked with other issues such as social status, poverty, education and trafficking in women. One of her organization's main tasks was to raise women's awareness of their needs, rights and responsibilities. It conducted national, regional and international seminars, including one on AIDS in Africa.

Prevention campaigns must be based on gender education, beginning with very young children and reaching all levels of society. Boys and girls must know that they had different needs, but the same human rights. Prevention of HIV infection was the most promising strategy for managing the AIDS epidemic in the long term, but meanwhile treatment with affordable drugs of the highest possible quality, health care and support for the millions of people already infected were needed. Member States should ensure that, before drugs were placed on the market, they were subjected to strict clinical trials and approved by established national regulatory authorities. Manufacturing facilities must be subjected to rigorous quality assessments. She expressed particular concern about the potential for double standards in treatment in Africa, compared with the developed world, and wanted such considerations to be reflected in the WHO prequalification scheme.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN and also on behalf of the International Pharmaceutical Federation and the World Medical Association, said that 250 representatives of the three organizations, meeting at the recent first conference of the World Health Professions Alliance (Geneva, 15-16 May 2004), had adopted a resolution urging governments and intergovernmental agencies to acknowledge the scale of the HIV/AIDS tragedy and to commit the funds and resources needed to combat it. He urged all physicians, nurses and pharmacists to act as advocates and leaders of society in the fight against HIV/AIDS.

His Council with its member associations, governments and industry had begun to deliver antiretroviral treatment to HIV-positive nurses and other health workers in Zambia, with plans to extend the programme to other high-prevalence areas. He called on WHO and Member States to improve health workers' access to antiretroviral treatment as a way of strengthening health system capacity. The three organizations he spoke for were committed to working with WHO and other agencies to mobilize nurses, pharmacists and physicians for the "3 by 5" initiative.

He asked when WHO planned to create the promised nursing posts at all levels as part of its HIV/AIDS activities and how care and support were to be aligned within the "3 by 5" initiative in order to guarantee a holistic approach.

Dr CHOW (Assistant Director-General) thanked delegates for their expressions of support and their contributions to the "3 by 5" campaign. A number of themes had emerged during the debate. It was important to accelerate the pace of prevention and treatment. Health systems must be strengthened, with more support for physicians, nurses, midwives and other health professionals, as well as community-based workers. Collaborative efforts across civil society must be encouraged, and political leadership promoted within countries in order to sustain efforts at country and community levels. WHO must redouble its efforts to combat inequities and gaps, particularly gender inequalities.

Headquarters and the regional and country offices would work with Member States and other partners to meet the "3 by 5" goals. WHO had improved its working practices and, with new financial support from Member States such as Canada, Sweden and the United Kingdom of Great Britain and Northern Ireland, and UNAIDS, looked forward to working with all partners in the future.

Implementation of resolutions (progress reports): Item 12.15 of the Agenda (Documents A57/18 and A57/18 Add.1) (continued from the fifth meeting)

- **Reducing global measles mortality** (Resolution WHA56.20)

Mr YOSHIDA (Japan) said that specific goals and frameworks designed to reduce mortality and eliminate measles in specific regions would contribute effectively to global activities. Japan had provided technical assistance, vaccines and training for countries with a heavy burden of measles. In Japan, the Government provided access to immunization throughout the year and planned, on the recommendation of a technical advisory committee, to introduce a two-dose routine schedule as soon as the coverage rate improved. The first week of March every year had been designated "Immunization Week", when governmental agencies, the Japanese Medical Association, the Board of Paediatrics and other agencies launched an immunization appeal throughout the country. He called upon WHO to work to ensure that all the children of the world had access to measles immunization.

Dr CUI Gang (China) said that in the past year China had gained considerable experience in measles control. The surveillance system had been improved, and a surveillance plan introduced, giving priority to measles surveillance in the north-west of the country and greater access to immunization for children. A feasibility study had been carried out on the eradication of measles and reduction of mortality. He supported WHO's planned activities to reduce measles mortality over the next three years and requested the Organization's support with China's own campaign.

Ms MATSOSO (South Africa) recalled that the Cape Town Measles Declaration had been approved in October 2003, reinforcing a commitment to measles mortality reduction and stressing the importance of reinforcing partnerships. As a result of mass immunization campaigns conducted since 1996, South Africa was one of the nine countries in southern Africa that had virtually eliminated the disease. Since elimination strategies had been put into effect, the number of measles cases had fallen from an annual average of 16 000 to less than 50.

A setback had been experienced in 2003, however, with outbreaks in two provinces, totalling 251 confirmed cases. As a result, South Africa was intensifying its measles elimination efforts, with

particular attention to strengthening the 2004 immunization campaign. A plan for early detection and response to measles outbreaks also placed emphasis on prevention and the strengthening of routine coverage.

Mrs PHUMAPHI (Assistant Director-General) applauded the achievements in measles reduction in recent years. Of the 29% global reduction in measles between 1999 and 2002, 67% had been in Africa. Member States of the South-East Asia and African Regions were starting to achieve sustainable measles mortality reduction; those in the other Regions already had elimination in sight. WHO remained willing to provide support whenever needed.

- **Severe acute respiratory syndrome (SARS)** (Resolution WHA56.29)

Dr HARPER (United Kingdom of Great Britain and Northern Ireland) said that WHO's strong leadership and coordination in relation to the outbreak of SARS, together with the cooperation and collaboration of the scientific and public health community, had been an excellent example of what could be achieved in infectious disease control. WHO should consider other important issues, including laboratory biosafety and the public health utility of risk management measures, such as exit screening. Its strong stance had set a precedent for the approach to be taken in any future global infectious disease emergencies.

Mr YOSHIDA (Japan), commending WHO's response to the SARS outbreak, said that its role needed to be enhanced to deal with any future infectious disease emergencies for which international collaboration was required. His Government had amended its Infectious Disease Law and its Quarantine Law in preparation for any future emergency, had devised action plans for local governments, and had introduced measures to ensure biosafety in laboratories and enhance influenza control. Rapid diagnostic kits and vaccines were being promoted and the loop-mediated isothermal amplification method to detect avian influenza subtype H5 viral DNA had been developed ahead of the winter season.

In an age of rapid international travel, international cooperation was critical for effective containment, and revision of the International Health Regulations was an urgent priority in the face of a second outbreak.

Dr CUI Gang (China) said that WHO's major contribution in the fight against SARS was highly appreciated. After the outbreak had reached its peak, China had continued to apply strict surveillance measures. A national plan had been drawn up for surveillance, diagnosis and treatment, regulations had been reinforced and laboratory research controlled, particularly with regard to the preservation of clinical and contaminated samples. In recent months, immediate action to diagnose and treat new cases had made it possible to keep the situation under control. Laboratory accidents were undoubtedly the cause of recent cases. China was ready to share its experience and information and would make public the results of further research as soon as they were available.

New communicable diseases were a serious global public health threat and research was essential in order to understand their characteristics. WHO should draw on experience gained and set up a network for pooling information and resources so that technical and financial support could be given if necessary. Research into SARS, and in particular its routes of transmission, should continue.

Dr LARIVIÈRE (Canada) said that since the outbreak in 2003 Canada had improved its surveillance measures and guidelines for containing infection in collaboration with WHO and the Centers for Disease Control and Prevention (Atlanta, Georgia, United States of America). Collaboration with provinces and territories continued to ensure that measures were in place to protect Canadian people. A real-time alert system had also been set up to ensure the rapid dissemination of information on serious respiratory disease to partners, including WHO. A handbook containing

guidelines on, among other things, protocols and surveillance tools had been produced by Santé Canada for the investigation and control of infection in cases of serious respiratory disease.

Dr AGARWAL (India) said that his country had controlled SARS by prompt detection, isolation, infection control in hospitals and the tracing and quarantining of contacts, supported by collaboration between scientists, institutions and countries. The Malé and New Delhi declarations on SARS were notable examples of such collaboration.

An integrated information technology-based disease-surveillance project had been phased in throughout the country, focusing on surveillance of identified diseases, and rapid-response units had been set up at state and district levels to react to any outbreak.

Efforts should be focused on early, high-level research to understand the origin of the SARS virus and develop quick and accurate diagnostics, specific drugs and an effective vaccine. Infection-prevention measures for health professionals also needed to be reinforced.

Dr OTTO (Palau) recalled that, largely owing to assistance from the Regional Office for the Western Pacific, the Secretariat of the Pacific Community and the United States of America, SARS had not reached his country. However, it had suffered considerable economic loss when flights from neighbouring countries had been suspended for more than three months. He thanked WHO and Palau's neighbouring countries for the preventive measures they had taken and from which his country had benefited.

Dr ASAMOA-BAAH (Assistant Director-General), welcoming the comments and guidance provided by delegates, said that the specific suggestions made by delegates would be taken into consideration in improving and strengthening WHO's disease response.

(For continuation of the discussion, see summary record of the eighth meeting, section 3, page 144.)

The meeting rose at 19:55.

EIGHTH MEETING

Saturday, 22 May 2004, at 09:25

Chairman: Dr Ponmek DALALOY (Lao People's Democratic Republic)

1. ORGANIZATION OF WORK

The CHAIRMAN proposed that two of the progress reports under agenda item 12.15, those on the resolutions on Integrated prevention of noncommunicable diseases (resolution WHA55.23) and the WHO Framework Convention on Tobacco Control (resolution WHA56.1), be transferred to the agenda of Committee B.

It was so agreed.

2. SECOND REPORT OF COMMITTEE A (Document A57/44)

Professor MIZANUR RAHMAN (Bangladesh), Rapporteur, read out the draft second report of Committee A.

Dr VIROJ TANGCHAROENSATHIEN (Thailand) recalled that his delegation had proposed an amendment to the clause which presently appeared as paragraph 4(9) of the resolution on Road safety and health.[1] That amendment had not been reflected in the report before the Committee.

Mr BURCI (Office of the Legal Counsel) pointed out that the Committee had already approved the resolution. The introduction of an amendment would require the agenda item to be reopened for consideration. That would itself require a decision by consensus or by a two thirds majority of the Committee, followed by a reconsideration of the text of the resolution.

The CHAIRMAN said that, as he heard no further comment, he would take it that the Committee wished to adopt its second report without change.

The report was adopted.[2]

---

[1] See summary record of the fifth meeting.

[2] See page 239.

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Health promotion and healthy lifestyles: Item 12.8 of the Agenda (Resolution EB113.R2; Document A57/11) (continued from the sixth meeting)

The CHAIRMAN drew attention to the revision of the draft resolution contained within resolution EB113.R2 which incorporated amendments proposed by Australia, Belgium, Canada, Germany, Greece, Hungary, Morocco, Sweden, Switzerland and Thailand, and which read as follows:

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA42.44 and WHA51.12 on health promotion, public information and education for health and the outcome of five global conferences on health promotion, from Ottawa (1986), Adelaide, Australia (1988), Sundsvall, Sweden (1991), Jakarta (1997), to Mexico City (2000), and the Ministerial Statement for the promotion of health (2000), and the adoption of the WHO Framework Convention on Tobacco Control (2003);

Having considered the report on health promotion and healthy lifestyles;[1]

Noting that *The world health report 2002*[2] addresses major risks to global health, and highlights the role of behavioural factors, notably unhealthy diet, physical inactivity, tobacco consumption and the harmful use of alcohol as key risk factors for noncommunicable diseases which constitute a rapidly growing burden;

Noting that promotion of mental health constitutes an important component of overall health promotion;

Recognizing that the need for health promotion strategies, models and methods is limited neither to a specific health issue nor to a specific set of behaviours, but applies to a variety of population groups, risk factors and diseases, and in various cultures and settings;

Recognizing that, in general, the overriding efforts in health promotion should be geared to reducing health inequalities by comprehensively tackling the determinant chain, including societal structures, environmental factors and lifestyles;

Recognizing the need for Member States to strengthen the policies, human and financial resources, and institutional capability for sustainable and effective health promotion that addresses the major determinants of health and their related risk factors, with a view to building national capacity, strengthening evidence-based approaches, developing innovative means of financing, and drawing up guidelines for implementation and evaluation;

Recalling the importance of primary health care and the five areas of action set out in the Ottawa Charter for Health Promotion,

1. URGES Member States:

(1) to strengthen existing capability at national and local levels for the planning and implementation of gender sensitive and culturally appropriate, comprehensive and multisectoral health-promotion policies and programmes, with particular attention to poor and marginalized groups;

(2) to set up appropriate mechanisms to collect, monitor and analyse national experiences in order to strengthen the evidence base for the effectiveness of health promotion interventions as an integral part of health systems with a view to achieving effective societal and lifestyle changes;

(3) to give high priority to promoting healthy lifestyles among children and young people – boys and girls both in and out of school or other educational institution –

[1] Document A57/11.

[2] *The world health report 2002: reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

including healthy and safe recreational opportunities and creation of supportive environments for such lifestyles;

(4) to include harmful use of alcohol in the list of lifestyle-related risk factors as stated in *The world health report 2002*, and to give attention to the prevention of alcohol-related harm and promotion of strategies to reduce the adverse physical, mental and social consequences of harmful use of alcohol, especially among young people and pregnant women, in the workplace, and when driving;

(5) to set up tobacco-cessation programmes;

(6) to consider actively, where necessary and appropriate, the establishment of innovative, adequate and sustainable financing mechanisms for health promotion with a firm institutional base for the management of health promotion;

2. REQUESTS the Director-General:

(1) to give health promotion highest priority in order to support its development within the Organization as requested in resolution WHA51.12, with a view to supporting Member States, in consultation with involved stakeholders, more effectively to address the major risk factors to health, including harmful use of alcohol and other major lifestyle-related factors;

(2) to continue to advocate an evidence-based approach to health promotion and to provide technical and other support to Member States in building their capacity for the implementation, monitoring, evaluation and dissemination of effective health promotion programmes at all levels;

(3) to provide support and guidance to Member States in relation to the challenges and opportunities stemming from the promotion of healthy lifestyles and the management of related risk factors, as outlined in *The world health report 2002*;

(4) to provide support to all Member States for development and implementation of tobacco-cessation programmes;

(5) to support Member States, where necessary and appropriate, in their attempt to establish an innovative, adequate and sustainable financing mechanism with a firm institutional base in order to coordinate effectively and monitor systematically their health promotion efforts;

(6) to report on progress made in the promotion of healthy lifestyles to the Executive Board at its 115th session and to the Fifty-eighth World Health Assembly, including a report on the Organization's future work on alcohol consumption.

The draft resolution was approved.[1]

Global strategy on diet, physical activity and health: Item 12.6 of the Agenda (Resolution EB113.R7; Document A57/9) (continued from the fifth meeting)

The CHAIRMAN drew attention to the revision of the draft resolution, which incorporated amendments from the informal drafting group formed after the third meeting, and which read as follows:

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA51.18 and WHA53.17 on prevention and control of noncommunicable diseases, and WHA55.23 on diet, physical activity and health;

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.16.

Recalling *The world health report 2002*,[1] which indicates that mortality, morbidity and disability attributed to the major noncommunicable diseases currently account for about 60% of all deaths and 47% of the global burden of disease, which figures are expected to rise to 73% and 60%, respectively, by 2020;

Noting that 66% of the deaths attributed to noncommunicable diseases occur in developing countries where those affected are on average younger than in developed countries;

Alarmed by these rising figures that are a consequence of evolving trends in demography and lifestyles, including those related to diet and physical activity;

Recognizing the existing, vast body of knowledge and public health potential, the need to reduce the level of exposure to the major risks resulting from unhealthy diet and physical inactivity, and the largely preventable nature of the consequent diseases;

Mindful also that these major behavioural and environmental risk factors are amenable to modification through implementation of concerted essential public-health action, as has been demonstrated in several Member States;

Acknowledging that malnutrition, including undernutrition and nutritional deficiencies, is still a major cause of death and disease in many parts of the world, especially in developing countries, and that this strategy complements the important work of WHO and its Member States in the overall area of nutrition;

Recognizing the interdependence of nations, communities and individuals and that governments have a central role, in cooperation with other stakeholders, to create an environment that empowers and encourages individuals, families and communities to make positive, life-enhancing decisions on healthy diet and physical activity;

Recognizing the importance of a global strategy for diet, physical activity and health within the integrated prevention and control of noncommunicable diseases, including support of healthy lifestyles, facilitation of healthier environments, provision of public information and health services, and the major involvement in improving the lifestyles and health of individuals and communities of the health and relevant professions and of all concerned stakeholders and sectors committed to reducing the risks of noncommunicable diseases;

Recognizing that for the implementation of this global strategy, capacity building, financial and technical support should be promoted through international cooperation in support of national efforts in developing countries;

Recognizing the socioeconomic importance and the potential health benefits of traditional dietary and physical activity practices, including those of indigenous peoples;

Reaffirming that nothing in this strategy shall be construed as a justification for the adoption of trade-restrictive measures or trade-distorting practices;

Reaffirming that appropriate levels of intakes for energy, nutrients and foods, including free sugars, salt, fats, fruits, vegetables, legumes, whole grains, and nuts shall be determined in accordance with national dietary and physical activity guidelines based on the best available scientific evidence and as part of Member States' policies and programmes taking into account cultural traditions, and national dietary habits and practices;

Convinced that it is time for governments, civil society and the international community, including the private sector, to renew their commitment to encouraging healthy patterns of diet and physical activity;

Noting that resolution WHA56.23 urged Member States to make full use of Codex Alimentarius Commission standards for the protection of human health throughout the food chain, including assistance with making healthy choices regarding nutrition and diet,

---

[1] *The world health report 2002: reducing risks, promoting healthy life.* Geneva, World Health Organization, 2002.

1. ENDORSES the Global Strategy on Diet, Physical Activity and Health annexed herewith;[1]

2. URGES Member States:

(1) to develop, implement and evaluate actions recommended in the strategy, as appropriate to national circumstances and as part of their overall policies and programmes, that promote individual and community health through healthy diet and physical activity, and reduce the risks and incidence of noncommunicable diseases;

(2) to promote lifestyles that include a healthy diet and physical activity and foster energy balance;

(3) to strengthen existing, or establish new, structures for implementing the strategy through the health and other concerned sectors, for monitoring and evaluating its effectiveness and for guiding resource investment and management to reduce the prevalence of noncommunicable diseases and the risks related to unhealthy diet and physical inactivity;

(4) to define for this purpose, consistent with national circumstances:

(a) national goals and objectives,

(b) a realistic timetable for their achievement,

(c) national dietary and physical activity guidelines,

(d) measurable process and output indicators that will permit accurate monitoring and evaluation of action taken and a rapid response to identified needs,

(e) measures to preserve and promote traditional foods and physical activity;

(5) to encourage mobilization of all concerned social and economic groups, including scientific, professional, nongovernmental, voluntary, private-sector, civil society, and industry associations, and to engage them actively and appropriately in implementing the strategy and achieving its aims and objectives;

(6) to encourage and foster a favourable environment for the exercise of individual responsibility for health through the adoption of lifestyles that include a healthy diet and physical activity;

(7) to ensure that public policies adopted in the context of the implementation of this strategy are in accordance with their individual commitments in international and multilateral agreements, including trade and other related agreements, so as to avoid trade-restrictive or trade-distorting impact;

(8) to consider, when implementing the strategy, the risks of unintentional effects on vulnerable populations and specific products;

3. CALLS UPON other international organizations and bodies to give high priority within their respective mandates and programmes to, and invites public and private stakeholders including the donor community to cooperate with governments in, the promotion of healthy diets and physical activity to improve health outcomes;

4. REQUESTS the Codex Alimentarius Commission to continue to give full consideration, within the framework of its operational mandate, to evidence-based action it might take to improve the health standards of foods consistent with the aims and objectives of the strategy;

5. REQUESTS the Director-General:

(1) to continue and strengthen the work dedicated to undernutrition and micronutrient deficiencies, in cooperation with Member States, and to continue to report to Member

[1] For Annex, see document WHA57/2004/REC/1, Resolutions and decisions.

States on developments made in the field of nutrition (resolutions WHA46.7, WHA52.24, WHA54.2 and WHA55.25);

(2) to provide technical advice and mobilize support at both global and regional levels to Member States, when requested, in implementing the strategy and in monitoring and evaluating implementation;

(3) to monitor on an ongoing basis international scientific developments and research relative to diet, physical activity and health, including claims on the dietary benefits of agricultural products which constitute a significant or important part of the diet of individual countries, so as to enable Member States to adapt their programmes to the most up-to-date knowledge;

(4) to continue to prepare and disseminate technical information, guidelines, studies, evaluations, advocacy and training materials so that Member States are better aware of the cost/benefits and contributions of healthy diet and physical activity as they address the growing global burden of noncommunicable diseases;

(5) to strengthen international cooperation with other organizations of the United Nations system and bilateral agencies in promoting healthy diet and physical activity throughout life;

(6) to cooperate with civil society and with public and private stakeholders committed to reducing the risks of noncommunicable diseases in implementing the strategy and promoting healthy diet and physical activity, while ensuring avoidance of potential conflicts of interest;

(7) to work with other specialized United Nations and intergovernmental agencies on assessing and monitoring the health aspects, socioeconomic impact and gender aspects of this strategy and its implementation and to brief the Fifty-ninth World Health Assembly on the progress of this activity;

(8) to report on the implementation of the global strategy at the Fifty-ninth World Health Assembly.

Mr AITKEN (Director of the Office of the Director-General), drew the Committee's attention to a typographical error: the footnote referring to document A57/9, on the fourth page of the Annex, which was to have been removed, had inadvertently been left in. That regrettable error would be rectified in the final version of the resolution, if approved, and a statement made to that effect in plenary.

The CHAIRMAN said that, as he heard no comment, he would take it that the Committee wished to approve the draft resolution.

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

Dr STEIGER (United States of America) suggested that, in keeping with the customary order of material in WHO documents, the "responsibilities for action" for Member States should be listed before those for WHO in the strategy document.

Dr OTTO (Palau) said that, while Palau had, in a spirit of reaching consensus, agreed to the revisions decided by the drafting group, and fully supported the strategy and looked forward to its implementation and use as a tool for the development of national plans to curb the epidemic of noncommunicable diseases, he wished to place on record two concerns. First, the strategy's focus on individual choice and lifestyle would not be always easy for many people in Palau to put into practice

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.17.

in the light of extensive commercialization of processed foods. He would have preferred a strategy that tackled more the underlying determinants of health and disease. Secondly, while he welcomed the participation of industry in the implementation of the strategy, the strategy would have been stronger if it had addressed a code of conduct for the engagement of industry.

Dr LEÓN GONZÁLEZ (Cuba) said that his delegation had given its strong political backing to the achievement of the strategy, and welcomed it as a valuable contribution to the prevention and control of noncommunicable diseases. Cuba was pleased with the final outcome of the Committee's deliberations. However, it regretted the procedure that had been followed during the discussion. Member States had been allowed virtually no opportunity to exchange views on the document presented, even though it was being raised at the Health Assembly for the first time. No change in the text had been permitted, although many delegations had expressed serious concerns. That seemed to be the new method of work being imposed by the Organization, not for the first time. His delegation was not prepared to agree to the imposition of such procedures and would not hesitate to protest any time they were applied. It was to be hoped that the Health Assembly would take due note of Cuba's concerns about procedure.

The CHAIRMAN, supported by many delegates, congratulated the delegate of South Africa on her chairing of the drafting group; its work had contributed much to the resolution.

Dr TSHABALALA-MSIMANG (South Africa) affirmed that adoption of the global strategy on diet, physical activity and health represented a major advance in public health, and thanked the members of the drafting group for their hard work.

Dr BELLO DE KEMPER (Dominican Republic) said that she shared Cuba's concerns about procedure. In a spirit of compromise, an attempt had been made to incorporate into the resolution the concerns of the various delegations about the strategy. When the strategy was eventually published, it should be in the form of a pamphlet, similar to the one on the global strategy on infant and young child feeding, which included the resolution approving that strategy. In that way, the strategy would always be accompanied by the resolution, and the concerns reflected in the resolution would be made known. She trusted that future evaluations of the results of the strategy's implementation would confirm that approving the strategy had been the right decision.

Mr SEADAT (Islamic Republic of Iran) expressed his satisfaction with the outcome of the negotiations, and emphasized the importance of the strategy for efforts to prevent and control noncommunicable diseases.

Mrs HERNÁNDEZ DE CASTILLO (Nicaragua) expressed satisfaction with the approval of the strategy and the constructive and participatory manner in which it had been drafted, but nevertheless shared the concerns raised by the delegate of Cuba about procedure. All Member States should have an equal opportunity to take part in such discussions. She called on the Organization to work to improve communication with all regions and to find more efficient procedures for consulting with countries, so that in future negotiations it would be easier to reach a consensus in which all Member States saw their interests reflected.

Dr PUSKA (Finland) reiterated the support of the Nordic countries for the strategy. Finland was pleased that the resolution called for a report on implementation in two years' time; that would enable an assessment of progress and provide further guidance for future work. Successful implementation, with action by Member States and WHO's leadership, had great potential for improving global public health. The Nordic countries looked forward to collaborating with WHO in that process.

Dr KIELY (Ireland), speaking on behalf of the European Union, said that the resolution struck a good balance between the concerns of the various parties. He reiterated the strong support of the Union's members for both the strategy and the resolution.

Mr DA ROCHAS PARANHOS (Brazil) said that Brazil shared Cuba's concerns about procedure. He reiterated his country's firm support for the strategy, but Brazil would have liked an opportunity to examine it thoroughly and introduce changes. Nevertheless, thanks to the work of the drafting group, the final text of the resolution was balanced. He welcomed the reaffirmation in the resolution that appropriate levels of intake for energy, nutrients and food would be determined in accordance with national dietary and physical activity guidelines. He was also extremely pleased that the resolution contained an explicit affirmation that nothing in the strategy should be construed as justifying the adoption of trade-restrictive measures or trade-distorting practices. Brazil was concerned about the possible effects of the implementation of the strategy and maintained that it should not be used to justify additional subsidization or internal support measures with regard to certain products. Although it was unquestionably an important public health document, it could have economic and trade implications, to which the Committee must be attentive.

Dr MAHJOUR (Morocco) said that the global strategy came at the right time to help countries, especially developing countries, to fight chronic diseases which, together with communicable diseases, represented a dual burden. He reiterated Morocco's support for its implementation.

Ms GILDERS (Canada) commended the strong sense of common purpose that had prevailed in the drafting group, which had enabled a consensus to be reached.

Dr DAYRIT (Philippines) said that the final text of the resolution successfully reflected the concerns of all countries, including his own. His delegation had wanted to propose some amendments to the strategy itself, on scientific points of detail that could not be included in the proposed resolution. Nonetheless, he was satisfied with the outcome.

Mr YOSHIDA (Japan) commended the drafting group's work. Recalling that the global strategy recommended several preventive actions concerning diet, nutrition and health, he stressed the importance of risk communication by the government to the general public in implementing the strategy at country level.

Dr STEIGER (United States of America), while agreeing that in future more extensive consultations would be useful in improving such a document, reiterated his delegation's support for the global strategy.

Dr TANGI (Tonga) endorsed the comments of the delegate of Finland.

Ms RUDDER (Barbados) reiterated the importance her country and the other members of the Caribbean Community attached to chronic disease prevention, and welcomed the endorsement of the global strategy and approval of the resolution. Barbados shared the concerns of Cuba about the consultation procedure, but looked forward to continued constructive collaboration in the implementation of the global strategy at national and international levels.

Ms DE HOZ (Argentina), welcoming the approval of the global strategy and the outcome of the drafting group's work, supported the proposal by the Dominican Republic about publication. She agreed with Brazil that the strategy must not be diverted from its purpose and used in such a way as to have commercial repercussions. Argentina was prepared for implementation of the strategy at the national level.

Mr PIRA PÉREZ (Guatemala) said that he shared the concerns expressed about failure to discuss certain points in the strategy.

Ms LIU Guangyuan (China) noted that the rendering of the term "physical activity" in the Chinese version was infelicitous, and should be changed.

Human organ and tissue transplantation: Item 12.14 of the Agenda (Resolution EB113.R5; Document A57/17) (continued from the seventh meeting)

The CHAIRMAN drew the Committee's attention to a revised draft resolution incorporating amendments proposed by the delegations of Denmark, Germany, Greece, Norway, Poland, Thailand and the United States of America, which read as follows:

The Fifty-seventh World Health Assembly,

Recalling resolutions WHA40.13, WHA42.5 and WHA44.25 on organ procurement and transplantation;

Having considered the report on human organ and tissue transplantation;[1]

Noting the global increase in allogeneic transplantation of cells, tissues and organs;

Concerned by the growing insufficiency of available human material for transplantation to meet patient needs;

Aware of ethical and safety risks arising in the transplantation of allogeneic cells, tissues and organs, and the need for special attention to the risks of organ trafficking;

Recognizing that living xenogeneic cells, tissues or organs, and human bodily fluids, cells, tissues or organs that have had *ex vivo* contact with these living xenogeneic materials, have the potential to be used in human beings when suitable human material is not available;

Mindful of the risk associated with xenogeneic transplantation of the transmission of known or as yet unrecognized xenogeneic infectious agents from animals to human beings and from recipients of xenogeneic transplants to their contacts and the public at large;

Recognizing that transplantation encompasses not only medical but also legal and ethical aspects, and involves economic and psychological issues,

I
Allogeneic transplantation

1. URGES Member States:

(1) to implement effective national oversight of procurement, processing and transplantation of human cells, tissues and organs, including ensuring accountability for human material for transplantation and its traceability;

(2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices in the procurement, processing and transplantation of human cells, tissues and organs, including development of minimum criteria for suitability of donors of tissues and cells;

(3) to consider setting up ethics commissions to ensure the ethics of cell, tissue and organ transplantation;

(4) to extend the use of living kidney donations when possible, in addition to donations from deceased donors;

[1] Document A57/17.

(5) to take measures to protect the poorest and vulnerable groups from "transplant tourism" and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs;

2. REQUESTS the Director-General:
(1) to continue examining and collecting global data on the practices, safety, quality, efficacy and epidemiology of allogeneic transplantation and on ethical issues, including living donation, in order to update the Guiding Principles on Human Organ Transplantation;[1]
(2) to promote international cooperation so as to increase the access of citizens to these therapeutic procedures;
(3) to provide, in response to requests from Member States, technical support for developing suitable transplantation of cells, tissues or organs, in particular by facilitating international cooperation;
(4) to provide support for Member States in their endeavours to prevent organ trafficking, including drawing up guidelines to protect the poorest and most vulnerable groups from being victims of organ trafficking;

II
Xenogeneic transplantation

1. URGES Member States:
(1) to allow xenogeneic transplantation only when effective national regulatory control and surveillance mechanisms overseen by national health authorities are in place;
(2) to cooperate in the formulation of recommendations and guidelines to harmonize global practices, including protective measures in accordance with internationally accepted scientific standards to prevent the risk of potential secondary transmission of any xenogeneic infectious agent that could have infected recipients of xenogeneic transplants or contacts of recipients, and especially across national borders;
(3) to support international collaboration and coordination for the prevention and surveillance of infections resulting from xenogeneic transplantation;

2. REQUESTS the Director-General:
(1) to facilitate communication and international collaboration among health authorities in Member States on issues relating to xenogeneic transplantation;
(2) to collect data globally for the evaluation of practices in xenogeneic transplantation;
(3) to inform proactively Member States of infectious events of xenogeneic origin arising from xenogeneic transplantation;
(4) to provide, in response to requests from Member States, technical support in strengthening capacity and expertise in the field of xenogeneic transplantation, including policy-making and oversight by national regulatory authorities;
(5) to report at an appropriate time to the Health Assembly, through the Executive Board, on implementation of this resolution.

The draft resolution was approved.[2]

---

[1] Document WHA44/1991/REC/1, Annex 6.

[2] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.18.

Health systems, including primary health care: Item 12.11 of the Agenda (Resolution WHA56.6; Document A57/14)

The CHAIRMAN drew the Committee's attention to a draft resolution on international migration of health personnel: a challenge for health systems in developing countries, which read as follows:

The Fifty-seventh World Health Assembly,

Recalling United Nations General Assembly resolution 2417 (XXIII) of 17 December 1968;

Recalling United Nations General Assembly resolution 58/208 on International migration and development, and the decision therein that, in 2006, the General Assembly will devote a high-level dialogue to international migration and development;

Further recalling resolutions WHA22.51 of 1969 and WHA25.42 of 1972;

Noting that the African Union declared 2004 "Year for Development of Human Resources in Africa";

Taking note of the Commonwealth Code of Practice for the International Recruitment of Health Workers, which was adopted at the meeting of Commonwealth health ministers (Geneva, 18 May 2003);

Noting the work in progress on international labour migration in the International Organization for Migration, the Global Commission on International Migration, and in other international bodies;

Recognizing the importance of human resources in strengthening health systems and in successful realization of the internationally agreed goals contained in the United Nations Millennium Declaration;

Noting with concern that highly trained and skilled health personnel from the developing countries continue to emigrate at an increasing rate to certain countries, which weakens health systems in the countries of origin;

Being aware of the work undertaken in United Nations organizations and in other international organizations with a view to strengthening the capacity of governments to manage migration flows at national and regional levels, and the need for further action to address, both at national and international levels, as an integrated part of the sector-wide approaches and other development plans, the issue of migration of trained health care personnel;

Noting further that many developing countries are not yet technically equipped to assess adequately the magnitude and characteristics of the outflow of their health personnel;

Recognizing the significant efforts and investment made by developing countries in training and development of human resources for health;

Further recognizing the efforts made to reverse the migration of health personnel from developing countries and aware of the need to increase these efforts;

Concerned that HIV/AIDS, tuberculosis, malaria and other such communicable diseases are placing additional burdens on the health workforce,

1. URGES Member States:

(1) to develop strategies to mitigate the adverse effects of migration of health personnel and minimize its negative impact on health systems;

(2) to frame and implement policies and strategies that could enhance effective retention of health personnel including, but not limited to, strengthening of human resources for health planning and management, and review of salaries and implementation of incentive schemes;

(3) to use government-to-government agreements to set up health personnel exchange programmes as a mechanism for managing their migration;

(4) to establish mechanisms to mitigate the adverse impact on developing countries of the loss of health personnel through migration, including means for the receiving countries to support the strengthening of health systems, in particular human resources development, in the countries of origin;

2. REQUESTS the Director-General:
(1) to establish and maintain, in collaboration with relevant countries, institutions/organizations, information systems which will enable the appropriate international bodies to monitor independently the movement of human resources for health;
(2) in cooperation with international organizations within their respective mandates, including the World Trade Organization, to conduct research on international migration of health personnel, including in relation to trade agreements and remittances, in order to determine any adverse effects, and possible options to address them;
(3) to explore additional measures that might assist in developing fair practices in the international recruitment of health personnel, including the feasibility, cost and appropriateness of an international instrument;
(4) to support Member States to strengthen their planning mechanisms and processes in order to provide for adequate training of personnel to match their needs;
(5) to develop, in consultation with Member States and all relevant partners, including development agencies, a code of practice[1] on the international recruitment of health personnel, especially from developing countries, and to report on progress to the Fifty-eighth World Health Assembly;
(6) to support efforts of countries by facilitating dialogue and raising awareness at the highest national and international levels and between stakeholders about migration of health personnel and its effects, including examination of modalities for receiving countries to offset the loss of health workers, such as investing in training of health professionals;
(7) to mobilize all relevant programme areas within WHO, in collaboration with Member States, in order to develop human resources capacity as well as improve health support to developing countries by setting up appropriate mechanisms;
(8) to consult with the United Nations and specialized agencies on the possibility of declaring a year or a decade of "Human Resources for Health Development";
(9) to declare the theme of World Health Day 2006 to be "Human Resources for Health Development";
(10) to include human resources for health development as a top-priority programme area in WHO's General Programme of Work 2006-2015;
(11) to submit a report on implementation of this resolution to the Fifty-eighth World Health Assembly.

Dr CISNEROS (Bolivia) stressed the importance of primary health care in a large country with low-density population such as his own, and endorsed the report.

Dr ABREU CATALÁ (Venezuela) described recent developments in her country in the implementation of primary health care principles and delivery of primary health care services to the most disadvantaged sectors of the population. On the basis of human-centred social policies and structural social and institutional change, a grass-roots, demand-driven initiative (*Misión barrio*

[1] It is understood that, within the United Nations system, the expression "code of practice" refers to instruments that are not legally binding.

adentro) had been launched in 2003, first as a pilot project in a disadvantaged urban district and subsequently country-wide. Based on solidarity and horizontal cooperation, it involved participation of the population of neighbourhoods or communities in integrated, comprehensive primary health care services provided through a network of centres, each with a resident physician, assisted by health committees and other structures. The programme, run in conjunction with educational and income-generating programmes, had had a significant impact on the prevention and control of communicable and noncommunicable diseases and on the overall health status of the population. She asked for further explanation of the potentially useful, proposed monitoring tool referred to in paragraph 12 of the report.

Dr STEIGER (United States of America) commended the work accomplished in producing the final version of the proposed resolution and the progress made in the area under discussion.

Dr TSHABALALA-MSIMANG (South Africa) said that Congo, Egypt, Ghana, Namibia, Sierra Leone and Thailand wished to be added to the list of sponsors of the proposed resolution.

International migration of health personnel threatened to undermine all countries' best efforts to strengthen health systems. It was pointless to discuss programmes to be implemented or strengthened when the human resources for service delivery were lacking. Increasing numbers of health professionals of all categories were being actively recruited to work in other countries, for example, by aggressive marketing from developed countries; monetary incentives made it extremely difficult for the developing countries to compete. The impact of that recruitment was felt most acutely by the poorest people in rural areas. Uncontrolled international migration of health professionals was severely undermining the human resource capacity of developing countries. The situation could be described as an international emergency, and it needed an appropriate response.

In order to facilitate adoption of the draft resolution by consensus, informal consultations had been held and a group had worked on drafting. Member States should ensure that the Director-General had sufficient resources to implement the resolution.

Dr WANG Bin (China) welcomed the Director-General's statement in 2003 at the Global Meeting on Future Strategic Directions for Primary Health Care (Madrid, 27-29 October 2003), in which he had reiterated WHO's continued inclusion of the principles of primary health care in all its activities and programmes and had emphasized the continuity of WHO's development strategies. The goals of strengthening primary health care and attaining health for all had won the commitment and support of all Member States as well as of the broad international community.

She commended the review and evaluation of existing health-for-all strategies and methods in the light of the current global health challenges and the continued adherence to the basic principles of primary health care. WHO had proposed new principles and had further defined the focus of activities, in particular the role of primary health care in driving public health systems.

Since the Declaration of Alma-Ata, primary health care had become an important part of China's national economic and social development. The Chinese Government was aware of the difficulties involved in developing primary health care and achieving health for all, but its determination remained unchanged. In recent years a great deal of effort had been put into establishing a new generation of cooperative medical systems for the rural population in a bid to improve health conditions. It was to be hoped that WHO could consolidate the status and role of primary health care. She appealed to the international community to pay close attention to the subject and urged all heads of state to make corresponding political commitments.

Mr KEENAN (Ireland), speaking on behalf of the European Union, said that strengthening health systems was essential if countries were effectively to meet the challenges they faced, including the Millennium Development Goals. The health workforce (which in most countries accounted for 65% to 80% of annual health-system expenditure) was central to the delivery and development of

services. Yet, WHO had reported that there was insufficient investment in health systems research, and insufficient support to countries, to resolve and manage workforce issues effectively.

In the area of recruitment and retention, some problems had arisen such as remuneration, working conditions and migration. In many countries, the delivery of services was affected by an absolute shortage of different types of health worker, the situation being aggravated by migration. He noted that WHO was working with external partners to secure the inclusion of health workforce issues in the workplans of international and national authorities and to provide policy options and strategies to reduce workforce-related constraints.

The draft resolution on international migration of health personnel was therefore timely and appropriate and a valuable contribution to the overall work of WHO to strengthen health systems.

Dr AHMED (Ghana) said that the migration of health workers had reached epidemic proportions in his part of the world, with active "poaching" of most experienced, strong and able young staff. That trend had shifted indirectly to the recruitment of auxiliaries. As countries struggled to achieve the Millennium Development Goals, the human capacity to implement strategies was simply lacking. He acknowledged the work done in drafting the resolution and urged its adoption and implementation, for the benefit of all.

Dr MATHESON (New Zealand) said that the report was helpful in ensuring that the principles of primary health care and the need for an effective primary health care infrastructure were well understood. Much of the global effort on health could be improved if the principles and the infrastructure of primary health care could underpin responses to health issues at that time. What further action was planned to ensure that primary health care principles underpinned WHO's activities? He acknowledged the importance of the workforce issues raised in that respect.

Mr HAN Sok Chol (Democratic People's Republic of Korea) said that, since the Declaration of Alma-Ata, effective action at global level had helped to strengthen health systems, reflected in lower infant morbidity and mortality rates, increased life expectancy and broader access to primary health care. Nevertheless, infectious diseases such as HIV, tuberculosis and malaria, and emerging diseases such as severe acute respiratory syndrome and avian influenza required redoubled efforts to strengthen health systems, including primary health care.

Mindful of the importance of primary health care, his Government had for several decades been working to strengthen health systems by setting up free medical-care and medical surveillance systems. Several natural disasters, however, in recent years had disrupted the normal functioning of the country's health system, and work was going on to restore its efficiency. A national centre had recently been established in collaboration with WHO to help to ensure the quality of primary care. He urged the Organization to take concrete measures to strengthen health systems, including primary health care, in Member States.

Dr RUIZ (Mexico) said that, in Mexico, health was recognized as an individual and enforceable right and citizens were guaranteed access to health care. Primary health care was considered very important and a number of strategies had been developed, including one for lifelong prevention and health promotion.

She requested that in paragraph 1(2) of the Spanish version of the draft resolution the word *retención* be replaced by *permanencia*, since *retención* connoted something being done against the will of the individual.

Mr WEEKES (Barbados) announced that the following countries of the Caribbean Community wished to sponsor the draft resolution: Antigua and Barbuda, Bahamas, Barbados, Grenada, Jamaica, Saint Vincent and the Grenadines, and Trinidad and Tobago. Human resources were critical to health sector reform and development, and the Community was a strong advocate of a managed migration programme. It had pledged to work with interested countries, WHO and other international agencies to

develop programmes for the retention of health-sector specialists in the developing countries, to strengthen their health systems and improve the quality of life of their peoples.

Dr LEÓN GONZÁLEZ (Cuba) welcomed the drafting of a resolution on such an important subject. Did the "institutions/organizations" mentioned in paragraph 2(1) refer to WHO and its regional offices?

Ms ALOPAEUS-STÅHL (Sweden), speaking on behalf of the five Nordic countries (Denmark, Finland, Iceland, Norway and Sweden), endorsed the statement by the delegate of Ireland on behalf of the European Union. Coordinated patient-centred care across the continuum of prevention, treatment and care in equitable health systems was essential to the achievement of all major health-related Millennium Development Goals and addressing the global increase in the burden of noncommunicable and chronic diseases. She welcomed the primary health care approach suggested in the report. She requested the Director-General to ensure that an equitable rights-based and gender-sensitive primary health care "lens" was built into the tools for monitoring the implementation of primary health care.

If the envisaged dramatic expansion in delivery of antiretroviral treatment was to strengthen rather than burden health systems, WHO must help Member States to forge stronger health systems. Priority must be given to health systems development, and the main strategy must continue to be primary prevention. In changing the history of weak health systems, it was crucial that all partners understood and took into account the relationship between health systems performance and the economic implications for stakeholders. She welcomed the work done in the High-Level Forum on the Health Millennium Development Goals and other such settings. Member States were owners of their own health systems development. Coherent action among all partners in, for example, the recruitment and retention of health workers in resource-poor countries and settings could be facilitated or made more difficult, depending on investment in health systems and on action taken in other policy areas, such as poverty-reduction strategies, in both developing and developed countries.

Dr DAYRIT (Philippines) expressed his support for the draft resolution. Filipino nurses worked in many parts of the globe and were known for their skills and caring capabilities. Although the Philippines produced thousands of nurses every year and had an oversupply of graduates, the rapid turnover of experienced nurses, particularly in tertiary care in both the public and private sectors, had led to a paradoxical shortage of nursing expertise. The rapid turnover of students and the establishment of many nursing schools in the Philippines had caused concern about the quality of nursing education in the "diploma mills" that sought to participate in the global market of human resources in nursing. The Philippine Government was endeavouring to safeguard the quality of nursing education and to create a favourable domestic labour environment for their retention, even as the migration of nurses continued. Contacts had already been made with the governments of countries in which the nurses worked, with a view to setting up health personnel exchange programmes and a mechanism for managing migration. The Philippines wished to be included as a sponsor of the resolution.

Ms MOTSUMI (Botswana) said that Botswana was suffering not only from the migration of nurses and other cadres to certain developed countries, but also from the fact that, increasingly, young professionals who were in training abroad were failing to return home. After HIV/AIDS, the problem of human resources was the greatest challenge facing the country's health system. She supported the draft resolution.

Mrs CAMPBELL GONZÁLEZ (Nicaragua) said that her delegation shared the concern expressed in the draft resolution and supported its proposals, which provided a starting point for tackling the serious problem of migration of health professionals. She agreed with the delegate of Mexico about the use of the term *permanencia*.

Mr HASHMIR (Pakistan) said that the International Association of Medical Regulatory Authorities was examining the issue of international migration of health professionals and was working to develop a "medical passport" to help different organizations to deal with the migration of doctors. It was important to tackle the causes of such migration. Some medical professionals did not want to work in their own countries because the job was more demanding or less well paid than elsewhere. Some governments did not want to spend money on medical education because it was too costly, preferring to recruit competent medical professionals from developing countries. Such governments should therefore compensate the developing countries concerned for what had been spent on medical education and on developing country health-care systems.

Mrs KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that her organization was encouraged by the unanimous support for primary health care in the 21st century and welcomed the opportunity to work with WHO to develop the "primary health care lens" in order to examine health policies and targets, thereby promoting the right to health for all through universal access. The actions highlighted in the report should be implemented alongside the "3 by 5" initiative, in order to spur progress towards attaining the health-related Millennium Development Goals.

She urged caution about new principles. Experience had shown the principles of equity and participation through a multisectoral approach to be effective when implemented together. For example, Sri Lanka had managed to maintain low child and maternal mortality rates despite spending less than 2% of its gross national product on health, in a context of ongoing conflict and high levels of malnutrition and poverty. Universal access, no user fees, access to services for all, free inpatient care, career structures for health workers, high levels of literacy, education and Government support for the social sector had been crucial to those achievements. Such approaches should be supported in other countries before developing new principles.

Concerning policy implementation, her organization had released a report on achieving the health-related Millennium Development Goals in child and maternal survival, which called for both a policy change from the current World-Bank-led cost-effectiveness model to a more rights-based, pro-poor approach, as set out in the OECD/WHO publication *Poverty and health*,[1] and international and national resources for the long-term support of health systems, including investment in the health workers of the future. In terms of health-system development Member States should follow the example of the Governments of Ghana and Uganda in abolishing user fees, in order to remove one of the key reasons for poor use of services and increasing poverty in the poorest communities worldwide. She supported WHO in exploring innovative mechanisms for redistributive taxation and social health insurance.

Mrs KINGMA (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that ensuring the safety of staffing in health services was a priority for her organization. Migration was often cited as a major factor in nursing shortages, but it was a symptom of dysfunctional health systems, not their primary cause. The need to migrate must be urgently addressed. Most health professionals, especially nurses, most of whom were women, did not wish to migrate. Emphasis must therefore be placed on retention measures, in both industrialized and developing countries.

In too many countries, there was a critical shortage of nurses willing to work in current pay and working conditions, not only in clinical practice but also in nursing faculties. Paradoxically, at the same time thousands of nurses were unemployed. Many locally trained registered nurses chose not to work in the health sector. Creating viable work practices, supportive infrastructures and targeted incentives would encourage them back into health-care facilities. Nurses in some developing countries faced a time-lag of up to 18 months between graduation and registration; once employed, they might

[1] OECD/WHO. *Poverty and health*. Paris, OECD, 2003.

have to wait nine months before being paid. In countries offering special allowances for scarce skills or placement in rural areas, nurses not only received lower salaries than other health sector professionals, but the allowances represented smaller percentages of their salaries. That inequality was demoralizing and prompted workers to consider migrating. Comprehensive information systems needed to be established to determine the nature and magnitude of migration. Innovative retention approaches must be found, including the provision of free HIV/AIDS care for nurses and their families. Mechanisms could be developed to direct some donor aid towards financing salaried positions within health systems in crisis and towards expanding training facilities. The retention of nurses in active practice was a key to resolving the present crisis. Her organization urged the Committee to adopt the draft resolution.

Mrs SACKSTEIN (International Alliance of Women), speaking at the invitation of the CHAIRMAN, and also on behalf of the International Federation of Business and Professional Women and the Worldwide Organization for Women, drew attention to United Nations General Assembly resolution 58/173, which called upon States to guarantee the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. New challenges were created by the growing trend towards privatizing health care and services through public-private partnerships; she questioned whether such partnerships always contributed to achieving the highest attainable standard of health, whether they differentiated between global and national priorities, whether the pursuit of donor-oriented goals limited the effectiveness of donations in the area of public health and whether they jeopardized implementation of the Alma-Ata principles. Some persistent concerns in the field were that those partnerships tended to be disease-selective and based on the commercial interests of the donor, thereby distorting national health strategies based on needs, long-term impact and sustainability; that the preferential attention accorded to new technologies could lead to discrimination, particularly against women and girls; that donor-led pressure to pursue a selective approach to treatment could divert funds away from other health priorities towards those that could be treated with the drug offered; and that the frequent failure to distinguish between public-interest nongovernmental organizations and those linked to commercial interests prevented clear identification of areas of effective collaboration and areas of potential conflicts of interest.

At its most recent session, the Executive Board had recommended ways of strengthening health systems and health financing. To ensure an equitable, ethical approach and increased access to health care, health-system indicators should be developed to measure performance of those partnerships; recipient countries should be involved from the outset in order to avoid distorting national health plans; contracts must be governed by transparent criteria that were consistent with internationally recognized guidelines and standards so as to increase the accountability of all partners; WHO should assist governments in developing national mechanisms to monitor the quality and long-term impact of such partnerships; and WHO should take the lead in providing clear criteria for differentiating public nongovernmental organizations from those associated with business interests. Those suggestions also reflected the outcome of a broad-based panel discussion among nongovernmental organizations and professional associations held at the most recent session of the Commission on Human Rights. She pledged cooperation with WHO in addressing those issues in order to help strengthen health systems.

Dr EVANS (Assistant Director-General), responding to questions and comments, acknowledged the recognition of the centrality of primary health care principles in health sector development. Describing WHO's ongoing efforts in relation to the five basic principles of primary health care, he said that all WHO priority programmes were committed to universal access, whether to vaccines, drugs or bednets. In line with the cross-cutting approach that was critical for the delivery and effectiveness of priority programmes, the Essential drugs and medicines policy programme incorporated the principle of universal access to medicines, and sustainable financing principles were being incorporated into health systems and priority programmes. A commission was being set up to examine the social and environmental determinants of health, with the goal of making recommendations on their integration into Member States' health policies, and providing a better

understanding of how they might be integrated into WHO priority programmes. In the area of intersectoral coordination and with regard to the Millennium Development Goals, ways were being sought to integrate health into poverty-reduction strategies. A study was being conducted on whether the funding frameworks for social sectors were adequate for the health sector and on the need to cooperate with the education sector in work on human resources. Those were examples of cooperation with key sectors not traditionally part of the health sector. With regard to community participation, the programmes on quality and on patient safety involved a strong consumer perspective. Means were being developed to facilitate local or decentralized planning at the district level.

In response to the question from Cuba about the reference to international organizations in paragraph 2(2) of the draft resolution, he said that those included the WHO regional offices and other organizations such as ILO, the International Organization for Migration and the World Bank.

Dr LEÓN GONZÁLEZ (Cuba) and Dr AHMED (Ghana) requested that their countries be named as sponsors of the draft resolution.

The draft resolution was approved.[1]

Implementation of resolutions (progress reports): Item 12.15 of the Agenda (Document A57/18) (continued from the seventh meeting)

- **Infant and young child nutrition: biennial progress report:** Item 12.15 of the Agenda (Document A57/18)

The CHAIRMAN drew attention to a draft resolution on infant and young child nutrition, proposed by the delegations of Fiji, Kiribati, Marshall Islands, Federated States of Micronesia, Nepal and Palau, which read as follows:

> The Fifty-seventh World Health Assembly,
>
> Recalling resolution WHA33.32 endorsing, in their entirety, the statement and recommendations made by the joint WHO/UNICEF Meeting on Infant and Young Child Feeding (1979) and noting that 2004 is the twenty-fifth anniversary of that landmark meeting;
>
> Recalling resolution WHA34.22 on the International Code of Marketing of Breast-milk Substitutes, which stresses that adoption of, and adherence to, the International Code is a minimum requirement;
>
> Recalling also resolutions WHA35.26, WHA37.30, WHA39.28, WHA41.11, WHA43.3, WHA45.34, WHA46.7, WHA47.5, WHA54.2 and, in particular, resolution WHA55.25 endorsing the global strategy for infant and young child feeding;
>
> Noting further resolution WHA49.15 which urges Member States to ensure that financial support for professionals working in infant and young child health does not create conflicts of interest;
>
> Recognizing the responsibility of industry to make full disclosure of known public health risks;
>
> Aware that several Member States have recently issued alerts to health professionals about the known public-health risks regarding the presence of pathogens in powdered infant formula and the vulnerability of infants to them;
>
> Aware that the Codex Committee on Food Hygiene is revising recommendations on hygienic practices for the manufacturing of foods for infants and young children;

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.19.

Concerned that, whereas consumers have the right to full and unbiased information, health and nutrition claims have become an effective means of promoting the sale of breast-milk substitutes;

Encouraged by the progress made by several Member States in adopting legislation prohibiting commercial sponsorship of health professionals or their associations;

Having considered the summary biennial progress report on infant and young child nutrition;[1]

1. URGES Member States:

(1) to ensure that health-care providers, parents and caregivers are informed that powdered infant formula may be contaminated intrinsically by pathogenic microorganisms and that this information is conveyed through explicit warnings on labels; and to take into consideration other risk-reduction strategies proposed by the Codex Alimentarius Commission;

(2) to ensure that false health and nutrition claims are not permitted for foods for infants and young children;

(3) to take steps to prohibit sponsorship of health professionals and/or their associations by any manufacturer or distributor of products within the scope of the International Code of Marketing of Breast-milk Substitutes;

(4) to ensure that research on infant and young child feeding, which forms the basis for public policies, is free from commercial influence;

(5) to continue their active participation in the work of the Codex Alimentarius Commission in this area;

2. REQUESTS the Codex Alimentarius Commission to give full consideration to recommendations made by the Health Assembly concerning quality standards of processed foods for infants and young children and, within the framework of its operational mandate, to give close attention to action urgently required for the revision of standards and guidelines on labelling, quality and safety of processed foods for infants and young children;

3. REQUESTS the Director-General:

(1) to continue taking action on the relevant recommendations of the joint FAO/WHO meeting on *Enterobacter sakazakii* and other microorganisms in powdered infant formula;

(2) to uphold the mandate of WHO for the protection of health and safety of infants and young children in the Codex Alimentarius standard-setting process;

(3) to encourage and support independent research on intrinsic contamination of powdered infant formula and to collect evidence in different parts of the world.

Dr SHRESTHA (Nepal) said that, after endorsement of the global strategy for infant and young child feeding, his Government was drawing up a national strategy. As a result of rapid urbanization and ready availability and intensive marketing of breast-milk substitutes in his country, their use was rapidly replacing breastfeeding. Although heat-resistant pathogens had been found in powdered infant formula in developed countries, so far, no studies had been conducted in developing countries, where the prevalence of such pathogens might prove to be much higher than in developed countries. He therefore requested WHO to assist in carrying out such studies.

He expressed concern also about the increasing use of health and nutrition claims by manufacturers of breast-milk substitutes, which had no scientific basis, confused parents and increased

[1] Document A57/18, section E.

use of the substitutes, leading to infant malnutrition and illness in developed and developing countries alike. He strongly supported the draft resolution and called on all Member States to support it.

Ms DE HOZ (Argentina) affirmed that Argentina had made progress in implementing the global strategy for infant and young child feeding, adopted by the Health Assembly in 2002. For example, impetus had been given to the Baby-friendly Hospital Initiative and to increasing exclusive breastfeeding rates. Given the strategic value, in public-health terms, of the promotion and support of exclusive, continued breastfeeding, its advantages were highlighted in Argentina's programme against childhood diseases, the aim of which was to prevent diarrhoea, respiratory diseases and malnutrition. Similarly, breastfeeding was one of the four pillars of Argentina's current campaign to prevent sudden infant death. Breastfeeding was better for all infants, and ensured that at least in that respect they would start life on an equal footing. A survey in Argentina in 2003 of breast-feeding in a sample of more than 60 000 infants and young children had shown that over 48% of infants under six months of age had been exclusively breastfed.

She welcomed inclusion of reference in the draft resolution to the presence of *E. sakazakii* in powdered infant formula. Argentina was implementing measures for detection of that bacterial contamination. She proposed that the word "false" be deleted from paragraph 1(2), since any health and nutrition claims relating to products were to be considered as a form of promotion, which was expressly prohibited by the International Code of Marketing of Breast-milk Substitutes. She welcomed the spirit of paragraph 1(4).

Dr ZOMBRE (Burkina Faso) stated that, following the adoption of the global strategy for infant and young child feeding, Burkina Faso was drawing up a corresponding national strategy with the support of WHO and UNICEF. The nutritional state of young children under the age of five in his country was a matter for concern: 60% were malnourished and 10% of newborns were underweight – low birth weight was related to the poor nutritional state of mothers and malaria during pregnancy. Only 9.8% of women exclusively breastfed their babies. To improve that situation, several measures had been taken, including the promotion of exclusive breastfeeding up to six months, complementary feeding when necessary and provision of micronutrient supplements. With regard to HIV/AIDS, Burkina Faso had reviewed its legislation relating to the International Code of Marketing of Breast-milk Substitutes and had provided training in nutrition and HIV/AIDS to staff involved in implementing the programme for the prevention of mother-to-child transmission of HIV. An action framework was required in order to create environments encouraging appropriate feeding for all infants, while increasing interventions to reduce HIV transmission. Updated recommendations on the energy and micronutrient requirements of children living with HIV/AIDS should be rapidly disseminated to all countries. He supported the draft resolution.

Dr AGARWAL (India) indicated that, in order to harmonize its national policies with the global strategy for infant and young child feeding, India had amended its legislation on breast-milk substitutes and infant foods in 2003 to include provisions on exclusive breastfeeding for the first six months; a ban on advertising and promotion of breast-milk substitutes or infant food claiming that such substitutes were as good as or better than breast milk; and a ban on sponsorship of breast-milk substitutes and infant foods in the education and research sectors. India had hosted the Asia Pacific Conference on Breastfeeding (New Delhi, 30 November – 3 December 2003); the resulting Delhi Declaration on Infant and Young Child Feeding called for urgent action to promote exclusive breastfeeding and legislation to stop all commercial practices that undermined optimal infant feeding practices. Similarly, the Indian Government's 10th five-year plan specified the goal of increasing exclusive breastfeeding to 80% by 2007. He agreed with the amendment proposed by the delegate of Argentina, and supported the draft resolution.

Dr LARIVIÈRE (Canada) said that because of the late distribution of the draft resolution, compounded by the problem of different time zones, there had been insufficient time to give it the

consideration it merited. Initial consultations indicated that it required considerably more work and would require many amendments. He proposed that consideration of the draft resolution be deferred to the 115th session of the Executive Board in January 2005.

Mr KINGDON (Australia) commended the progress report and the response of WHO experts to requests for technical advice concerning the marketing in Australia of infant formula. He endorsed the proposal by Canada, as many issues required further consideration: for example, paragraph 1(1) sought to issue a global alert on the possible contamination of certain products. Such alerts were usually issued by WHO after careful assessment of all the evidence, and he questioned the appropriateness of addressing the matter in a Health Assembly resolution.

Mr HOHMAN (United States of America) welcomed the report, but he concurred with the comments and proposal of the previous speakers regarding the draft resolution. Work was currently under way in other bodies on the subject of *E. sakazakii*, and he preferred to await the outcome of that work before considering the draft resolution.

Dr CHIRWA (Zambia) welcomed the report and the draft resolution, given that malnutrition and micronutrient deficiency were major contributing factors to disease and death, particularly in southern Africa, and learning problems, thus further compromising the development of children. Tackling infant and child malnutrition was therefore a key to development and to implementation of the Millennium Development Goals. The issue of breastfeeding had been complicated by the rising prevalence of HIV/AIDS in many countries, particularly in southern Africa, and further research on the prevention of mother-to-child transmission of HIV must be given high priority, with global cooperation. He highlighted the need to implement the International Code of Marketing of Breast-milk Substitutes in low- and middle-income countries. He supported the draft resolution.

Dr AL-MAZROU (Saudi Arabia), urging that the draft resolution be approved as soon as possible, proposed that paragraph 1(2) be amended to read: "to ensure that no false health and nutrition claims be permitted for foods for infants and young children."

Dr OTTO (Palau) indicated that his country had made progress in implementing the Baby-friendly Hospital Initiative. He expressed his disappointment that delegates had had insufficient time to consider the draft resolution. It had been submitted on time; the delay had been due to a subsequent reworking by the secretariat. He asked that similar situations be avoided in the future by allowing draft resolutions to be discussed in their original form and amended, if necessary, by Member States.

Statements to the effect that contamination of powdered infant formula with *E. sakazakii* had been a cause of infection and illness in infants, even leading to serious developmental sequelae and death, could be found in the executive summary of the joint FAO/WHO Workshop on *Enterobacter sakazakii* and Other Microorganisms in Powdered Infant Formula, held in Geneva in February 2003. An article in a recent issue of *The Lancet* indicated that breastfed babies became healthier adults and that breastfeeding was a significant factor in the prevention of death and disability from heart disease or stroke in adulthood. It therefore had to be safeguarded. In the light of previous Health Assembly resolutions to promote breastfeeding, the recent approval of the global strategy on diet, physical activity and health, and the research indicating reduced health risks in adulthood for breastfed babies, reluctance to take action to safeguard and promote breastfeeding was not only unjustified but would leave a legacy of guilt and shame. Recalling the comments made by Mr Jimmy Carter, former President of the United States of America, in his address to the Health Assembly,[1] in particular about clearly defining the future in order to mobilize political will at the highest levels, he urged action.

[1] Document A57/DIV/8.

Mr YOSHIDA (Japan) commended the efforts made by Palau and other countries. Although the issue of infant and young child nutrition was of great importance, he concurred with other delegates that consideration of the draft resolution should be postponed to take into account the results of discussions being held within the Codex Alimentarius Commission.

Dr CHETTY (South Africa) said that the measures taken to implement the global strategy for infant and young child feeding in her country included administration of high-dose vitamin A capsules to all women in the postpartum period and to children between the ages of six months and five years; vitamin A supplements for children in that age group who suffered from severe malnutrition, measles, persistent diarrhoea or xerophthalmia; fortification of all maize meal and wheat flour with vitamin A, thiamine, riboflavin, and nicotinic acid and iodination of food-grade salt. Exclusive breastfeeding was recommended for six months, followed by safe, appropriate complementary feeding together with breastfeeding until the infant was two years old. The nutrition of people with HIV/AIDS was of great importance; the tools developed by WHO for assessing feeding options had been field-tested in her country and would ultimately be adapted in the light of those tests.

Dr VON VOSS (Germany) said that, since careful reflection was needed on the wide-ranging implications of the text, he agreed with other speakers that the draft resolution should be considered at a later date. His Government would submit several amendments.

Ms NGHATANGA (Namibia) said that in her country about 94% of mothers exclusively breastfed their infants for four to six months. The approval in 2003 of a national policy on infants and young children aimed at promoting and protecting breastfeeding in all communities had been a major achievement. However, more attention should be paid to the feeding of orphans and vulnerable children whose biological mothers were unable to breastfeed.

Dr MATIUR RAHMAN (Bangladesh) said that his Government promoted breastfeeding within its nutritional programmes. Powdered milk could be adulterated by a variety of pathogens, which were some of the chief causes of diarrhoeal diseases. Hence, it was best to breastfeed infants for six months and advisable to do so until they reached the age of two. Breastfeeding had the added advantage of helping to prevent breast cancer. His delegation therefore strongly supported the draft resolution.

Dr KUNENE (Swaziland) said that the issue of infant and young child feeding had to be treated as a matter of urgency in order to ensure the survival of children in southern Africa. While there was some risk of HIV transmission to the infant through breastfeeding, formula-fed children were faced with an even greater risk of dying from gastroenteritis in areas where there was no safe water. It was necessary to have a properly controlled environment before breast-milk substitutes could be sold. His country's national strategy promoted exclusive breastfeeding for the first six months of an infant's life, vitamin A supplementation and appropriate weaning. The need to consider the draft resolution in greater depth should be weighed against the need for its immediate adoption in order to ensure children's survival. His delegation endorsed the draft resolution and trusted that it would be adopted.

Dr ABREU CATALÁ (Venezuela) said that her Government promoted exclusive breastfeeding for the first six months of an infant's life, and was making progress in setting up baby-friendly hospitals. Three milk banks had been created, and 13 more would be opened in the near future. Community milk-supply points were being established in the neediest communities with a view to providing human milk for the babies of mothers with HIV/AIDS. Her delegation supported the draft resolution, subject to deletion of the word "false" in paragraph 1(2).

Dr AL-JABER (Qatar) said that, as it was essential to make sure that very young children were not exposed to bacteria or lead, his Government endorsed the draft resolution with the amendment proposed by Saudi Arabia, and the request by Nepal.

Dr ZAHER (Egypt) drew attention to the fact that the draft resolution did not mention breastfeeding, although natural breastfeeding was excellent for young children. She therefore proposed the addition of a paragraph urging Member States to promote breastfeeding, especially during the first six months of life. She also supported deletion of the word "false" from paragraph 1(2).

Dr AL-JUBAHJI (Syrian Arab Republic) endorsed the draft resolution with the amendment proposed by Saudi Arabia, and the request by Nepal.

Mr FURGAL (Russian Federation) said that he shared the concerns expressed by Australia, Canada, Germany, Japan and the United States of America. Member States should be given an opportunity to examine the text in greater detail. It would be wise to defer consideration of the draft resolution to the 115th session of the Executive Board in January 2005 and to hold further consultations during the intersessional period.

Dr MUKELABAI (UNICEF) welcomed the progress report and draft resolution on infant and young child nutrition, because of the 11 million deaths of children under five each year 50% to 70% were due to preventable diseases brought on partly by malnutrition. He drew attention to a UNICEF/WHO booklet on the global strategy for infant and young child feeding which stressed the impact of feeding practices on nutritional status, growth, development and survival, and strongly emphasized the importance of exclusive breastfeeding during the first six months of life.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, pointed out that, while breastfeeding was always best, no other breast-milk substitute was as safe as infant formula developed according to national legislation or FAO/WHO Codex Alimentarius standards when mothers could not or chose not to breastfeed. Infant formula was used to replace inferior and low-quality breast-milk substitutes and played a critical role in meeting the nutritional needs of infants who were not breastfed. Infant-food manufacturers would continue to comply with the highest scientific standards. When scientific data made it possible to improve infant formulae, producers worked closely with national health authorities and FAO/WHO Codex Alimentarius to adapt their products accordingly. Member States should keep up to date with research in the field of infant nutrition in order to ensure that future health policies were based on sound scientific evidence. Her organization fully supported the International Code of Marketing of Breast-milk Substitutes and wholeheartedly endorsed its implementation. Many of its member companies had taken steps to ensure that the Code was observed to the letter and had established national associations to facilitate dialogue with government authorities responsible for implementing it. Governments should incorporate the Code into their national legislation and establish impartial and transparent monitoring procedures. WHO should initiate a constructive dialogue among all concerned parties so that efforts could be concentrated on reducing malnutrition, one of the Millennium Development Goals.

Mrs KUONEN-GOETZ (La Leche League International), speaking at the invitation of the CHAIRMAN, welcomed the worldwide increase in exclusive breastfeeding during the first four months of life. Exclusive breastfeeding was the most effective way of improving infants' health in low-income communities, and could reduce child mortality by 13%. Exclusive breastfeeding for the first six months and then breastfeeding coupled with complementary foods for a further two years made for greater food security and safety. Research had demonstrated the many health benefits of breastfeeding in the short and long term. Even in wealthy industrialized countries, bottle-feeding could jeopardize infants' lives and lead to a greater risk of cardiovascular disease among adults. There was growing recognition that women needed support for breastfeeding, and her organization provided that backing in various ways in more than 60 countries.

Mrs YEONG (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, co-founded by Consumers International, and Save the Children, said that her organization defended the rights of the most vulnerable consumers, infants and young children, through the protection and promotion of breastfeeding, which played a vital role in reducing the burden of chronic diseases and helped to prevent malnutrition. Many people suffered the lifelong consequences of not having been breastfed. A survey in the United States of America had shown that infants who were not breastfed faced a 21% higher risk of dying in the post-neonatal period than breastfed infants. Serious illness and even death could ensue when powdered infant formula was contaminated with *E. sakazakii*.

Her organization had documented the unethical practices employed in the marketing of breast-milk substitutes, and its latest publication supplied evidence of systematic and pervasive violations of the International Code of Marketing of Breast-milk Substitutes in 69 countries. There had been an alarming increase in claims of health and nutrition, aimed at boosting the sale of such products. If any changes were made to the composition of breast-milk substitutes, they should be applied to all products and not used as advertising tools. Member States should make more vigorous efforts to implement the International Code. Persons working in infant and young child feeding should be alert to potential conflicts of interest when conducting research or attending meetings or educational activities sponsored by the baby food industry. She commended the action of Azerbaijan and India in that respect.

Mrs PHUMAPHI (Assistant Director-General) highlighted the section of the report that emphasized the continuing disparity in exclusive breastfeeding; even the increase to 38% applied only to exclusive breastfeeding for the first four months of life. WHO would continue to support Member States in reaching the target of six months of exclusive breastfeeding and in introducing baby-friendly hospitals. The energy and nutrient requirements of children living with HIV/AIDS had recently been published.[1]

Dr LEITNER (Assistant Director-General), responding to comments made, noted that many Member States had developed national strategies to implement the global strategy. Although all speakers had supported the spirit, purpose and direction of the draft resolution, there were clearly issues requiring further debate; she offered to facilitate debate between Member States in order to arrive at a resolution that reflected the concerns and policies of all. She pledged WHO's support for independent research on those issues at country level. Work would continue to be accelerated in the Codex Alimentarius committees, and WHO would report back to Member States on the results of their deliberations and discussions.

The CHAIRMAN proposed that the draft resolution be submitted to the Executive Board for discussion at its 115th session in January 2005.

Dr SHRESTHA (Nepal), Dr SADRIZADEH (Islamic Republic of Iran) and Dr OTTO (Palau) expressed their reservations about postponing approval of the draft resolution, as any delay denied justice to infants and children.

Mr DO NASCIMENTO PEDRO (Brazil) also expressed his preference for the matter to be concluded during the current meeting but said that he would not block a consensus to submit the draft resolution to the Executive Board.

---

[1] *Nutrient requirements for people living with HIV/AIDS. Report of a technical consultation:* (Geneva, 13-15 May 2003). Geneva, World Health Organization, 2003.

The CHAIRMAN said that he took it that the Committee wished to submit the draft resolution to the Executive Board for discussion at its 115th session in January 2005.

It was so agreed.

(For continuation of the discussion, see the summary record of the fifth meeting of Committee B, section 3.)

4. THIRD REPORT OF COMMITTEE A (Document A57/47)

Professor MIZANUR RAHMAN (Bangladesh), Rapporteur, read out the draft third report of Committee A.

The report was adopted.[1]

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of the Committee completed.

The meeting rose at 12:40.

[1] See page 239.

COMMITTEE B

FIRST MEETING

Thursday, 20 May 2004, at 09:15

Chairman: Dr Jigmi SINGAY (Bhutan)

1. OPENING OF THE COMMITTEE: Item 13 of the Agenda (Document A57/36)

The CHAIRMAN welcomed participants and introduced Dr Yin Li and Dr Al-Jarallah, who would attend the Committee's meetings in their capacity as representatives of the Executive Board. The views they expressed would be those of the Board, not their national governments.

He drew attention to document A57/36, which contained proposals by the Committee on Nominations for the posts of Vice-Chairmen and Rapporteur.[1]

Decision: Committee B elected Professor N.M. Nali (Central African Republic) and Dr S.A. Al Kharabseh (Jordan) as Vice-Chairmen and Mrs Z. Jakab (Hungary) as Rapporteur.[2]

2. HEALTH CONDITIONS OF, AND ASSISTANCE TO, THE ARAB POPULATION IN THE OCCUPIED ARAB TERRITORIES, INCLUDING PALESTINE: Item 19 of the Agenda (Documents A57/30, A57/INF.DOC./1, A57/INF.DOC./2 and A57/INF.DOC./3)

The CHAIRMAN drew attention to a draft resolution, which read as follows:

The Fifty-seventh World Health Assembly,

Mindful of the basic principle established in the Constitution of WHO, which affirms that the health of all peoples is fundamental to the attainment of peace and security;

Recalling all its previous resolutions on health conditions in the occupied Arab territories;

Expressing appreciation for the report of the Director-General on the health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine;[3]

Expressing its concern at the deterioration of health conditions and the humanitarian crises resulting from military activities which caused severe restrictions on the movement of Palestinian people and goods, including restrictions on the movement to and from Palestinian territories, particularly of ambulances, health workers, the wounded and sick;

Expressing its concern at the continued use of excessive force by the Israeli military forces which resulted in the killing and injuring of thousands of Palestinians, including children;

Expressing its concern at the serious deterioration of the economic and health situation resulting from closures and curfews imposed on the Palestinians by the Israeli occupying forces,

---

[1] See page 237.

[2] Decision WHA57(4).

[3] Document A57/30.

which together with the withholding of Palestinian tax revenues, has resulted in unprecedented levels of unemployment, with implications for poverty, food insecurity and nutritional vulnerability; and at reports of malnutrition among children, and evidence of endemic anaemia among nursing mothers;

Expressing its concern at the widespread destruction of civilian infrastructure during Israeli military incursions, and particularly at the continued construction by Israel of a "security fence", which is not being built on or near the 1967 borders, and which produces humanitarian and economic hardship for the Palestinians, and prevents access to hospitals and to health care;

Expressing its concern at the grave violations of international humanitarian law by the Israeli occupation authorities in the occupied Arab territories, including the unlawful arrest of thousands of Palestinian civilians, among whom hundreds of children locked up in Israeli jails, some of whom detained without charge and others sick, without receiving medical care;

Affirming that the targeting of civilian populations by any party, in particular extrajudicial executions, is another violation of international humanitarian law;

Affirming that the ongoing violence, closures and curfews and the continuing occupation of the Palestinian territories are among the main causes of acute psychological distress and emotional problems among Palestinian children and adults, including psychosomatic problems, rejection of authority, risk-taking behaviour, decreasing hope in the future, and those caused by the general atmosphere of hopelessness and frustration;

Affirming the right of Palestinian patients and medical staff to be able to benefit from the health facilities available in the Palestinian health institutions in occupied east Jerusalem,

1. CALLS upon Israel, the occupying power, to halt immediately all its practices, policies and plans which seriously affect the health conditions of civilians under occupation, particularly its excessive use of force and military actions against Palestinian civilians;

2. EXPRESSES gratitude to all Member States, and intergovernmental and nongovernmental organizations for their continued support in meeting the health needs of the Palestinian people;

3. EXTENDS its thanks and appreciation to the Director-General for his efforts to provide necessary assistance to the Palestinian people, the rest of the Arab population in the occupied Arab territories, and other peoples of the region;

4. REQUESTS the Director-General:

(1) to dispatch as soon as possible to the occupied Arab territories, including Palestine, a fact-finding committee on the deterioration of the health and economic situation resulting from both the current crises and erection of the "security fence" in the occupied Palestinian territories;

(2) to take urgent steps, in cooperation with Member States, to support the Palestinian Ministry of Health and other medical service-providers in their efforts to overcome the current difficulties, in particular so as to guarantee the free movement of all health personnel and patients and the normal provision of medical supplies to the Palestinian medical premises;

(3) to take steps, in cooperation with Member States, to ensure the free movement of goods, workers and people in order to allow trading, farming and other forms of economic activities inside the occupied Palestinian territories and the access by the population in general to basic services;

(4) to continue providing necessary technical assistance to meet needs arising from the current crises, including health problems resulting from erection of the "security fence";

(5) to take the necessary steps and make the contacts needed to obtain funding from various sources, including extrabudgetary, to meet the urgent health needs of the Palestinian people;
(6) to take urgent action to implement the joint Ministry of Health/WHO strategy for mental health;
(7) to report on implementation of this resolution to the Fifty-eighth World Health Assembly.

Dr KARAM (Secretary) said that the delegations of Algeria, Bangladesh, Cuba, Indonesia, Mauritania and Pakistan wished their names to be added to the list of sponsors. He had also been advised that, owing to an error, for which he apologized, the beginning of operative paragraph 1, which had read "CALLS upon both sides ... peace settlement and" should have been deleted. The text should begin, as shown above, with the words "CALLS upon Israel".

Mrs GABR (Egypt), introducing the draft resolution on behalf of the sponsors, said that it assumed special importance at the current juncture, when there was an unprecedented deterioration in the health conditions of the Palestinian people because of the use of excessive military force by the Israeli forces against innocent civilians and their homes. The work of international agencies in providing health services and humanitarian relief, including food aid, was being hampered by assaults on their staff, vehicles and facilities, with dire consequences. The situation had been exacerbated by a policy of oppression, blockades and closures. The so-called "security fence", which had been condemned by the international community, formed an obstacle to the provision of health services to civilians, especially the more vulnerable. The report of the Director of Health, UNRWA (document A57/INF.DOC./1) and that of the Director-General (document A57/30) outlined the deteriorating health situation in the occupied territories. The toll exacted on the Palestinian people since September 2000 by the Israeli forces was very high: more than 200 children had been killed and more than 10 000 others had been injured; overall, there had been 2636 deaths and 24 363 casualties among Palestinian civilians over the past four years. She stressed that the information in the two reports was based on objective observations made by humanitarian organizations in situ. As WHO was concerned primarily with health issues and the Health Assembly was the main forum that could be used to mobilize humanitarian efforts in order to improve the deteriorating situation, she called upon the Health Assembly to adopt the draft resolution. The sponsors had agreed with difficulty to some amendments, on the assumption that adoption with a broad majority would be facilitated.

Dr ARAFAT (Palestine) said that the Palestinian people had been enclosed in a small prison by sieges, closures and curfews, an action that had led to the deterioration of their health, economic and social conditions. That situation was due to the presence of Israeli forces, which continued to perpetrate repressive and aggressive measures against the Palestinian population. The latest had been the destruction of 200 houses in the area of Raffah and its refugee camp, which had resulted in the displacement of hundreds of people, adding to the 16 000 who had already been displaced from the cities and villages of Palestine since September 2000. Hundreds of people in the area had been killed or injured, and there were virtually daily campaigns in which thousands of Palestinian civilians, including women and children, were arrested. He had just been informed of an attack on a village, in which 10 people had been killed and hundreds injured, an action that had been roundly condemned by the United Nations.

The records of the emergency services in Palestinian hospitals showed that, over the past four years, 50 000 Palestinians had been wounded and more than 3000 killed. Children under the age of 18 accounted for 22% of that figure, and 58 infants had died. One third of the children had died because the Israeli forces had refused to allow ambulances to cross checkpoints, thus denying them access to hospitals. Furthermore, 450 persons had been assassinated as a result of the Israeli Government's policy, which was contrary to all international conventions and legal practice.

Some 165 km of the planned 650 km of the "apartheid wall", called the "security wall" by the Israelis, had been constructed on occupied Palestinian territory. It would lead to the absorption of 50% of the West Bank, and consequently to the isolation of many villages and the separation of others from the land they cultivated. Its completion would isolate more than 500 000 Palestinians and thus prevent their access to basic facilities. Recently, missiles had been fired on civilians demonstrating peacefully for the provision of food and water to Palestinians besieged in Tal Al-Sultan, resulting in 23 deaths and hundreds of wounded.

The Israeli Government's policy towards the Palestinian people had increased the poverty rate to 64.9%, according to the statistics of the World Bank. As a result, 10.2% of children were suffering from acute malnutrition, and anaemia was prevalent in 44% of children under the age of five, 52.8% of women in Gaza and 43.9% of those in the West Bank. In addition, medical teams had been the targets of aggression, with 30 personnel killed and 428 wounded. Hospitals had been attacked, and 30 ambulances had been destroyed. The effects of the restrictions on immunization programmes were of particular concern: continual closures and electricity cuts interrupted the cold chain, which reduced the efficacy of vaccines. The Israeli practices had also had disastrous consequences on the psychological health of the Palestinian people. Children, in particular, suffered consequences ranging from shock to insecurity.

The high rates of poverty and unemployment engendered by the sieges, closures and curfews had inevitably affected the diet of the Palestinian people. Studies conducted by researchers from Johns Hopkins University in the United States of America had shown that the level of consumption of meat, fruit and vegetables had been reduced by 70%, with a consequent increase in the prevalence of anaemia to 60% among pregnant women and 75% among children. Children also suffered vitamin A deficiency and other nutritional problems. The monitoring and surveillance of diseases had been affected. Spraying of pesticides had been interrupted, and consequently diseases such as leishmaniasis had spread.

In spite of the tragic conditions in which they had been living for the past few years, the Palestinian people had not lost hope that the countries of the world would endeavour to put an end not only to the suffering but also to the occupation, which was its cause, and to establish an equitable peace in which the children of Palestine and Israel could live together.

Mr LEVY (Israel) said that the debate and the draft resolution were politicized and neither served to improve the health of Palestinians or Israelis nor contributed to the image or the work of WHO. There were many crises in the world that required WHO's attention, yet only the health situation of the Palestinian population was the subject of a separate discussion at the Health Assembly. Not only Palestinians but also Israelis were suffering, both physically and mentally. He expressed outrage that 10 leaders of various Palestinian factions were medically trained, lending their medical expertise to members of those factions who perpetrated violent acts against Israelis. The error in the draft resolution that had been rectified by the Secretary had not, in fact, been a technical oversight: deletion of the words "Calls upon both sides to put an immediate end to violence and to resume negotiations towards a comprehensive peace settlement ..." indicated the unwillingness of the other side to condemn terrorism, which their factions committed, and to resume negotiations.

The health situation of the Palestinians was much better than that of many other groups in the world, including in the Middle East. Although resolution WHA56.5 had requested "the immediate institution of a fact-finding committee on the deterioration of the health situation in the occupied Palestinian territory, enabled to undertake its role as soon as possible", Israel had not received any mission or a visit from high-ranking WHO officials. His delegation had cautioned at the time the resolution was adopted that Israel would not be able to work with any party wishing to implement it, and its position was unchanged.

The only way to ensure the free movement of Palestinian workers would be to call upon the Palestine Authority and associated groups not to abuse the free movement that they had enjoyed in Israel before the current wave of violence had begun. The need for a security fence could be obviated

only by creating a situation in which it was not needed. Israel's recent action near Raffah was essential to prevent the smuggling of rockets and explosives for use against its population.

Before the recent crisis, public health had been an area in which Israelis, Palestinians and other Arabs had worked closely together. The work of joint committees on public health, environmental health, food control and drugs had, however, been frozen by the Palestinian Authority. Nevertheless, 40 Palestinian physicians were working in Israeli hospitals, for example, and sick and wounded Palestinians were regularly brought to Israeli hospitals for treatment. Israel's national emergency medical and disaster relief service and the Palestinian Red Crescent continued to cooperate in emergencies and in evacuating the wounded, but, because of attacks on and hijacking of ambulances, their free movement had also been restricted.

Although there was little trust politically, trust should be re-established at the humanitarian and professional levels. His country was willing to cooperate with any Member State, agency or organization to assist Palestinians. The draft resolution would not, however, contribute to the well-being of Arabs or Jews, and he appealed to the Committee to reject it in its entirety.

Dr EL ISMAILI LALAOUI (Morocco), expressing his delegation's support for the draft resolution, requested the Director-General and all interested parties to mobilize every possible resource in order to halt the deterioration of the health situation in the Palestinian territories, particularly among women and children.

Dr NIKNAM (Islamic Republic of Iran) said that the health situation in the occupied Palestinian territories had deteriorated since the previous year because of the continued aggression by Israeli forces against the Palestinian people and general restrictions on movement, which aimed at isolating the occupied territories. Restrictions on passage through checkpoints had prevented many Palestinians from gaining access to health-care services, and deaths due to lack of access to emergency health care or treatment of chronic diseases were common. In numerous incidents, Palestinian women in labour had given birth at checkpoints after being delayed there or refused permission to reach medical facilities. Israel had consistently pursued a policy of driving the Palestinian people into desperation and hopelessness. Most Palestinian adults and children presented clinical symptoms of psychological trauma and stress.

Restrictions on movement also prevented medical teams from accessing their places of work, resulting in the suspension of health services and the disruption of immunization programmes, increasing the risks for preventable diseases, acute blood shortages in hospitals and difficulties in distributing medical supplies. Medical aid from the international community was consistently seized by the Israeli border-control authorities. In addition, Israeli armed forces threatened the lives of Palestinian medical teams by firing shots or missiles at ambulances and staff, or obstructed their work by hampering their access to the wounded. Hospitals were targeted during military operations. The heads of United Nations agencies had recently indicated that some critical humanitarian relief operations in Gaza might have to be scaled back or terminated because of new restrictions imposed by Israel on humanitarian assistance and the movement of United Nations staff. The United Nations was therefore calling on Israel to restore full access to Gaza for its staff and for humanitarian workers and goods.

The Israeli "security fence" had huge socioeconomic implications. Within a steadily shrinking, increasingly fragmented space, the economic and social networks of the local Palestinian population, including the provision of health care, were unravelling. The International Committee of the Red Cross had recently expressed its growing humanitarian and legal concerns in relation to the barrier and had called on Israel not to plan, construct or maintain the barrier within occupied territory.

Israel's practices breached the fourth Geneva Convention (Relative to the Protection of Civilian Persons in Time of War) and the Protocol Additional to the Geneva Conventions of 12 August 1949, and relating to the Protection of Victims of International Armed Conflicts (Protocol I), which were legally applicable to the occupied Palestinian territories. In particular, they violated articles of the fourth Convention that guaranteed the protection of civilian hospitals and of persons who engaged in

the search for and the removal and transporting of and caring for wounded and sick civilians and allowed medical personnel of all categories to carry out their duties. Moreover, there had been clear violations of articles guaranteeing the safety of medical units and their access to any place where their services were essential, the non-punishment of persons for carrying out medical activities compatible with medical ethics, regardless of the person benefiting therefrom, and respect for and protection of medical vehicles.

It was incumbent on the international community to take effective measures to bring an end to Israeli atrocities. His delegation therefore fully supported the draft resolution.

Dr AMMAR (Lebanon) said that the killings, dispersion and discrimination suffered by the Palestinian people could not be recounted adequately in the few minutes available. The international community could not simply regard the situation in Palestine as one of many conflicts taking place in the world and thus unworthy of discussion at WHO. Only the previous day, an incident had occurred in Palestine in which civilians, including women and children, had come under fire and had been deprived of medical attention. WHO, as an organization that specialized in health issues, was a highly appropriate forum in which to discuss that situation. He supported the comments made by the delegate of Egypt and wished his country to be counted among the sponsors of the draft resolution.

Mr HENDRASMORO (Indonesia) commended the work of WHO and UNRWA to improve the health conditions of the Arab populations in the occupied territories and said that he hoped that the necessary funding would continue to be available for technical assistance on health programmes.

His Government was deeply concerned at the situation in Palestine. The building of the "security fence" had created new difficulties by cutting off Palestinians' access to medical and health services and decent food and by threatening relief operations in the refugee camps. The importance of unlimited access for health workers could not be overemphasized. He condemned the systematic harassment of the civilian population by Israeli forces and their ongoing policy of "preventive" destruction. The destruction of houses in refugee camps had resulted in a severe threat to health.

He strongly supported the draft resolution. The time had come for decisive action, to campaign for the complete cessation of hostilities and the negotiation of a lasting and just peace.

Mr DE LAURENTIS (United States of America) expressed concern about a situation that had taken a terrible toll on both sides and said that his country had worked intensively to find a solution. The draft resolution was, however, largely political and the issues fell clearly outside the scope of the Health Assembly's mandate, neither helping the search for peace nor improving the health conditions of those living in the occupied territories. The resolution should address only the health of the Palestinian people, which the United States was committed to improving. Efforts by his country to encourage a balanced resolution had gone unheeded. Given the biased language of the draft resolution, he opposed its adoption and requested a roll-call vote.

Dr ABDALLA (Sudan), observing that health conditions in the region were worse than ever, said that the draft resolution's sponsors wanted it to shed light on the tragic plight of Palestinians, where civilians were being subjected to violent attacks and health-care workers were fired upon daily. Israel's position was illegitimate: it ignored all United Nations Security Council resolutions and prevented visits from WHO staff at the behest of the Director-General. Those actions reflected its intransigence.

The draft resolution was neither political nor biased; it concentrated exclusively on health matters. He asked the Committee to adopt it as a matter of conscience.

Ms GONZÁLEZ FRAGA (Cuba) recalled that numerous reports and resolutions had been formulated on the issue of Palestine since the creation of the United Nations, which had repeatedly stressed that measures must be taken to improve human rights in the region, including the health conditions of Palestinian people. Year after year, the United Nations General Assembly, the Security

Council and the Commission on Human Rights had expressed concern about the situation. All had been unequivocal in recognizing the inalienable rights of the Palestinian people in rejecting illegal Israeli occupation and in condemning the flagrant violations of human rights perpetrated by the occupying power. Various reports had shown that mental health problems, malnutrition and the prevalence of low birth weight and anaemia had increased and immunization coverage had decreased among Palestinians. Access to medical care was limited, and many pregnant women could not obtain prenatal care. Military incursions, curfews, closures, withholding of Palestinian tax revenues, confiscation of land, demolition of housing and building of the "security fence" had interrupted economic activity and increased unemployment to unprecedented levels. The Palestinian health system was severely short of financial resources and the fact-finding mission on the deterioration of the health situation in the occupied Palestinian territories set up under resolution WHA56.5 had been unable to fulfil its functions. The Health Assembly should make an international appeal for demolition of the fence and an end to the military incursions, closures, curfews, destruction of houses and the assassination of Palestinian leaders. It was imperative that the fact-finding mission be provided with all the necessary guarantees to allow it to carry out its work. Once the health problems of the Palestinians had been evaluated, a plan should be drawn up to tackle them. He urged the Committee to adopt the draft resolution to show its solidarity with the cause of the Palestinian people.

Mr AL-HATMI (Qatar) said that the draft resolution, of which his country was a sponsor, asked the Israeli Army to stop murdering Palestinian civilians in the occupied territories; nobody could oppose such a just request. The text was not political. Crimes such as those seen on television the previous day, in which civilian demonstrators were fired upon, were a daily occurrence. Israel should be called upon to put an end to the violence, which challenged the conscience of humanity.

Mr MTESA (Zambia) said that his country had always supported the right of Palestinians and Israelis to live in peace and security as descendants of the same prophet, Abraham. Violence had reached alarming levels, and even the United States had asked for clarification about the situation. Zambia condemned all forms of violence, especially when committed against innocent civilians. He wondered how many people must die before decisive action would be taken to end hostilities. He called on all parties concerned to help to end the carnage so as to give both Palestinians and Israelis the peace they deserved and unrestricted access to medical services. He supported the draft resolution.

Dr RAJMAH HUSSAIN (Malaysia) urged support for the draft resolution of which her country was a sponsor; the situation in the occupied Palestinian territories and the deterioration of health conditions were grave concerns. Malaysia called on WHO to address the various problems in the region, particularly nutritional needs, the decline in immunization coverage for Palestinian infants, the movement restrictions imposed on medical personnel, and the general deterioration of health.

She strongly supported the proposed call to the Director-General for a fact-finding committee charged with studying the deterioration of Palestinians' health and economic situation. Israel, as the occupying force, must end its policy of excessive force and aggression. The smooth functioning of the health system was essential if Palestinians were to enjoy the basic human rights of well-being and general health.

Dr AL-MAZROU (Saudi Arabia) said that the figures in the reports revealed the suffering of the civilian Palestinians and demonstrated at the very least a lack of humanity in the situation. Hundreds, even thousands, of people were dying, and health workers were impeded in the conduct of their work. Nonetheless that was only part of the problem. The lack of hope and humiliation caused by living under occupation was leading to Palestinian youths destroying themselves rather than working to build up their country.

People continued to hope that one day the occupying forces would withdraw so that Palestinians could live without fear, in freedom and with independence while enjoying full access to health

services. That was especially so for those who suffered most from the present situation; namely children, mothers and the elderly.

Mr FERGUSON (Canada), expressing his country's concern at recent developments in the Middle East and the effects of the conflict on the health of both Palestinians and Israelis, recalled the humanitarian assistance provided by Canada, including contributions to the International Red Cross and Red Crescent Movement and funding for local community projects designed to improve the health conditions of Palestinians. During the previous decade its development assistance to the Palestinians had exceeded Can$ 240 million. Dialogue and negotiation could both improve health conditions and advance the goal of a lasting peace. Canada had therefore also supported projects aimed at promoting regional cooperation on public health issues. In the Middle East, as elsewhere, conflict and health were interlinked.

The worsening humanitarian situation in the Palestinian territories was unacceptable and the Government of Canada reiterated its support for the Middle East Quartet's statement of 4 May, which called inter alia for all parties to advance dialogue. In that respect, the draft resolution needed to be more reflective and balanced; the selective focus of the Health Assembly on one regional conflict was questionable, given its mandate to address core global health issues such as HIV/AIDS and global health strategies.

In view of the reports and analysis already provided on the health situation in the region by both international and local health-related organizations, he questioned the draft resolution's call for a fact-finding committee – that would only detract from consideration of core issues. Canada would therefore vote against the draft resolution.

Dr ABBAS (Iraq) said that Iraq, a sponsor of the draft resolution, strongly supported it as a minimum proposal in view of the health situation of the Palestinian people. Goodwill was required from Israel.

Dr FAOURI (Jordan) said that the entire world had seen the increasingly difficult situation in Palestine and the virtual destruction of its health system. Rather than destruction, there should be cooperation, to strengthen and improve the health and living conditions of the Palestinian people. Aggression had been widely directed against health services such as those for immunization, and epidemic control. His Government closely followed the health situation in the occupied Arab territories, through medical and surgical facilities in Jordan, and wanted to help the Palestinian people. He called on the Israeli Government to end the destruction of infrastructure and Palestinian houses, and to give Palestinian people access to the necessary medicine and hygiene facilities. Jordan appreciated the efforts made by the Director- General to help the Palestinian people and attached great importance to the proposed fact-finding mission.

Mr CONG Jun (China) recalled the objective of strengthening international cooperation in the area of health and achieving health for all, noting the effect of the armed conflict between the Palestinians and Israel as leading to many casualties and the deterioration of the health situation of the Palestinian people: a humanitarian crisis. The Chinese Government was very concerned; the international community could not ignore that situation. WHO should offer the necessary support to the Palestinians. The draft resolution was a good response to the requests of the international community and should be supported by countries around the world. The Chinese Government would vote for the resolution.

Dr TSHABALALA-MSIMANG (South Africa), recalling that South Africa had itself experienced conflict, supported the draft resolution. The situation could not be condoned where innocent people, especially women and children, were being killed or maimed for no reason. The world could not just accept the regular television coverage of those incidents as normal. The Committee was a technical review group, but composed of human beings, sensitive to the images they

had seen. They could not watch the Palestinian health system being systematically destroyed while discussing how to strengthen health systems. The boundary wall did little to improve the health of the people of Palestine.

The right of each country to live at peace with itself and its people must be respected and thus the Committee could not reject the draft resolution with a clear conscience. There were other areas in the world experiencing conflict; however, only one draft resolution had been tabled, therefore questions about other conflict areas were not relevant at present. South Africa urged the Committee to support the draft resolution, and called for a withdrawal of forces and restoration of normality to Palestine.

Mr ASLAM (Pakistan) observed that the world was watching with dismay the spectacle of human misery among the women, children and old people of Palestine, who were being denied access to the basic health facilities and human needs that were their fundamental human right. Houses and refugee camps were being ruthlessly targeted and demolished. Pakistan strongly appealed to the world community and to WHO to ensure the safety and health of suffering innocent civilians and to mobilize support for an end to carnage and to the denial of the basic rights of access to health facilities and safety. Pakistan strongly supported the draft resolution and asked to be included as a sponsor.

Dr KUARTEI (Palau) recalled his island State's experience of the consequences of violence, and expressed his empathy with the issue addressed in the draft resolution. Member States should refrain from all forms of violence so that health could be promoted everywhere. WHO's focus should be on health issues and he therefore supported providing humanitarian assistance to the people of Palestine. However, as there were specific provisions for condemnation of a Member State, he was unable to support the draft resolution as it stood.

Mr HOSSAIN (Bangladesh) noted that, despite WHO's commendable efforts, in cooperation with the United Nations and other organizations and governments concerned, the health situation did not seem to have improved. Bangladesh's concern about those deteriorating health conditions had led it to sponsor the draft resolution.

Dr CAPELLA MATEO (Venezuela) supported the draft resolution and asked that Venezuela's name be added as a sponsor. Venezuela believed in building peace for both peoples; it had experienced violence from those seeking to impose political ideas without understanding of the rules of the democratic process. He therefore had every sympathy for the Palestinian people, and supported the draft resolution.

Dr MAHAMAT SALEH (Chad) also supported the draft resolution. The situation in the occupied Arab territories was of increasing concern. It was deeply distressing to witness daily on television what was happening to the Palestinian people, such as the images of children running away from their bulldozed homes. He deplored the transformation of children, women and the civilian population into innocent victims.

Mr MARTABIT (Chile) recalled Chile's stance on previous resolutions dealing with various aspects of the situation in the Middle East. He stated his clear and unambiguous condemnation of terrorist acts which, under various pretexts, endangered and destroyed innocent lives, whether perpetrated by civilians, the military, paramilitary groups or political organizations. He utterly rejected all acts of violence, especially when they undermined and disregarded international law and stepped aside from the legal stipulations sponsored by Member States of the United Nations. Nothing could justify the murder of women and children. The Palestinians had the right to live in a viable, independent state, and Israel had the right to exist within secure and recognized borders. He appealed strongly to all parties involved in the conflict to do whatever they could to return to the framework of

the peace process. In that regard, he would have preferred the initial phrase of paragraph 1 in the draft resolution to remain. He was in favour of the draft resolution.

The CHAIRMAN announced that Algeria, Kuwait, Lebanon, Malaysia, Mauritania, Morocco, Qatar and Somalia had requested that their names be added to the list of sponsors of the draft resolution.

Dr MOUSA (Director of Health, UNRWA) provided a summary of the humanitarian crisis that had continued since late 2000. No imminent end was seen to the spiral of violence and human suffering, only greater human loss, increasing numbers of people dropping into poverty, becoming food insecure and suffering from restricted access to basic survival needs and essential services. Health systems would remain overtaxed, their focus on emergency relief assistance at the expense of regular programme activities, with ever-increasing obstacles to humanitarian access and considerable risks to staff.

Nutritional assessments sponsored by the United States Agency for International Development and conducted by CARE International and Johns Hopkins University had revealed alarming overall rates of acute and chronic malnutrition (as reported in document A57/INF.DOC./1). A survey conducted by FAO in collaboration with WFP had estimated that 40% of people were food insecure and that 30% were under threat of being insecure. Another survey revealed that 90% of parents had reported that their children exhibited traumatic stress-related symptoms. The World Bank estimated that 60% of people lived below the poverty line of US$ 2 per day. Demand on UNRWA general clinic services had increased by 58% in the West Bank and 60% in Gaza.

There had been serious breakdowns in service delivery and quality, including a decline in the access of women to prenatal and postnatal care, setbacks to the family planning programme in the Gaza Strip, and a decline in immunization coverage in several areas of the West Bank which had been under prolonged curfews and closures. There had been an outbreak of mumps in the northern districts of the West Bank and there was an imminent threat of an outbreak of measles, representing a risk to the local population and increasing the risk of cross-border outbreaks.

According to the United Nations Office for the Coordination of Humanitarian Affairs, construction of the separation wall would isolate about 15% of the West Bank between the barrier and the green line (excluding the East Jerusalem and Jordan valley sections), affecting the access to basic services of more than 250 000 Palestinians living in 122 communities.

UNRWA was a major provider of education, health and social services in the occupied Palestinian territories, and had launched several emergency appeals since October 2000. The total funding requested by such appeals, including the 2004 emergency appeal, amounted to US$ 723 million, of which US$ 311 had been pledged by the international community between the beginning of the crisis and the end of 2003. It was of concern that funding for the repeated emergency appeals was declining, not only because the extraordinary had become the norm, but also because donors were concerned about subsidizing relief efforts which, according to international law, were the responsibility of the occupying authority. As the crisis continued, it attracted not only less attention but also less sympathy, and as conditions worsened, emergency interventions had to be curtailed. Suffering went beyond cold statistics; it concerned individual human beings, often wholly bereft of any relation to the ongoing battle raging around them: women, children, even the elderly.

He appealed to the Health Assembly to make appropriate recommendations that would help to strengthen WHO's role in the occupied Palestinian territories, supporting the relief efforts of local and international aid organizations and providing much-needed technical assistance in the areas of mental and psychological health, disability rehabilitation, nutrition, food security and immunization services. He also appealed to all governments to provide the necessary support to local and international aid organizations operating on the ground, including UNRWA, to enable them to sustain the programmes of emergency humanitarian assistance by every means possible, until it were possible to move from conflict to recovery.

The CHAIRMAN recalled that there had been a proposal to proceed to a roll-call vote.

Mr TOPPING (Legal Counsel) set out the protocol for such a process, noting that a list of Member States that had had their right to vote suspended by a Health Assembly resolution had been read out on 17 May 2004. Togo, which had since paid its arrears, had automatically had its right to vote restored.

A vote was taken by roll-call, the names of the Member States being called in the French alphabetical order, starting with Thailand, the letter T having been determined by lot.

The result of the vote was as follows:

In favour: Algeria, Austria, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brunei Darussalam, Burkina Faso, Cambodia, Chile, China, Congo, Cuba, Cyprus, Democratic People's Republic of Korea, Democratic Republic of the Congo, Egypt, Finland, France, Greece, Guinea, Iceland, India, Indonesia, Islamic Republic of Iran, Ireland, Jamaica, Japan, Jordan, Kenya, Kuwait, Lebanon, Luxembourg, Malaysia, Maldives, Mali, Malta, Mauritania, Mexico, Morocco, Mozambique, Myanmar, Namibia, Nepal, Nigeria, Oman, Pakistan, Philippines, Portugal, Qatar, Russian Federation, San Marino, Saudi Arabia, Senegal, South Africa, Spain, Sri Lanka, Sudan, Sweden, Switzerland, Syrian Arab Republic, Tunisia, Turkey, Uganda, United Arab Emirates, United Republic of Tanzania, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe.

Against: Canada, Costa Rica, Israel, Marshall Islands, Palau, United States of America.

Abstaining: Albania, Australia, Bahamas, Brazil, Bulgaria, Colombia, Côte d'Ivoire, Croatia, Czech Republic, Denmark, Ecuador, El Salvador, Estonia, Germany, Guatemala, Honduras, Hungary, Italy, Latvia, Lithuania, Monaco, Netherlands, New Zealand, Nicaragua, Norway, Paraguay, Peru, Poland, Republic of Korea, Romania, Rwanda, Serbia and Montenegro, Singapore, Slovakia, Slovenia, Solomon Islands, Thailand, United Kingdom of Great Britain and Northern Ireland, Uruguay.

Absent: Andorra, Angola, Azerbaijan, Belize, Benin, Burundi, Cameroon, Cape Verde, Cook Islands, Djibouti, Equatorial Guinea, Eritrea, Ethiopia, Fiji, Gabon, Gambia, Ghana, Grenada, Guyana, Haiti, Kazakhstan, Kiribati, Lao People's Democratic Republic, Lesotho, Libyan Arab Jamahiriya, Madagascar, Malawi, Mauritius, Federated States of Micronesia, Mongolia, Panama, Papua New Guinea, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Samoa, Sao Tome and Principe, Seychelles, Sierra Leone, Swaziland, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Tonga, Trinidad and Tobago, Tuvalu, Uzbekistan.

The draft resolution was therefore approved by 76 votes to 6, with 39 abstentions.[1]

Mrs WHELAN (Ireland), speaking in explanation of vote on behalf of the European Union and associated countries Bulgaria, Romania and Turkey, expressed deep concern at the deterioration of health conditions in the occupied Palestinian territories. She condemned the continued violence on both sides, which led to unbearable suffering for the civilian population and caused numerous deaths and injuries, mostly among Palestinians. The European Union had repeatedly expressed its firm belief that all acts of violence targeting civilians were totally unacceptable, irrespective of who were the

[1] Transmitted to the Health Assembly in the Committee's first report and adopted as resolution WHA57.3.

victims or the perpetrators. They should cease immediately and a sustainable solution should be found through negotiations based on international law and United Nations Security Council resolutions. Moreover, she regretted that the Director-General had not yet been able to visit the occupied Arab territories, including Palestine, for a first-hand assessment of the health conditions.

Mr SOBASHIMA (Japan), speaking in explanation of vote, appreciated the content of the resolution in general, but regretted that the first part of paragraph 1 had been deleted, as his country attached great importance to the cessation of cycles of violence by both sides.

Mr SAWERS (Australia), speaking in explanation of vote, said that the resolution lacked balance and was highly politicized for such a forum. It drew attention to health and related hardships of concern to the international community but not in such a way as to maximize constructive cooperation.

Mr SMITH (Jamaica), speaking in explanation of vote, expressed continuing concern at the situation in the occupied Arab territories and the deepening plight of the Palestinian people, and would have fully supported the deleted paragraph had it remained in the text, in accordance with his country's belief in the right of all parties to live in peace and security within secure and internationally recognized boundaries. He underlined that assistance to be provided or measures to be taken by WHO should be fully consistent with its objectives and functions.

Mr FAESSLER (Switzerland), speaking in explanation of vote, expressed great concern at the situation in the occupied Arab territories. He deplored the health problems and the deterioration in the living conditions of the population, which affected both Palestinians and Israelis. However, it was important not to detract from the problems by politicizing them. WHO's mandate was to define specific measures to improve the situation with regard to health. As the depository State for the Geneva Conventions, Switzerland attached fundamental importance to respecting international humanitarian law as the best means of ensuring the safety of people involved in improving health conditions. He reiterated his country's appeal to all parties to comply with their obligations under international humanitarian law and to take all measures necessary to improve the health situation.

Dr LEAFASIA (Solomon Islands), speaking in explanation of vote, said that, although nobody had the right to deprive another person of their right to life and health, the resolution did not take into account the reality of the situation and therefore could not be seen as a solution to it. Neither WHO nor the Health Assembly had the mandate or resources to end the conflict which had given rise to the problems being addressed. The State of Israel could not be singled out as the cause of the Palestinian people's health problems which were symptoms of the deeper problems of humanity. The United States of America, the United Kingdom of Great Britain and Northern Ireland, the European Union and the Islamic world must take full responsibility for the plight of Palestinians, but in a different forum. WHO could only tackle the issue after political questions had been resolved. He could not support the resolution, but neither did he condone the forces resulting in the poor health of Palestinians.

Mr KURTTEKIN (Turkey), speaking in explanation of vote, said that health conditions in Palestine clearly contravened the principles of WHO's Constitution and goals. The spiral of violence caused health conditions to deteriorate further and obstructed efforts to improve the situation, and he therefore urged both sides to put an end to violence and resume negotiations.

Mr WEEKES (Barbados), speaking in explanation of vote, reiterated his country's position that Israel had the right to secure borders and the Palestinian people had the right to self-determination. Barbados had developed on the basis of the twin pillars of health and education and wished to see

Palestinians enjoying the same level of health as other people. Although he regretted the deletion in paragraph 1, he expressed particular support for the requests made to the Director-General.

Mrs BIGI (San Marino), speaking in explanation of vote, said that she shared the views of the delegate of Switzerland. The text should have concentrated more on health issues, and she particularly regretted the deletion in paragraph 1. She had voted in favour of the right to health and access to health services for all people everywhere.

Mr ONG (Singapore), speaking in explanation of vote, said that Singapore's abstention was neither a pronouncement on the merits or demerits of the issue nor a reflection of its support for the Palestinians on the Middle East issue. His country's position on the Middle East question could be clearly seen from its voting record in the United Nations General Assembly and the United Nations Security Council. Singapore had abstained because it considered the Health Assembly to be an inappropriate forum in which to raise political issues.

The meeting rose at 12:05.

SECOND MEETING

Thursday, 20 May 2004, at 14:40

Chairman: Dr Jigmi SINGAY (Bhutan)

1. FIRST REPORT OF COMMITTEE B (Document A57/41)

Mrs JAKAB (Hungary), Rapporteur, read out the first report of Committee B.

The report was adopted.[1]

2. INTERNAL AUDIT AND OVERSIGHT MATTERS: Item 14 of the Agenda

Report of the Internal Auditor and comments thereon made on behalf of the Executive Board (Document A57/19)

The CHAIRMAN said that the report of the Internal Auditor had been reviewed at the tenth meeting of the Audit Committee of the Executive Board held on 13 May 2004. The report had been noted by the Administration, Budget and Finance Committee (ABFC) of the Board at its meeting on 14 May 2004. He invited the Chairman of ABFC to introduce the report.

Dr YOOSUF (representative of the Executive Board), speaking as Chairman of ABFC, said that the report of the Internal Auditor provided a review of audit results from 2003. ABFC had welcomed the news that the Office of Internal Oversight Services was henceforth responsible for programme evaluations and had been expanded by three additional positions. It had noted the adoption of two important measures to increase the capacity to handle fraud cases, including clarification of roles and responsibilities, issued by the Director-General, and detailed fraud prevention measures, instituted by the Comptroller. The Auditor had reported that the number of fraud cases to date for 2004 was well below that for the same period in 2003. He had provided ABFC with updates on a number of issues noted in his report, including the recent development of a study commissioned by the Regional Director for Africa on improving the delivery of financial services. Appreciation had been expressed for the efforts to reinforce the control environment.

Mr NAKAZAWA (Japan), referring to paragraph 37 of the report, said that the city of Kobe welcomed the new Director of the WHO Centre for Health Development. The Government looked forward to his bringing about reforms to the Centre, besides responding adequately to other matters.

Dr SADRIZADEH (Islamic Republic of Iran) said that WHO was predominantly an organization of medical scientists, and few outside auditing fully understood its procedures. Nevertheless, having sought the views of experts, he had certain comments to make.

In the report of the fifth meeting of the Audit Committee of the Executive Board (document EBAC5/5), the question had been raised, in paragraph 27, whether regional operations could be properly covered with a single visit per year. Since it was clear, from the report in document A57/19,

---

[1] See page 240.

that not all regional offices had been visited; not even one annual visit to each Region had been achieved. A substantial amount of activity, therefore, had not been covered by the audit. One reason might be that, according to paragraph 25 of document A57/19, during 2003 about 30% of total staff time in the Office had been spent on investigations. Paragraphs 27-32 of the report gave details of the oversight work, the largest amount investigated being US$ 233 000 and the smallest US$ 4800. In that regard, he wondered whether there had been any oversight activities by the unit other than those mentioned in the report, which said nothing of an investigation of a further US$ 30 000 he had been told about.

On the qualification of the investigators, paragraph 9 of the report referred to seven auditor posts; but an auditor was not automatically an investigator. He wondered whether the unit did have any qualified investigators and, if not, what steps were being taken to employ one. He had been given to understand that the reorganization of the audit unit at the end of 2003 had paralleled that of the office of the United Nations Board of Auditors, but it seemed that the investigation unit in the United Nations system was not matched in the WHO arrangements. Since the reorganized WHO unit had no investigation section, it seemed that, while 30% of staff time was being spent on investigation, the setting up of an investigation subunit was being avoided.

He asked why the amount of investigation was so large. He doubted whether more effective auditing was the reason, since there was no indication that oversight activities began when wrongdoings were revealed. One reason could be faulty risk assessment by the audit; in that connection, financial audits had been reduced in recent years to almost nil.

From what he had learnt from specialists, there was an increasing focus on other types of audit, such as performance audit, but financial audit remained valuable in preventing fraud. He wondered, therefore, how much financial auditing was involved in evaluating the administration's procedures for safeguarding the Organization's assets.

The adopted internal audit system called for a quality assurance review every five years, but he knew of no such review during the past decade, at least. Even a decision to hold such a review in the near future, therefore, would not remove all doubts about audit procedures during that period.

Mr MACPHEE (Canada) said that Canada had been a member of the Audit Committee. His delegation was pleased with the thorough discussions that had taken place in that Committee and ABFC. Canada particularly welcomed the strengthening of the Office of Internal Oversight Services, which was thereby well equipped to carry out evaluations. It encouraged the Internal Auditor to continue identifying areas for improvement, and urged WHO to address the issues raised and report in good time.

Mr SAHA (India) said that, as the Internal Auditor was required to evaluate the various control and governance mechanisms available to the management, the responsibilities of oversight covered compliance with WHO's rules, policies, standards and procedures, ensuring that resources were applied efficiently. The report pointed out some weaknesses across the different regional and country offices and programmes, and referred to activities involving financial transactions that failed to respect established controls and procedures. It also mentioned that Regional Directors and WHO Representatives sometimes failed to enforce controls while exercising their authority, and that they were not held accountable for discrepancies in transactions approved by them. He trusted that the Director-General would take steps to remedy such unconcern.

WHO's work was accorded the highest priority everywhere, and the Organization was thus able to attract almost instinctive support and goodwill. It therefore had a special responsibility for unfailingly trustworthy activity, so as to ensure the continued confidence both of its membership and of its much wider constituency of supporters. It was disturbing, in that context, to find instances where WHO decisions with substantial financial implications had been motivated not by disease-prevention and health concerns, but by pressure of personal interest of senior officials. Management must never lose sight of the Organization's essential goals, or allow persons involved to divert effort from them. For example, the creation of a senior position at a cost of US$ 300 000, an amount that might seem

small when set against the annual programme administered by WHO, undermined confidence among WHO's supporters and created a misleading perspective, since for that amount, half a million more children per year could be immunized against poliomyelitis in the South-East Asian Region. Every decision with financial implications should be carefully weighed; to assume that a large resource base could absorb indulgences would do the Organization great harm and seriously undermine trust.

Mr LOZINSKIY (Russian Federation) expressed appreciation for the Office's efforts in auditing the activities of a major United Nations organization; the task, especially in a climate of decentralization, was not easy. He was particularly concerned about the state of control systems in regional offices, in view of the considerably greater flow of financial resources to the regions in recent years. It was essential to establish, at all levels of WHO, a culture of financial discipline. Since it was difficult for the Office to carry out that task independently itself, the participation of all parties, beginning with management, was necessary. With regard to auditing, his country took an interest in all abuses uncovered, particularly the major instances. He agreed with the Internal Auditor on the need to create the necessary conditions for responsible officers to exercise control. In that regard, at the risk of anticipating matters, he drew attention to a recommendation by the External Auditor, not yet implemented, for development of a fraud prevention and contingency policy, referred to in paragraph 23 of document A57/20.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) said that the Office of Internal Oversight Services had identified poor procedural controls in certain country and regional offices. It was important for there to be a proper control environment throughout the Organization, as more resources were transferred to country level. Three audit reports remained open from 2001 and 2002 because the Office had not received full responses to its recommendations; they should be closed as soon as possible to demonstrate commitment to oversight and control in general. An indication of when the work was likely to be completed would be useful.

Ms BLACKWOOD (United States of America) said that she had been pleased to learn that the Office of Internal Oversight Services passed on all its internal audit reports to the External Auditor and that he had broadly approved WHO's financial and administrative control procedures. The Internal Auditor had identified some offices and programmes at all levels where those controls were inadequate. It was to be hoped that the problems could be remedied as a matter of urgency.

Dr SAMBA (Regional Director for Africa) recalled that he had first attended a Health Assembly in 1974 and the current one would be his last. In 1994, the year before he had joined the Regional Office for Africa, it had been the subject of a damning audit report and he had undertaken to look into the matter. In 1997, however, the Regional Office had had to move hurriedly to Harare, leaving behind files and equipment and only returning to Brazzaville in 2001. In the interim, the number of staff had increased from 240 to more than 700, with a corresponding increase in the country offices. In 1995, US$ 600 000 per annum had been spent on poliomyelitis eradication, whereas, in 2004, the figure topped US$ 170 million. Citing the Democratic Republic of the Congo as an example, he noted that efforts to control poliomyelitis had been successful, albeit at a cost of some US$ 80 million, partly because of a lack of various forms of infrastructure, including banks and roads. He expressed his gratitude to the Internal and External Auditors, and to staff at headquarters for their support. Undoubtedly, there were still weaknesses in the Region's financial management procedures, but the necessary remedial steps were being taken.

Mr LANGFORD (Internal Auditor), replying to questions, said that the outstanding issues relating to pharmaceutical procurement would be resolved as soon as the new procedures were verified; work was in hand with the new Director of the WHO Centre for Health Development, Kobe, Japan to correct the identified weaknesses; problems connected with the extrabudgetary partner agreements at the Regional Office for the Americas/PAHO were within a few weeks of being

resolved. The level of fraud during 2003 had been unusual and, consequently, the Office of Internal Oversight Services had devoted almost a third of its time to investigations. Most of the cases referred to in the report had been examined and would soon be wound up. In some instances, individuals had been disciplined, some funds had been recovered and others were being pursued. The case mentioned in paragraph 27 was being dealt with by the host Government's judicial system. His Office would attempt to pursue all cases vigorously in order to seek redress through either recovery or disciplinary measures. There had been a corresponding increase in WHO's efforts to deal with fraud and prevent it in the future.

With respect to the audit process, the Office of Internal Oversight Services subscribed to and sought to comply with the standards set by the Institute of Internal Auditors, which had been adopted as the audit standards for internal audit functions within the United Nations system. The Office's work was underpinned by three concepts: risk, control and governance. An annual work plan was produced for execution the following January. That plan could change, but only if the risk profile had changed. A high-risk fraud case would always take precedence, even if it was not in the plan, over a visit to a lower-risk office. The Institute's standards also applied to control of the auditors and an external risk assessment had to be carried out every five years. The current standards had come into effect on 1 January 2002 and the Office of Internal Oversight Services would undergo an external evaluation of its work in either 2006 or 2007, as funding permitted.

The CHAIRMAN invited the Committee to note the report of the Internal Auditor contained in document A57/19.

The Committee noted the report.

3. FINANCIAL MATTERS: Item 15 of the Agenda

Financial report on the accounts of WHO for 2002-2003, report of the External Auditor, and comments thereon made on behalf of the Executive Board: Item 15.1 of the Agenda (Documents A57/20, A57/20 Add.1 and A57/21)

Dr YOOSUF (representative of the Executive Board), speaking as Chairman of ABFC and introducing its first report (document A57/21), said that the Committee had examined the financial report for 2002-2003, the salient points of which were set out in paragraphs 2 and 4 of ABFC's report (document A57/21). It had also examined the report of the tenth meeting of the Audit Committee, the salient points of which were set out in paragraph 5 of ABFC's report, and the report of the External Auditor (document A57/20). Having taken due account of all three reports, ABFC recommended the adoption of the draft resolution contained in paragraph 6 of document A57/21.

Mr FAKIE (External Auditor), introducing his report (document A57/20), said that he had expressed an unqualified audit opinion. As his term of office was coming to an end, he reviewed some highlights of the past eight years, and the significant items of the 2002-2003 financial period. He was pleased to note an improvement in communication between the External Auditor and the governing bodies and the development of a forum for frank exchange with Member States, enhanced by the creation of an Audit Committee. He supported the review of existing structures, with a view to improving effectiveness, but felt that an active dialogue on external audit matters at governing body level was essential. Improving communication with the Secretariat had also been a priority, and he appreciated the high level of cooperation and consensus that had been achieved.

His reviews during his term had resulted in some 190 recommendations in 2000-2001 and 195 recommendations in 2002-2003, of which 67% had already been implemented. Overall, he was satisfied with progress made in giving effect to those recommendations. Attention had increasingly

been paid to the importance of good governance structures, including full implementation of United Nations System Accounting Standards, a comprehensive review of the Financial Regulations, improved financial reporting, and continued strengthening of the internal oversight function.

His report highlighted some areas that required further attention, including the need for a more formalized risk management process, a more comprehensive fraud prevention and contingency policy and a comprehensive code of ethics and conduct, and the need to strengthen the procedures for reviewing declarations of conflicts of interest. The lack of progress made in addressing issues previously raised, such as delegations of authority, the development and dissemination of financial and administrative procedures and the relevance for WHO of having an environmental policy, was disappointing. He had expressed particular concern in paragraphs 53-57 about the lack of progress in following up recommendations about asset-management systems for non-expendable equipment. Although the audit had not revealed evidence of irregularities or significant losses of such equipment, general weaknesses in the system persisted, and the Director-General had personally undertaken to tackle them. The weakening of financial and accounting controls in the Regional Office for Africa during the 2002-2003 financial period had been particularly regrettable.

He had also considered the rising trend of extrabudgetary resources and the need for more accurate information about the support costs involved. Accountability for local cost subsidies and fellowships called for timely reporting by Member States. An overriding priority for the Organization was to increase WHO's contribution to health and development at country level, where the country cooperation strategies had proved to be a key instrument in determining its role.

With regard to strategic budgeting and improved programme management, he had reviewed the degree of compliance with procedures and had indicated in paragraphs 37-51 the areas where improvements were needed. Human resources were the Organization's most significant asset. Compliance with the requirements of the performance management and development system should be improved and attention paid to addressing competency gaps and the interrelationship between organizational and individual performance.

Issues related to information technology had been regularly followed up, and issues such as the need for adequate staff resources were being systematically addressed. He was pleased to note the appointment of a Director of Information Technology, which would provide momentum for developing information technology strategies and policies throughout the Organization. Information technology and the associated risks called for active management.

He had been gratified by the acceptance of his comments. The implementation of his recommendations should lead to improvements in management and control structures. He expressed his appreciation to the present and former Directors-General, Regional Directors and WHO staff for the courtesy extended to him and his team, and extended his best wishes to his successor, the Comptroller and Auditor-General of India.

Mr MACPHEE (Canada) welcomed the informative, clear and comprehensive financial reports and the External Auditor's excellent report. He was particularly pleased to note the successful collaboration between the Director-General and the External Auditor. For Canada, an independent external auditor was a key element in promoting integrity and accountability as a basis for good corporate governance. He was therefore encouraged by the improvements in corporate governance. He supported the Director-General's goal of reversing the rising proportion of expenditure at headquarters, which had reached 44% in the 2002-2003 period. Concerted action must be taken to bring it down to the 30% target, and he welcomed the efforts being made to update the management systems of the Organization to that end.

He welcomed the External Auditor's comments on risk management, on the need for a more comprehensive fraud policy and the development of a code of ethics, as well as on the need to strengthen procedures with regard to conflicts of interests. He endorsed the remarks about record-keeping for non-expendable equipment and the management of information technology, and the improvements needed in implementing the programme budget. Although he appreciated the increased rate of collection of assessed contributions, he shared the External Auditor's concern about the lack of

progress in reducing arrears, and urged the Director-General to renew his efforts in that regard. All Member States should pay their contributions on time, in full and unconditionally.

Mr LOZINSKIY (Russian Federation) agreed with the views expressed in paragraphs 53-57 of the External Auditor's report, which indicated a need to strengthen the governance system of the Organization. The system must comply with established standards, and information should be presented in line with the accounting system of the United Nations. Failure to observe proper accounting procedures could have serious repercussions, including the loss of valuable property. He was particularly concerned about the situation in the Regional Office for Africa, where budgetary discipline had been slack as a result of the move from Harare to Brazzaville. It was a matter for concern that the situation had been brought to light by the Auditor rather than by the Secretariat. Financial difficulties should not be solved by breaching financial rules and regulations but by recourse to the Member States; any difficulties that arose should be reported to the governing bodies of WHO. He was likewise concerned about the lack of financial discipline in the fellowship programme, and hoped that new fellowships would be withheld, if necessary, until reports were available on existing ones.

Mr SAWERS (Australia) welcomed the Auditor's positive comments on recent improvements in corporate governance. The Secretariat should strive for progress in certain areas discussed in the report: the related corporate governance issues of risk management, fraud, ethics and conduct, and other more routine matters such as information technology, governance and knowledge management; delegations of authority; performance assessment and development of staff. It was important that WHO's avowed goal of decentralization did not result in greater risk of financial loss, especially given the Organization's highly diversified operating environments. Decentralization also required better use of knowledge and communication tools to ensure that decisions were always made on the basis of the highest quality information and experience available: that could not be achieved without a sophisticated structure integrating management of information with corporate objectives. He welcomed the recent developments in that area, and urged WHO to work towards early and ambitious gains. Noting the External Auditor's comments on the implementation of the performance management and development system, he called for further improvements, as the system was central to achieving the linkage between organizational and individual performance, and was a key mechanism for developing the Organization's capacity.

Ms BLACKWOOD (United States of America) recalled that the External Auditor had previously noted, in reports going back to 1996-1997, that WHO had not maintained accurate and reliable asset-management systems. Despite WHO's assurances and the engagement of a consultant to review the systems, the External Auditor's current report noted no sign of any significant progress. Furthermore, while there had been steady improvements in programme planning and monitoring, the External Auditor had noted that the activity-management system was not being used across the Organization to support those activities. It was to be hoped that progress would soon be made in both those areas.

Mr SAHA (India) wondered why, in Table 6 of document A57/20, salaries and common staff costs accounted for almost 50% of the regular budget, but only a tiny share of voluntary funds. The reason could be that the regular budget covered a disproportionate amount of the Organization's overheads, but, if so, the accounting picture was distorted. In the interests of transparency, extrabudgetary resources should, from an accounting point of view, be treated in the same way as regular funds. A related issue was the high level of 98% use of funds, expressed in paragraph 30 of the External Auditor's report as the "implementation rate". Laudable though that was, closer scrutiny might reveal it to be no more than an accounting convention, in the sense that the regular budget was fully spent before extrabudgetary resources were called upon, in which case the high utilization

percentage would seem less impressive. Since the budget was an integrated one for all activities, there should be a common costing structure.

He requested an explanation of the workings of the foreign exchange hedging transactions mentioned in section 7 of the Notes to the accounts, and especially the option contracts for different rates of exchange of the Swiss franc. With regard to the tax equalization fund, were the figures given for salaries and staff costs gross or net?

Mr MCKERNAN (New Zealand) expressed concern that headquarters expenditure, as a proportion of total spending, had increased from 37% in 2001 to 44% for the biennium 2002-2003. He noted that 166 staff posts had been filled at headquarters during the previous biennium. He supported the Director-General's commitment to reduce the figure to 30%, but asked how that would be done, and when.

Ms AUER (France) welcomed the overall implementation rate of 98%, and the improvement in collection of assessed contributions to 94%. However, there had been virtually no improvement in the payment of arrears. She agreed with the remarks by the delegate of Canada in that regard. She also shared the concern of the delegate of the Russian Federation about infringements of correct accounting procedures. The failure to maintain proper inventory records prevented effective management of the Organization's assets. Major irregularities had been found in the management of the Regional Office for Africa, resulting in a genuine budgetary crisis. Those shortcomings necessitated better spending controls and a clearer definition of responsibilities, and brought into question the relationship between regular and extrabudgetary resources. The regular budget must have enough funds to cover the administrative and support costs generated by the growth in extrabudgetary funds. A detailed analysis of the costs of administering the extrabudgetary funds, as recommended by the Joint Inspection Unit, would be highly desirable.

She welcomed the progress achieved in performance-based management and budgeting, and supported the Auditor's recommendations in that regard. However, the question of geographical and gender distribution of human resources appeared to exceed the Auditor's mandate. She agreed with his recommendations on strengthening surveillance procedures, notably in the areas of risk management, fraud prevention and the code of ethics and conduct, particularly in the context of the decentralization of resources.

The report of the Internal Auditor, which the Committee had studied under the preceding agenda item, had also drawn attention to a number of fundamental shortcomings that entailed financial risk for the Organization. She therefore agreed with the warning, in paragraph 111 of the report, against increased delegation of authority to WHO Representatives until adequate safeguards were in place.

Mr KINGHAM (United Kingdom of Great Britain and Northern Ireland) agreed with the Auditor's recommendation that, when the Executive Board was considering a revised structure for its committees, efforts should be made to retain and enhance interaction with the External Auditor and other key players. He also agreed with the recommendation that the Director-General should include in future reports an explanation of his responsibility for preparing the financial statements, and a statement on the effectiveness of the system of internal control. WHO should review its risk assessment activity and implement an appropriate risk management process. On fraud prevention, he supported the recommendation for a structured policy, and asked why none had been finalized. He shared the Auditor's concerns about difficulties caused by late payment of assessed contributions, and urged all Member States concerned to take steps to reduce their arrears. He welcomed the significant progress made in strategic budgeting and programme management, and endorsed the need for a more structured and transparent framework for both resource mobilization and allocation of voluntary funds. He noted the Auditor's continuing concerns about the significant lack of progress in disclosing the value of non-expendable equipment; urgent steps must be taken to resolve that long-standing problem.

He welcomed the action taken to address the weaknesses in financial management in the Regional Office for Africa.

Dr NORDSTRÖM (Assistant Director-General) thanked the External Auditor for his excellent collaboration and useful recommendations. The Director-General was strongly committed to increasing WHO's organizational efficiency, focusing on results and priorities, and delivering services closer to the target groups in countries. That, in turn, meant pursuing decentralization and making progress towards a 30% share for headquarters expenditure. Much hard work was being done on implementing results-based management and budgeting. A serious approach was being adopted to planning for results, monitoring progress, and assessing the most efficient use of resources. The Organization was fine-tuning systems for strategic planning, and trying to improve its budget-planning practices. Considerable effort had gone into operational planning for 2004-2005, as well as into monitoring performance. Attempts had also been made to ensure greater transparency in the Organization. Financial figures were available for review, and there was open and transparent discussion about what was being undertaken and what resources were available. The Organization was also trying to improve accountability, which involved a clear delegation of authority and a clear managerial framework.

The Organization was not merely talking about an integrated budget; it was actually producing one. However, there were still historical issues to be resolved, of which human resources allocation, mentioned by the delegate of India, was one. By tradition, much of the Organization's staff costs had been financed from the regular budget, although it was probably only a matter of time before a more balanced pattern of expenditure emerged. WHO was a knowledge-based organization dependent on professional staff, and would inevitably incur high staff costs. Later in the year a management and leadership programme would be introduced, enabling the Organization to manage both financial and human resources better. More resources were being invested in staff development and learning. All those aspects were captured in the strategic framework for general management.

Ms WILD (Comptroller) said that WHO had reviewed its policy on asset management and was strengthening its procedures. In the past, more attention had been paid to ensuring the financial integrity of the accounts than to maintaining the security of the assets.

Noting the concerns expressed about the Regional Office for Africa, she reported that several steps had been taken to strengthen internal controls, including a review of procedures and of the delegation of authority, and appointment of an external consultant to examine financial operations. His report was being finalized, and its recommendations would be considered at both the Regional Office and headquarters.

With regard to the policy areas of governance, fraud prevention, the code of ethics and delegation of authority, draft proposals were being prepared.

Regarding the overall rate of implementation, she drew attention to Table 1 in document A57/20. The overall rate of implementation was just 100% for all sources of funds, covering both the regular budget and the other sources budgeted for 2002-2003.

On the question of staff costs, Table 6 took account of not only salaries and common staff costs, but also short-term staff costs. The level of expenditure for short-term staff funded from sources other than the regular budget was inevitably higher, because for that item WHO did not have the same secure commitments of income from all donors as for the regular budget. Expenditure as shown in the table reflected actual outgoings rather than initial allocations. She confirmed that salary costs were net of the transactions flowing through the tax equalization fund.

With regard to the foreign exchange hedging transactions, the purpose of the strategy was to purchase Swiss francs at a rate of 1.40. It was a means of using the appropriation provided by the Health Assembly in a cost-effective way, i.e. purchasing Swiss francs at the best possible rate on the market in the future. There were other options, but they were all more expensive and probably less effective.

Dr NORDSTRÖM (Assistant Director-General), referring to the decentralization process, explained that the target of a 30%/70% distribution of resources between headquarters and regional and country offices had been broken down by area of work and by office, and had been presented to the Executive Board in January 2004. The Director-General, in consultation with the various Regional Directors, had made it clear that the target should be achieved, and progress was being evaluated on a monthly basis. A total of US$ 153 million had already been moved away from headquarters, and other resources would be moved to meet the target. The result would be to reduce spending by 3% at headquarters, while increasing it by 28% in Africa, 92% in the Americas, 51% in South-East Asia, 26% in Europe, 30% in the Eastern Mediterranean and 48% in the Western Pacific Region. That would mean a significant shift of resources, even during the current biennium.

Dr TANGI (Tonga) asked what resources would be moved away from headquarters.

Dr NORDSTRÖM (Assistant Director-General) explained that moving resources was not an end in itself. The aim was to use resources more efficiently, so that WHO could deliver the results expected by the Health Assembly. The Organization was presently seeking to achieve a better balance and availability of resources. The process of allocating funds and staff in new directions would take place over time.

The CHAIRMAN invited the Committee to consider the draft resolution recommended by ABFC in paragraph 6 of document A57/21.

The draft resolution was approved.[1]

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 15.2 of the Agenda (Document A57/22)

Dr YIN Li (representative of the Executive Board) said that, at its 113th session in January 2004, the Executive Board had noted the report on the status of collection of assessed contributions,[2] and been updated on further developments since 31 December 2003, notably the rise in the collection rate for 2003 from 90% at 31 December 2003 to 91% by the time of its 113th session. That figure was significantly higher than the collection rate for 2002. Arrears of contributions in respect of previous years had fallen to US$ 118 million, compared with US$ 153 million as at 31 December 2002. Furthermore, the number of countries paying their contributions in advance had risen from 31 to 36, as against 29 a year earlier.

The Board had also noted that a further update on the status of collection and Members in arrears would be provided to the ABFC meeting in May 2004, immediately before the Health Assembly.

Dr YOOSUF (representative of the Executive Board), speaking as Chairman of ABFC, introducing its second report (document A57/22) said that the Committee had noted that the rate of collection of assessed contributions had risen from 67% at 30 April 2004 to 68% on the date of the meeting. The arrears in respect of previous years had been reduced to US$ 100 million at 17 May 2004 compared with US$ 110 million at 30 April 2004 and US$ 106 million at 30 April 2003.

ABFC had also considered the arrears situation of Member States that justified invoking Article 7 of the Constitution, noting that two such countries, Solomon Islands and Uruguay, were in

---

[1] Transmitted to the Health Assembly in the Committee's second report and adopted as resolution WHA57.4.

[2] Document EB113/16.

arrears to such an extent ABFC had decided to recommend that the current Health Assembly should suspend their voting rights for the Fifty-eighth World Health Assembly unless sufficient payment was received before that time.

ABFC had also discussed the requests of Armenia and Ukraine; it had supported both but recommended further improvements. In considering those requests, ABFC had emphasized the importance for countries requesting special arrangements to acknowledge the full amount of arrears to be paid and clearly state the period over which payments would be made.

In the course of further discussions, Armenia had been unable to commit itself to payment over a 10-year period or to make any commitment to a time frame for payment. However, it was committed to making the payment in full, on condition that it was allowed to return to the Health Assembly in three years' time, agreeing that, if after three years its proposal to pay the balance of its arrears was not accepted, it would forfeit its voting privileges. It also requested that, in return for a commitment over the first three years to pay US$ 50 000 per year, its voting rights should be restored by the current Health Assembly.

Ukraine had been unable to commit itself to a reduction in the 15-year repayment period, but was committed to making full payment over that period, and had pledged to pay at least half of its arrears, just over US$ 18 million, within half that period. That commitment was a key improvement intended to ensure that its proposal found favour with the current Health Assembly. In return for those commitments, Ukraine had requested restoration of its voting privileges.

Ms WILD (Comptroller) said that, since ABFC's meeting on 14 May 2004, a further US$ 625 000 had been received in payment of arrears and current-year assessed contributions. Jamaica and Nepal had paid in full for 2004 and Togo had not only paid in full for 2004 but had also paid all arrears due. Togo was therefore no longer subject to the provisions of Article 7 of the Constitution and would consequently be removed from the list in the second preambular paragraph of the draft resolution in document A57/22. Uruguay, too, had made a payment sufficient for it to be excluded from the provisions of Article 7 and would also be removed from the list. Two other Member States, Antigua and Barbuda and Chad, had also made significant payments, but not such as would exclude them from the provisions of Article 7.

Dr ABBAS (Iraq) said that he had contacted the Regional Director for the Eastern Mediterranean about Iraq's outstanding arrears of more than US$ 6 million. As everyone knew, Iraq was in a very difficult situation and unable to pay its arrears. Did that mean that, pursuant to Article 7 of the Constitution, Iraq's failure to pay its arrears would result in the suspension of all assistance? The Health Assembly had the power to reinstate health services and assistance, and Iraq was eagerly awaiting further WHO assistance to re-establish those services.

In addition to those discussions, Iraq had submitted a proposal requesting its full participation in all WHO activities. A communication would also be sent to the Director-General for consideration by the Health Assembly in 2005.

Ms WILD (Comptroller) confirmed that WHO would collaborate with Iraq and assist it in developing a specific proposal for submission to the Health Assembly in 2005 regarding the settlement of its arrears.

Mr TOPPING (Legal Counsel) explained that the resolutions adopted by the Health Assembly suspended voting rights, but not services and assistance to the countries involved.

The CHAIRMAN invited the Committee to approve the draft resolution set out in paragraph 17 of document A57/22, as amended by the Comptroller.

Mr UNA (Solomon Islands) said that the failure of his country to pay was due to the civil strife it had experienced for the past four years. He promised that it would do its best to meet its obligations to WHO.

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

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

The meeting rose at 16:50.

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.5.

THIRD MEETING

Friday, 21 May 2004, at 09:45

Chairman: Dr Jigmi SINGAY (Bhutan)

1. SECOND REPORT OF COMMITTEE B (Document A57/42)

Mrs JAKAB (Hungary), Rapporteur, read out the draft second report of Committee B.

The report was adopted.[1]

2. FINANCIAL MATTERS: Item 15 of the Agenda (continued)

Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution: Item 15.2 of the Agenda (Document A57/22) (continued from the second meeting, section 3)

The CHAIRMAN invited the Committee to consider a draft resolution on arrears in payment of contributions by Armenia, which read:

> The Fifty-seventh World Health Assembly,
>
> Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, with respect to the request of Armenia for the settlement of its outstanding contributions,[2] and noting that Armenia is committed to the full payment of all arrears outstanding which total US$ 2 496 150,
>
> 1. DECIDES to restore the voting privileges of Armenia at the Fifty-seventh World Health Assembly subject to the terms below:
>
> (1) Armenia shall make annual payments of US$ 50 000 in each of 2004, 2005 and 2006;
>
> (2) Armenia shall submit a further proposal by 31 March 2007 indicating the minimum annual payment and period over which the then remaining arrears shall be paid in full, for consideration by the Sixtieth World Health Assembly and shall make such payments of its remaining arrears in accordance with any resulting resolution adopted by that Health Assembly;
>
> (3) in addition to the amount set out in (i) above, Armenia shall ensure full payment of its current-year assessed contributions, in accordance with the provisions of Financial Regulation 6.4;

---

[1] See page 240.

[2] Document A57/22.

2. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if no proposal is adopted at the Sixtieth World Health Assembly or if Armenia does not meet the commitments referred to in (i) and (ii) above;

3. REQUESTS the Director-General to report to the Fifty-eighth World Health Assembly on the prevailing situation;

4. REQUESTS the Director-General to communicate this resolution to the Government of Armenia.

Mr MNATSAKANYAN (Armenia) said that the draft resolution was the product of lengthy and intensive discussions aimed at finding the most realistic way of ensuring that Armenia honoured its obligations. Consideration of the causes, history and structure of Armenia's arrears would demonstrate that they had not arisen through negligence or unwillingness. Its assessed contributions for the years 1992-1998 had been calculated on the basis of its economic performance and statistical information from the period preceding its independence in 1991 and had not reflected the actual situation in the country in the relevant period. Those assessed contributions had averaged US$ 300 000 per year, whereas the country's national budget had averaged US$ 300 million; it would have been impossible to allocate 0.1% of that amount to one organization, given that overall expenditure on health had amounted to only 6% of the total budget. During that period, therefore, Armenia had accumulated about 89% of its total outstanding contributions of US$ 2.5 million.

By contrast, Armenia's assessed contribution was currently US$ 8500 – in other words, only 2.7% of the average annual figure for the period 1992-1998. Armenia had paid its dues in full for 2002, 2003 and 2004. Moreover, in April 2004 it had voluntarily contributed US$ 50 000 (six times the current assessed contribution) to the Organization's budget in order to demonstrate its willingness to resolve the existing situation.

The payment plan set out in the draft resolution, to which Armenia was committed, was based on the maximum amount that the country could afford on top of its regular assessed contributions.

Armenia was aware that the Committee had a practice for dealing with cases of outstanding contributions; however, the reasons for the accumulation of arrears and the realistic capability of the country in question to pay them should be taken into account. Failing that, the Committee's expectations would not be fulfilled. Armenia did not wish to prolong the current situation for an unacceptable period of time, nor was that the aim of the draft resolution. It wished to assume obligations that it would be able to fulfil and that would ensure its continued participation in the affairs of WHO. The proposal in the draft resolution was serious, and the consequences of a default would be damaging for Armenia. His country knew what was within its capabilities and had declared its willingness to meet its obligations. He hoped that it would be given the opportunity to do so.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland), welcoming the efforts to resolve the question of Armenia's outstanding contributions, encouraged all Member States currently in arrears to make urgent efforts to settle the amounts in full. If the full amount could not be repaid immediately, credible schemes for repayment over a limited period of time could be considered. Noting that Armenia was proposing to repay US$ 150 000 over three years and to submit a further proposal in 2007 indicating the minimum annual payment and the period over which the remaining arrears would be paid, she expressed concern at the precedent such an arrangement might establish. WHO and Armenia should work out an improved proposal for the repayment of all outstanding arrears within an agreed, specific period of time.

Ms BLACKWOOD (United States of America) also welcomed Armenia's serious efforts to pay its outstanding contributions but shared the concern expressed by the previous speaker about the precedent that might be set by allowing an open-ended period for the settling of arrears and about the broader implications of such an arrangement for WHO. Discussions on the matter should continue and

a comprehensive plan for payment within a predetermined period of time should be submitted for approval the following year.

Mr SAWERS (Australia), supported by Mr MACPHEE (Canada), welcomed Armenia's commitment to settling its arrears but said that he would have preferred a more detailed payment plan. Armenia and WHO should continue their discussions, taking into account Armenia's ability to pay, with a view to the matter being reconsidered at the next Health Assembly.

Ms MIDDELHOFF (Netherlands), endorsing the comments made by the previous speakers, urged all Member States in arrears to conclude realistic payment plans with WHO. Timely, unconditional and full payment of assessed contributions by all Member States was vital to enable the Organization to perform its crucial tasks.

Mr MNATSAKANYAN (Armenia), acknowledging the concerns expressed about the broader implications of Armenia's payment plan, emphasized that the reasons for accumulation of arrears varied from case to case. At its current level of assessed contributions of US$ 8500, it would have taken Armenia 295 years to clear its existing arrears of US$ 2.5 million. His country was prepared to continue its discussions with WHO and interested countries.

The CHAIRMAN said that, in the absence of any objections, he would take it that the Committee agreed to the matter being discussed further and to review the situation the following year.

It was so agreed.

The CHAIRMAN invited the Committee to consider a draft resolution on arrears in payment of contributions by Ukraine, which read:

> The Fifty-seventh World Health Assembly,
>
> Having considered the second report of the Administration, Budget and Finance Committee of the Executive Board on Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution, with respect to the request of Ukraine for the settlement of its outstanding contributions,[1]
>
> 1. DECIDES to restore the voting privileges of Ukraine at the Fifty-seventh World Health Assembly on the following conditions:
>
> (1) Ukraine shall pay its outstanding arrears of assessed contributions, totalling US$ 36 163 544 over 15 years, subject to payment of at least half the total amount of arrears, i.e. US$ 18 081 772, by the end of 2011;
>
> (2) Ukraine shall make a minimum payment of US$ 1 500 000 per annum, which shall be applied first, against its current-year assessment, second, against the eight annual instalments of US$ 342 848 each, due under resolution WHA45.23, and third, against the balance of its arrears;
>
> 2. DECIDES that, in accordance with Article 7 of the Constitution, voting privileges shall be automatically suspended again if Ukraine does not meet the requirements laid down in paragraph 1 above;

[1] Document A57/22.

3. REQUESTS the Director-General to report to the Fifty-eighth World Health Assembly on the prevailing situation;

4. REQUESTS the Director-General to communicate this resolution to the Government of Ukraine.

Mr BIELASHOV (Ukraine) said that the main reasons for the large arrears accumulated by Ukraine were obvious. Some were similar to those affecting Armenia, such as the fact that the contributions assessed in the early 1990s had not corresponded to the actual situation in Ukraine. Acknowledging that the payment terms proposed in the draft resolution were unprecedented for WHO, he requested that special allowances be made for his country, which had worked intensively with the Organization and with the Administration, Budget and Finance Committee of the Executive Board in order to find a mutually acceptable solution. Ukraine was ready to implement the draft resolution fully, subject to its approval by the Committee, and would make every effort to settle its arrears before the specified deadline.

The draft resolution was approved.[1]

Scale of assessments for 2005: Item 15.3 of the Agenda (Document A57/23)

Dr YIN Li (representative of the Executive Board) said that the Executive Board had considered the report of the Director-General on the scale of assessments contained in document EB113/46 and had noted that, by resolution WHA56.33, the Health Assembly had decided to accept thenceforth for WHO the latest available United Nations scale of assessments. The report set out the WHO scale for 2005 that would result from application of the new United Nations scale. The Board, having reviewed the report, had decided to recommend that the Health Assembly, acting in accordance with Financial Regulation 6.1, should consider amending the scale of assessments to be applied in 2005, the second year of the current financial period. It had also requested that additional information should be provided for the Fifty-seventh World Health Assembly, as set out in paragraph 3(a)-(d) of document A57/23. That information had been supplied by the Director-General in the same document.

The CHAIRMAN invited the Committee to consider a draft resolution on the scale of assessments for 2005, which read:

The Fifty-seventh World Health Assembly,
Having considered the report of the Director-General,[2]

1. DECIDES to adopt a revised scale of assessments for 2005, reflecting the latest available United Nations scale as shown below:

Members and Associate Members	Revised WHO scale for 2005
	%
Afghanistan	0.00200
Albania	0.00500

[1] Transmitted to the Health Assembly in the Committee's third report and adopted as resolution WHA57.6.

[2] Document A57/23.

Members and Associate Members	Revised WHO scale for 2005 %
Algeria	0.07600
Andorra	0.00500
Angola	0.00100
Antigua and Barbuda	0.00300
Argentina	0.95600
Armenia	0.00200
Australia	1.59200
Austria	0.85900
Azerbaijan	0.00500
Bahamas	0.01300
Bahrain	0.03000
Bangladesh	0.01000
Barbados	0.01000
Belarus	0.01800
Belgium	1.06900
Belize	0.00100
Benin	0.00200
Bhutan	0.00100
Bolivia	0.00900
Bosnia and Herzegovina	0.00300
Botswana	0.01200
Brazil	1.52300
Brunei Darussalam	0.03400
Bulgaria	0.01700
Burkina Faso	0.00200
Burundi	0.00100
Cambodia	0.00200
Cameroon	0.00800
Canada	2.81300
Cape Verde	0.00100
Central African Republic	0.00100
Chad	0.00100
Chile	0.22300
China	2.05300
Colombia	0.15500
Comoros	0.00100
Congo	0.00100
Cook Islands	0.00100
Costa Rica	0.03000
Côte d'Ivoire	0.01000
Croatia	0.03700
Cuba	0.04300
Cyprus	0.03900
Czech Republic	0.18300
Democratic People's Republic of Korea	0.01000
Democratic Republic of the Congo	0.00300
Denmark	0.71800

Members and Associate Members	Revised WHO scale for 2005 %
Djibouti	0.00100
Dominica	0.00100
Dominican Republic	0.03500
Ecuador	0.01900
Egypt	0.12000
El Salvador	0.02200
Equatorial Guinea	0.00200
Eritrea	0.00100
Estonia	0.01200
Ethiopia	0.00400
Fiji	0.00400
Finland	0.53300
France	6.03010
Gabon	0.00900
Gambia	0.00100
Georgia	0.00300
Germany	8.66230
Ghana	0.00400
Greece	0.53000
Grenada	0.00100
Guatemala	0.03000
Guinea	0.00300
Guinea-Bissau	0.00100
Guyana	0.00100
Haiti	0.00300
Honduras	0.00500
Hungary	0.12600
Iceland	0.03400
India	0.42100
Indonesia	0.14200
Iran (Islamic Republic of)	0.15700
Iraq	0.01600
Ireland	0.35000
Israel	0.46700
Italy	4.88510
Jamaica	0.00800
Japan	19.46830
Jordan	0.01100
Kazakhstan	0.02500
Kenya	0.00900
Kiribati	0.00100
Kuwait	0.16200
Kyrgyzstan	0.00100
Lao People's Democratic Republic	0.00100
Latvia	0.01500
Lebanon	0.02400
Lesotho	0.00100

Members and Associate Members	Revised WHO scale for 2005 %
Liberia	0.00100
Libyan Arab Jamahiriya	0.13200
Lithuania	0.02400
Luxembourg	0.07700
Madagascar	0.00300
Malawi	0.00100
Malaysia	0.20300
Maldives	0.00100
Mali	0.00200
Malta	0.01400
Marshall Islands	0.00100
Mauritania	0.00100
Mauritius	0.01100
Mexico	1.88300
Micronesia (Federated States of)	0.00100
Monaco	0.00300
Mongolia	0.00100
Morocco	0.04700
Mozambique	0.00100
Myanmar	0.01000
Namibia	0.00600
Nauru	0.00100
Nepal	0.00400
Netherlands	1.69000
New Zealand	0.22100
Nicaragua	0.00100
Niger	0.00100
Nigeria	0.04200
Niue	0.00100
Norway	0.67900
Oman	0.07000
Pakistan	0.05500
Palau	0.00100
Panama	0.01900
Papua New Guinea	0.00300
Paraguay	0.01200
Peru	0.09200
Philippines	0.09500
Poland	0.46100
Portugal	0.47000
Puerto Rico	0.00100
Qatar	0.06400
Republic of Korea	1.79600
Republic of Moldova	0.00100
Romania	0.06000
Russian Federation	1.10000
Rwanda	0.00100

Members and Associate Members	Revised WHO scale for 2005 %
Saint Kitts and Nevis	0.00100
Saint Lucia	0.00200
Saint Vincent and the Grenadines	0.00100
Samoa	0.00100
San Marino	0.00300
Sao Tome and Principe	0.00100
Saudi Arabia	0.71300
Senegal	0.00500
Serbia and Montenegro	0.01900
Seychelles	0.00200
Sierra Leone	0.00100
Singapore	0.38800
Slovakia	0.05100
Slovenia	0.08200
Solomon Islands	0.00100
Somalia	0.00100
South Africa	0.29200
Spain	2.52000
Sri Lanka	0.01700
Sudan	0.00800
Suriname	0.00100
Swaziland	0.00200
Sweden	0.99800
Switzerland	1.19700
Syrian Arab Republic	0.03800
Tajikistan	0.00100
Thailand	0.20900
The former Yugoslav Republic of Macedonia	0.00600
Timor-Leste	0.00100
Togo	0.00100
Tokelau	0.00100
Tonga	0.00100
Trinidad and Tobago	0.02200
Tunisia	0.03200
Turkey	0.37200
Turkmenistan	0.00500
Tuvalu	0.00100
Uganda	0.00600
Ukraine	0.03900
United Arab Emirates	0.23500
United Kingdom of Great Britain and Northern Ireland	6.12720
United Republic of Tanzania	0.00600
United States of America	22.00000
Uruguay	0.04800
Uzbekistan	0.01400
Vanuatu	0.00100

Members and Associate Members		Revised WHO scale for 2005 %
Venezuela		0.17100
Viet Nam		0.02100
Yemen		0.00600
Zambia		0.00200
Zimbabwe		0.00700
	Total	100.00000

2. DECIDES to implement the amounts available under the adjustment mechanism for 2005, shown below, modified to reflect the revised assessments for 2005, and in accordance with the method of calculation established in resolution WHA56.34, the amounts to be proportionally reduced, if necessary, to ensure that the total claimed, on the basis of notifications received by 31 October 2004, is fully covered by the amount appropriated for the adjustment mechanism in 2004-2005.

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale) US$
Afghanistan	-
Albania	3 435
Algeria	-
Andorra	1 715
Angola	-
Antigua and Barbuda	1 715
Argentina	-
Armenia	-
Australia	228 355
Austria	-
Azerbaijan	-
Bahamas	-
Bahrain	22 320
Bangladesh	-
Barbados	3 435
Belarus	-
Belgium	-
Belize	-
Benin	-
Bhutan	-
Bolivia	3 435
Bosnia and Herzegovina	-
Botswana	3 435
Brazil	130 490
Brunei Darussalam	24 035
Bulgaria	10 300
Burkina Faso	-
Burundi	-
Cambodia	1 715
Cameroon	-

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Canada	214 620
Cape Verde	-
Central African Republic	-
Chad	-
Chile	152 810
China	1 844 005
Colombia	82 415
Comoros	-
Congo	-
Cook Islands	-
Costa Rica	24 035
Côte d'Ivoire	1 715
Croatia	13 735
Cuba	32 620
Cyprus	10 300
Czech Republic	66 960
Democratic People's Republic of Korea	-
Democratic Republic of the Congo	-
Denmark	63 525
Djibouti	-
Dominica	-
Dominican Republic	34 340
Ecuador	-
Egypt	96 150
El Salvador	17 170
Equatorial Guinea	1 715
Eritrea	-
Estonia	-
Ethiopia	-
Fiji	-
Finland	-
France	-
Gabon	-
Gambia	-
Georgia	-
Germany	-
Ghana	-
Greece	317 635
Grenada	-
Guatemala	20 605
Guinea	-
Guinea-Bissau	-
Guyana	-
Haiti	1 715
Honduras	3 435
Hungary	13 735
Iceland	5 150
India	218 055
Indonesia	-
Iran (Islamic Republic of)	-
Iraq	
Ireland	223 205

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Israel	211 185
Italy	-
Jamaica	3 435
Japan	-
Jordan	8 585
Kazakhstan	-
Kenya	3 435
Kiribati	-
Kuwait	61 810
Kyrgyzstan	-
Lao People's Democratic Republic	-
Latvia	-
Lebanon	13 735
Lesotho	-
Liberia	-
Libyan Arab Jamahiriya	17 170
Lithuania	15 455
Luxembourg	17 170
Madagascar	-
Malawi	-
Malaysia	39 490
Maldives	-
Mali	-
Malta	-
Marshall Islands	-
Mauritania	-
Mauritius	3 435
Mexico	1 552 125
Micronesia (Federated States of)	-
Monaco	-
Mongolia	-
Morocco	12 020
Mozambique	-
Myanmar	3 435
Namibia	-
Nauru	-
Nepal	-
Netherlands	144 225
New Zealand	6 870
Nicaragua	-
Niger	-
Nigeria	18 885
Niue	-
Norway	135 640
Oman	34 340
Pakistan	-
Palau	-
Panama	10 300
Papua New Guinea	-
Paraguay	-
Peru	-
Philippines	25 755

Members and Associate Members	Adjustment mechanism Members eligible 2005 (new scale)
	US$
Poland	460 145
Portugal	78 980
Puerto Rico	-
Qatar	54 940
Republic of Korea	1 383 860
Republic of Moldova	-
Romania	8 585
Russian Federation	68 680
Rwanda	-
Saint Kitts and Nevis	-
Saint Lucia	1 715
Saint Vincent and the Grenadines	-
Samoa	-
San Marino	1 715
Sao Tome and Principe	-
Saudi Arabia	274 710
Senegal	-
Serbia and Montenegro	-
Seychelles	-
Sierra Leone	-
Singapore	363 995
Slovakia	29 190
Slovenia	37 775
Solomon Islands	-
Somalia	-
South Africa	-
Spain	
Sri Lanka	8 585
Sudan	1 715
Suriname	-
Swaziland	-
Sweden	-
Switzerland	1 715
Syrian Arab Republic	-
Tajikistan	-
Thailand	72 110
The former Yugoslav Republic of Macedonia	3 435
Timor-Leste	1 715
Togo	-
Tokelau	-
Tonga	-
Trinidad and Tobago	10 300
Tunisia	8 585
Turkey	-
Turkmenistan	-
Tuvalu	-
Uganda	3 435
Ukraine	-
United Arab Emirates	103 015
United Kingdom of Great Britain and Northern Ireland	1 916 460
United Republic of Tanzania	5 150

Members and Associate Members		Adjustment mechanism Members eligible 2005 (new scale) US$
United States of America		-
Uruguay		1 715
Uzbekistan		-
Vanuatu		-
Venezuela		24 035
Viet Nam		24 035
Yemen		-
Zambia		-
Zimbabwe		-
	Total	11 182 830

Ms AYLWARD (Ireland), speaking on behalf of the European Union, expressed support for the draft resolution. At the previous Health Assembly, the European Union had expressed its strong support for the application by WHO of the United Nations scale of assessments, duly adjusted for differences in membership, and the Health Assembly had adopted resolution WHA56.33, accepting thenceforth the latest available United Nations scale. It was logical, therefore, that the United Nations scale for 2004-2006 should be applied in 2005. The Health Assembly should also accept the proposal that the amounts available under the adjustment mechanism be proportionately reduced, if necessary, as set out in paragraph 13(b) of document A57/23.

Mrs DIALLO (Senegal), speaking on behalf of the Member States of the African Region, said that the adoption of a new scale of assessments by the United Nations General Assembly in December 2003 meant that the commitment outlined in resolution WHA56.33 would come into effect. The countries of the African Region supported the adoption of a revised scale of assessments for 2005 that reflected the latest available United Nations scale, as set out in document A57/23, even though the assessed contributions of some would increase as a result. The principle of solidarity on which any scale of assessments was based should make it possible to reach a consensus. WHO faced unprecedented challenges, and the only way to meet them was to put its finances on a more solid footing by sharing out the financial burden equitably in accordance with different countries' levels of development. The Member States of the African Region invited all delegates to consider the matter from the viewpoint of solidarity and mutual support.

Mr MACPHEE (Canada) expressed support for the Director-General's proposal on the scale of assessments for 2005. There was no reason to depart from the practice established by the Health Assembly in resolution WHA56.33, whereby the specialized agencies used the latest United Nations scale. The scale would next be reviewed by the General Assembly in 2006, when all Member States would have an opportunity to make changes to the method used to calculate the scale.

Mr HE Jinguo (China) said that the scale of assessments adopted by the United Nations General Assembly in December 2003 would result in a large increase in contributions for some Member States of WHO, including China, which would have to pay an additional US$ 2.34 million, the third largest increase after Mexico and the United Kingdom. The WHO Financial Regulations authorized the adoption of the latest United Nations scale; however, WHO had an adjustment mechanism and it was to be hoped that the Health Assembly would bear that in mind. If the Health Assembly decided to apply the new scale, China would not object, but he requested that China's contribution be mitigated in accordance with resolution WHA56.34.

Mrs VALLE (Mexico) recalled Mexico's intention the previous year, when the United Nations General Assembly approved the scale of assessments for 2004-2006, to seek a review of the methods of calculation to ensure a proper reflection of Member States' capacity to pay and avoid sharp increases in contributions, such as the 80% increase being imposed on her country, the greatest increase imposed on a Member State for 2005. Increases should be applied more gradually, and the financial burden distributed more equitably among Member States; under the new scale of assessments, it would be shouldered by only a minority of countries, including her own. Mexico would therefore review the budget in greater detail to ensure that its priority programmes and those of the Region of the Americas were fully implemented. It would also seek to increase the level of allocations to the Region, which had fallen off since the implementation of resolution WHA51.31, so that they more closely reflected the increases imposed by the new scale of assessments.

Mr SAHA (India), supported by Mrs MODISE (Botswana), said that certain aspects of the report and its recommendations were problematic. Automatic application of the United Nations scale of assessments was contentious because the basis on which it was calculated was unclear, especially with respect to the sharp increases in assessments from one period to another. In order for countries to be confident that the increases were justified and that any changes were based on the situation in the countries concerned, the criteria used for calculating the scale of assessments should be made available.

While India had agreed to the adjustment mechanism, there was some lack of clarity concerning appropriations to fund that mechanism. India had made significant financial contributions and noted that a large proportion of the funds available for the adjustment mechanism had been exhausted, mainly by developing countries but also by one major developed country. The suggestion that when the ceiling was reached it should be scaled down proportionately was not necessarily a logical consequence of the decision taken the previous year to appropriate only a specific amount, with no restriction on supplementary appropriations. The matter clearly required thorough debate, although the Health Assembly was not the most appropriate forum for that.

Mr HAMED (Iraq), drawing attention to the problems his country was facing as a result of the prevalent anarchy and the expenditure required to deal with it, said that the previous Government had not taken part in discussions on the scale of assessments or the question of paying off Iraq's arrears. The country's budget was under review, and he would be grateful for any support in helping Iraq meet the health needs of its people.

Mr SOLANO-ORTIZ (Costa Rica) said that his country was one of those affected by an increased assessment. It was a matter for concern that such increases had been combined with a significant decrease in resources for the region, which would have a direct impact on the provision of cooperation programmes and support and advisory services in Costa Rica. The situation was made more difficult by the fact that his country's projects were rarely approved by WHO. Costa Rica would therefore be making a formal request for compensation for the increase in assessments.

Ms WILD (Comptroller) explained that the scale of assessments was calculated in a fully transparent way by the United Nations Committee on Contributions, that the process allowed for full participation by Member States through their representatives and that the records of that Committee were available for consultation, including United Nations General Assembly document A55/11 SUPP, issued at the fifty-fifth session, which gave details of the method and the consequences of its application. Discussions in Committee B would only replicate those of the Committee on Contributions.

Responding to a question from Mr SAHA (India), Mr TOPPING (Legal Counsel) advised that the Committee could either decide whether to approve the draft resolution or postpone its consideration pending further consultation.

Mr SAHA (India) said that, as several delegations had difficulties with the draft resolution, the Committee would be unable to accept it by consensus. Consultation was necessary; if not on the issue of the scale of assessments, it might be deemed unnecessary on other important issues. Other issues also merited further discussion, including the adjustment mechanism and the subject of appropriations. Adopting the draft resolution at the present juncture would deprive the Committee of an opportunity to discuss such issues.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland), supported by Mr MACPHEE (Canada), Mr SAWERS (Australia), Professor PAKDEE POTHISIRI (Thailand) and Mr LOZINSKIY (Russian Federation), expressed support for the draft resolution, which was in accordance with resolution WHA56.33; resolutions on financial matters had always been adopted by consensus.

Ms WILD (Comptroller) recalled that the Health Assembly had appropriated US$ 12.4 million from Miscellaneous Income to meet the costs of the adjustment mechanism, but it had been recognized that the sum would not be sufficient if all the countries entitled to claim under the facility did so. The only alternative to the Director-General's proposal for a pro-rata allocation would be to increase Member States' contributions or to redirect funds from the budget allocated to health technical work. Acknowledging the complexity of the method used to derive the scale of assessments, she offered to clarify matters for any delegation seeking further explanation.

Mr SAHA (India) requested that the item be postponed until his delegation were satisfied that the proposal was soundly based.

The CHAIRMAN said that he took it that the Committee wished to postpone consideration of the draft resolution.

It was so agreed.

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

3. PROGRAMME AND BUDGET MATTERS: Item 16 of the Agenda

Regular budget allocations to regions: Item 16.1 of the Agenda (Documents A57/24 and A57/INF.DOC./4)

Dr NORDSTRÖM (Assistant Director-General) recalled that resolution WHA51.31 contained a request to the Director-General to evaluate the model used to determine regional allocations and to report to the Fifty-seventh World Health Assembly.

Results-based budgeting had been implemented gradually over the past three bienniums, resulting in improved programme budgets, with greater clarity in terms of priorities, Organization-wide expected results and indicators. There was more robust accountability, both in terms of financial and programme results. The report on the programme budget 2002-2003 (document A57/25), to be discussed later, would indicate the actual progress made. The planning process for 2006-2007 had

been strengthened, with an emphasis on consultation and learning from the past. Resources were being targeted where needed by focusing on Organization-wide expected results.

Over the past few years, voluntary contributions had increased in relation to the regular budget. An integrated approach to the budget was necessary, so that the total resource envelope could be examined to ensure an alignment between priorities and resources, be they assessed or voluntary contributions, earmarked or unearmarked.

The Director-General had expressed his commitment to strengthening the Organization at all levels. The decentralization policy was best exemplified by the commitment to allocate 70% of resources to the regional and country levels. Only the previous week, an additional US$ 6 million had been transferred to the regions and countries. The spirit of resolution WHA51.31 nevertheless remained valid – equity in responding to countries in greatest need.

The application of resolution WHA51.31 had addressed some imbalances, but was limited to the regular budget and to the balance of resources between regions, not those between headquarters and regions and countries. A positive trend in decentralization and apportionment of resources at various levels of the Organization had been seen between 1998-1999 and 2000-2001; in 2002-2003, however, the trend had been reversed, and the proportion of headquarters allocations and expenditure had increased. Work to revise that new trend was being undertaken.

The results-based budgeting and management approach needed further development, and priorities had to be guided by clear objectives and expected results. An integrated approach to the budget and to resource allocation was being implemented, which better reflected WHO's financial situation and its capacity to respond to countries' needs. An appropriate mechanism was in place to monitor the allocation of resources by area of work and by level of the Organization, thereby increasing transparency and allowing resources to be allocated in accordance with the targets that the governing bodies had agreed upon. The regional committees should have an even greater role and more opportunities to provide appropriate feedback and guidance on priorities and on the total budget before the Director-General finalized his proposals to the Executive Board and the Health Assembly.

He pointed out that, in the table in document A57/INF.DOC./4, the total expenditure for headquarters and the Eastern Mediterranean Region included substantial funds for the Iraq oil-for-food programme, which partly distorted the picture.

Mr ESPINOSA SALAS (Ecuador), speaking on behalf of the Latin American and Caribbean Group, expressed concern about the decrease in allocations to the Region of the Americas from the regular budget over the past six years, which had resulted in reductions in the Regional Office and in country programmes. The situation was compounded by the fact that the Region received a very small proportion of the extrabudgetary resources raised by WHO. The reduction ran contrary to WHO's objective of allocating 70% of the resources in the 2004-2005 biennium, 75% in 2006-2007 and 80% in 2008-2009 to the regions.

The Region of the Americas supported the idea that the allocation of resources should take account of the needs and priorities of global health. That should enable the Region to receive more resources to combat communicable diseases and prevent and reduce the incidence of noncommunicable diseases. HIV/AIDS needed special attention in various countries of the Region, and the Organization's programmes should have both a regional and country approach. Most countries in Latin America and the Caribbean were experiencing economic crises, which reduced the effectiveness and efficiency of their health systems; the increasing poverty had a major impact on health and, in the long run, on attaining the Millennium Development Goals.

The purpose of resolution CD44.R5 adopted by the Directing Council of PAHO, at the fifty-fifth session of the Regional Committee for the Americas, was to convey its view that the reduction in the regional allocation resulting from resolution WHA51.31 should be implemented over only three bienniums, ending in 2004-2005, and that resolution WHA51.31 should be discontinued by the Fifty-seventh World Health Assembly. The Resolution also called on members of the Executive Board from the Region of the Americas to coordinate a common position with other Regions similarly affected. It further requested the Director of PAHO to transmit to the Director-General the views of the Regional

Committee on the reallocation of resources among regions, particularly with regard to extrabudgetary resources, and expressed concern over reductions in some programme activities caused by the lower regional allocation.

Mr NAKAZAWA (Japan) noted that the model recommended in resolution WHA51.31 had introduced flexibility in budget allocations to regions, whereas they had previously been based on historical precedent. Although the model had been adopted in order to bring about improvements in WHO, the regions had had to struggle to manage programmes with reduced budgets; the reductions had affected basic regional activities such as routine immunization and child health. Use of the model should therefore not be continued beyond the current biennium. In the light of the policy of decentralization from headquarters to regions and countries, allocation rates should apply not only to the regions, but also to headquarters, and programmes implemented at headquarters should be reviewed for effective budget use. As about 60% of the programme was funded by extrabudgetary resources, allocations to regional budgets should also take that revenue into account.

Mrs CISSE WONE (Senegal), speaking on behalf of the 46 Member States of the African Region, noted that paragraph 21 of document A57/24 stated that resource allocation would no longer be guided by the model contained in resolution WHA51.31, but would be based on clear results-based budgeting rather than resource-based budgeting. In resolution WHA51.31, the Health Assembly recalled that equity and support to countries in greatest need were the two basic principles governing the work of WHO. Of the world's 48 least developed countries, 34 were in Africa, and therefore the needs of the African Region were greater than those of the other regions. Furthermore, the burden of diseases such as AIDS, malaria and tuberculosis was much heavier in Africa than elsewhere. The increase in the budget for the African Region resulting from the current model could not therefore be considered unjust; it was simply a reflection of the fundamental principles that underpinned WHO's work. The Regional Committee for Africa, meeting in September 2003, had called for the maintenance of the current model, a call which should be understood in the context of the overwhelming needs of the African Region.

In the interests of consensus, the Member States of the African Region were prepared to consider an adjustment in implementation of the model on the basis of paragraph 21 of the report, while maintaining the fundamental principle of differences in level of development. Instead of relying solely on results-based budgeting, the model should also take into account levels of development. Whatever model was adopted, it should both be effective and help those in greatest need to meet the multiple challenges which they faced.

Mr CONSTANTINIU (Romania) said that, like many countries in the European Region, Romania needed WHO support; however, the Regional Office did not have sufficient financial resources to implement planned responses to the most critical needs. As resolution WHA51.31 had not been fully implemented, European programmes had been deprived, and the principles behind the resolution were being questioned. It was critical to retain those principles and to include all resources, not only the regular budget. In practical terms, the European Region would see a net increase of about US$ 20 million. That would neither solve all the funding needs nor restore equity in the implementation of the resolution, but would at least bring consistency to the way in which WHO allocated resources from an integrated budget to regions and countries. During the previous biennium, 44% of WHO resources had been used by headquarters – a far cry from the 30% objective announced by the Director-General for the current biennium. He urged immediate action to transfer appropriate resources to the regions, in particular the European Region.

Mr SAHA (India) said that the South-East Asia Region was home to 25% of the global population, 40% of the world's poor and 40% of the world's disease burden. It should therefore receive 30% to 40% of WHO's budget: however, it received only 11%. Even excluding the global component on the grounds that it was common to all regions, the Region's share was less than 16%.

The Director-General had been requested in 1998 to present the current Health Assembly with a thorough evaluation of the model adopted that year, and he had looked forward to such an analysis. The current strange formula, which accounted for the inequitable treatment accorded to his Region, was based on the adjusted log population squared method. He asked why such a complex transformation was necessary; it was no basis for determining the needs for assistance in the health sector. Why could allocations not be made according to population-weighted health indicators, to which resource needs were related in a straightforward way? The only reason for using the convoluted model was fear that resources would be deployed mainly for the health needs of a few large countries. A country's resource needs for health care were no different from those for other social sectors, such as education, all of which followed a common sense law of linearity. The formula should therefore be rejected conclusively by the Health Assembly.

It appeared that the Director-General proposed to determine the needs of the various regions and countries and make allocations from an integrated budget on the basis of the results-based approach. Much of the extrabudgetary component appeared to be determined according to the wishes of the donors, which had no obligation to WHO. How was it possible to ensure that their preferences did not override the genuine requirements of health care worldwide? As it would be difficult to ensure that extrabudgetary resources were deployed according to strict health-needs criteria, they should be separated from that part of the budget that Member States were required to contribute and the regular budget should be allocated according to objective criteria, to meet the health needs of all regions.

Regions and countries needed some degree of certainty about the level of allocations. Their determination solely on the basis of a results-based approach would not work in practice and would leave many doubts about fair treatment. It was important to have a predetermined basis for allocations to regions, going beyond 2004-2005, leaving the allocation of extrabudgetary resources to be decided by the donors.

The Director-General had made no recommendation beyond broadly suggesting that the matter be left to him. India considered that the deployment of more resources to the regions would compound the problem if there was no reasonable certainty about the level of allocations. Furthermore, unbalanced distribution of resources would be perceived by many countries and regions as not reflecting their true needs and disease burden. He urged the Director-General to make a proposal for the allocation of resources from the regular budget on a predetermined basis. The uncertainty of extrabudgetary resources would continue to be unavoidable. He welcomed the overall allocation of 70% of resources to the regional and country levels, but the distribution among regions and countries should be determined by the Health Assembly on the basis of proposals from the Director-General.

Dr CICOGNA (Italy), echoing other speakers' views and concerns, said that the report did not present a thorough evaluation of the model, as had been requested in resolution WHA51.31. That resolution had been adopted only after a long debate, with presentations of clear scenarios for different options. It had not yet been fully implemented. Before deciding whether the current model should be discontinued, more information should be provided on what would guide allocations in the immediate future. A new formula or model was needed for the distribution of all WHO funds among the regions. He asked for clarification of the statement in paragraph 21 of the report that resource allocation would be based on clear results-based budgeting that covered both regular budget and extrabudgetary resources. As resolution WHA51.31 had been implemented gradually, he wondered whether its discontinuation would also be gradual.

Mr HE Jinguo (China) welcomed the proposal to reduce the budget for headquarters and to increase the proportion of the budget allocated to the regions to 75% in 2006-2007. He also supported the proposal to introduce a new resource allocation model to cover both the regular budget and extrabudgetary resources, which should be both rational and fair, and either replace or amend resolution WHA51.31. Although the UNDP Human Development Index as a parameter for resource allocation reasonably accurately represented a country's health situation and economic development, the population adjustment factor should be taken out of the calculations, or at least its impact on the

amounts allocated reduced, for the simple reason that the greater a country's population, the greater its need for investment in health. Other indicators of available health resources, such as total health expenditure per capita or the number of hospital beds or doctors per 1000 population, might also be used.

Mr SAWERS (Australia) said that the implementation of results-based budgeting and improvements in WHO's capacity to identify health needs at regional and country levels meant that it was able to identify and prioritize needs and direct resources to them more effectively. Ad hoc arrangements, such as those enshrined in the regional allocation model, were no longer necessary. Where concerns remained about the extent to which priorities were being met, they should be dealt with in the context of the integrated programme budget.

Dr KIM (Republic of Korea) endorsed the views expressed by the delegates of other countries from the Western Pacific Region, and strongly supported the Director-General's commitment to decentralization. The Region had a large population and a rapidly increasing number of people infected with HIV, along with the highest numbers of cases of severe acute respiratory syndrome and avian influenza recorded, yet its share of resources was still relatively low. Its growing needs should be duly considered in allocation of the budget, particularly extrabudgetary resources.

Dr BENJAMIN (Federated States of Micronesia) noted the Director-General's courageous efforts to increase the allocation of resources to the regions. Although he appreciated that initiative, any formula used should be fair, equitable and transparent. The share of resources allocated to the Western Pacific Region had continued to decrease for several years, and that trend should change in the future, given its direct impact on health services. Although financial resources must be directed to priority health programmes and services, they should also be used as an incentive for successful programmes. At times, WHO's resources were not allocated in the best way possible; it seemed that financial incentives were given to programmes or Member States that were not doing a good job, at the expense of those who performed well. The main emphasis in resource allocation should be on results, since WHO had already implemented a results-based budgeting system, and the distribution formula used for resource allocation should be reviewed and assessed, taking into account rapid changes in the health situation of Member States.

Dr ENOSA (Samoa) expressed great concern at the decrease in the amounts allocated to the Western Pacific Region since 2000, from both the regular budget and extrabudgetary resources. The Region urgently needed financial resources, as it was the most highly-populated region and geographically very wide-ranging and, along with the South-East Asia Region, it contained many of the least developed countries. Headquarters was doing its best to help all the regions: however, the reductions in allocations had had a direct impact on achieving the Millennium Development Goals. He requested the Director-General to review the allocation, and to consider increasing the share of the Western Pacific Region from 8.1% to more than 10% from the regular budget and from 3% to between 6% and 8% from extrabudgetary resources.

Mr KOCHETKOV (Russian Federation) observed that resolution WHA51.31 had been intended to establish a system of resource allocation based on the real needs of regions, and had been generally supported as a step forward. Inevitably, the resources allocated to some regions had decreased and those allocated to others had increased, as would happen with any model used. The Director-General's proposal for a results-based approach to budget allocation in place of resolution WHA51.31 was surprising, since there appeared to be no contradiction between them. Either the present model or a similar one must be used. He was prepared to discuss improvements to the existing model, but would continue to support its use until a suitable alternative was devised.

Ms BLACKWOOD (United States of America) said that resolution WHA51.31 had been beneficial for overall equity when adopted in 1998, but it had run its course. However, equity should continue to be a key principle in resource allocation. Given that the budget for headquarters had not been significantly affected by resolution WHA51.31 and that spending at headquarters had continued to increase disproportionately in 2003, she was gratified that the Director-General was addressing the matter and had set goals for the future. She supported his initiative to allocate more resources to countries and regions, provided that the normative functions of headquarters were not disrupted, and expressed satisfaction at the continued integration of WHO resources, including better distribution of voluntary resources in regions and countries. Donors' flexibility to donate to specific countries or purposes should be maintained. All WHO resources should be allocated according to agreed priorities, global public health needs, achievement of results and results-based budgeting and accountability. A focus on results meant that WHO would need to strengthen its monitoring and evaluation systems. Given the different numbers of countries in each region, the shares allocated to individual Member States could vary significantly, and greater equity could be achieved in that respect. The least developed countries should be protected from any decrease in resource allocation. Her Government generally agreed with the approach outlined in the report.

Mr MACPHEE (Canada) endorsed the comments made by the previous speaker. The Assistant Director-General's introductory remarks might usefully be made available to Member States, since they were pertinent and seemed to address many of the concerns raised. Although the model contained in resolution WHA51.31 had been created with the best of intentions, it was obvious from the comments made that it had failed to achieve its aims. However, the development of a new tool, in the shape of the programme budget, provided reassurance that the Director-General would not shoulder the decision-making burden alone. The development of the next programme budget would begin with regional consultations at which countries could discuss the priority issues they wished to be taken into account. Decisions could then be taken in 2005 on allocating the integrated budget, with Member States playing a much more significant role than had been envisaged in 1998, when resolution WHA51.31 had been adopted. The importance of evaluation in ensuring that the programme budget would be an effective tool could not be overemphasized.

Mrs LE THI THU HA (Viet Nam) welcomed the Director-General's commitment to transfer up to 70% of resources to regions and countries by the end of 2004-2005, but expressed concern that the budget allocation to the Western Pacific Region had been substantially reduced, partly as a result of the effects of resolution WHA51.31. The Region had a large population and a heavy burden of both noncommunicable diseases and communicable diseases such as tuberculosis, HIV/AIDS and emerging, hard-hitting diseases such as severe acute respiratory syndrome and avian influenza. More resources were needed and she therefore favoured amending resolution WHA51.31.

She also expressed concern about the modality for distributing extrabudgetary resources to regions. In 2000-2001, the Western Pacific Region had spent only 3.32% of overall WHO "other sources" funds, and in 2002-2003 the figure had been 3.96%. She requested a more equitable, transparent, results-based and needs-based approach to the distribution of those resources in future, so that the Region could receive a larger share in order to help it to meet its countries' requirements.

Mrs FERNANDO (Sri Lanka) supported the policy of decentralization and said that resolution WHA51.31 should no longer be used as a guide for allocating resources. In the interests of solidarity with the African Region, her country had supported the adoption of the resolution in 1998, despite the fact that it drained resources from the South-East Asia Region, but the time had come for a new formula to be devised. She endorsed previous comments that the size of the Region's population should be taken into account. There was merit in the suggestion made by the delegate of India, namely to consider a formula based on population-weighted health indicators.

Dr BALAGUER (Cuba) observed that, when resolution WHA51.31 had been adopted, there had been no other method for allocating resources to regions. It had thus solved a problem at that time. Rightly, the UNDP Human Development Index had been used, and it was not possible to analyse at present whether it had been pertinent. There had been disagreement between Member States when the resolution was first implemented, because certain regions had been affected while headquarters was not, which had seemed inappropriate. An allocation method that satisfied all parties should be sought. The Director-General's proposal to increase funding to regions and countries and decrease the headquarters budget, the integration of the regular budget and extrabudgetary resources, and the allocation of 75% of the budget to regions and countries in 2006-2007 were steps forward. Basing resource allocation on needs, priorities and results provided greater equity than other methods, bearing in mind that the headquarters share would be decreased, funding for regions would be increased and a new method would be used. The Director-General should present a draft resolution to the Executive Board so that the Fifty-eighth World Health Assembly could discuss which method would be adopted. Resolution WHA51.31 would not be abandoned but improved, by using a new method based on the experience gained.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) observed that it was necessary to establish what paragraph 21 of the document meant in practice for the Organization. The shift agreed in resolution WHA51.31 had been seen as a compromise solution for the conditions prevailing at that time. Since then, there had been evidence of further changes that had increased variations between regions, not only through the policy of directing more resources to country level, but also in the balance of resources between voluntary and assessed contributions.

The allocation of resources to the European Region should be in line with the significant variation in health needs of its countries' populations. The health needs of all Member States must be measured by a transparent process, so that resources could be applied fairly across each region in accordance with the principle of "one WHO". As the Organization devoted a high proportion of its resources to the country level, it needed a results-based management process that was open and easily understood by all Member States. WHO should therefore develop guiding principles for the allocation of funds from all sources in order to ensure that support reached those countries in greatest need, and report to the Executive Board in January 2005.

Mrs AUER (France) supported the view expressed by the delegate of Italy that the report did not seem adequately or fully to tackle the problems raised by resolution WHA51.31, which requested the Director-General to present a thorough evaluation of the model for resource allocation to the current Health Assembly. The report simply summarized the financial impact of the model and took note of discussions in the regional committees. Furthermore, it was not necessary to abandon overnight a system that had provided an overall rebalancing of resource allocation to regions, in spite of the fact that four regions had seen their share decrease in absolute terms. The African Region had benefited the most, with four of the other regions experiencing a small decrease in their shares. The European Region had seen its share increase only slightly, and it should be borne in mind that significant changes had taken place in that Region. The proposal in paragraph 21 was not entirely convincing, since the current model was de facto a results-based one and the UNDP Human Development Index, the principal criterion used in the model, had been modified. She therefore joined previous speakers in calling for improvements in and clarification of the model which the Secretariat planned to use in the future.

Dr YOOSUF (Maldives) said that wealth of resources was clearly linked to good health. However, the present WHO formula for regular budget allocations indicated continuing ill-health for the South-East Asia Region. In the past, there had been a lack of transparency in distribution of resources, and he welcomed the move to results-based budgeting, covering both regular and extrabudgetary resources. There should be greater fairness and consultation so that future budgets would be based on the health needs of countries and regions and thus improve global health.

Mr PADMO SARWONO (Indonesia), emphasizing the implications of budget allocations for the delivery of health programmes, noted the substantial decrease in that for the South-East Asia Region since the adoption of resolution WHA51.31. He shared the concern expressed by previous speakers from that Region; a new, transparent and equitable model for allocation of the regular budget should be proposed by WHO.

Mr SELIM-LABIB (Egypt) said that significant improvement was needed in the level of resources committed to the Eastern Mediterranean Region countries, to enable them to meet the serious health challenges facing them, while further developing their health systems. He supported the decentralization policy as an effective means of achieving fair resource allocation between the regions and headquarters, thereby responding to countries' needs. He therefore advocated the preparation of a budget integrating regular budget and extrabudgetary resources which took a results-based approach. The current allocation model was complicated, did not respond to countries' needs and should be reviewed.

Ms ALONSO CUESTA (Spain) agreed with previous speakers that resolution WHA51.31 was not perfect, but that it was an improvement on the previous budgeting approach and should not be abandoned. The search for an improved model should first entail discussions with the regions to establish their needs. To that end, objective indicators were needed. Statistical sources had improved, but were still not sufficiently reliable and timely. As the delegates of Egypt and Japan had stated, regular and extrabudgetary sources should be integrated into such models. She supported the decentralization of 70% of the budget to the regions, but doubted whether such an ambitious target could be achieved, and was afraid that the costs of staff working on country or regional projects would be included in the regional allocation, even if they continued to work at headquarters.

Mr JØRGENSEN (Denmark) agreed that there might be a need to review the current arrangements set out in resolution WHA51.31, but recalled that the present mechanism was the result of thorough consideration in a special group, in the Executive Board and in the Health Assembly; the aim was to replace a discretionary allocation by a transparent and predictable mechanism. It was of paramount importance that any future mechanism should be based on objective criteria and modelled on the current arrangement, as the delegate of the Russian Federation had suggested.

Mr MCKERNAN (New Zealand) concurred with the comments made by the delegate of Japan. He was concerned at the reduction in the regular budget allocations that had occurred in the Western Pacific Region, with a negative impact on the Region's programme activity. Any model for allocation should be based on the principles of need and equity. The current formula had run its course and a new mechanism should be applied. New Zealand fully supported the Director-General's efforts to reduce headquarters expenditure from 44% to 30% of the budget and urged that additional resources thus freed should be allocated to the regions for expenditure on additional programme activity at country level.

Dr TANGI (Tonga) said that the health parameters recommended in resolution WHA51.31 were limited. His small country was proud to have improved its immunization coverage; however, that success had caused Tonga's allocation to be reduced, despite the prevalence of certain noncommunicable diseases. The current criteria should cease to be applied, therefore, at the end of 2005. Even though the Western Pacific Region was the most populous in the world, it received only 3.9% of extrabudgetary resources. Allocation of such resources in future should be more transparent. Tonga wished to see more assessment of the impact of programmes that had received allocations. He approved the Director-General's commitment to reducing the allocation to headquarters to 30% of resources, and would wait with interest to see how the reduction would be effected.

Dr ACHARYA (Nepal) expressed satisfaction at the greater focus on decentralization of resources to the countries and regions. In deciding on allocations, the population factor should be taken into account, as well as the level of poverty and health development in populous regions such as South-East Asia, which needed greater resources to meet their health challenges. In that context, he urged that budget allocations to the Region should be increased.

Mr GUNNARSSON (Iceland) said that he supported resolution WHA51.31; he found it easy to understand both UNDP's Human Development Index and the "logarithmic smoothing" applied to population statistics and found the system transparent. However, circumstances had changed and it was perhaps time to work out a new formula. The demand for funds was greater than the supply and therefore distribution would always be difficult. The essential was to see that fairness and transparency were guaranteed. He fully agreed with the delegate of India that the method used should ensure that each country knew its allocation for the forthcoming period. The Director-General should be requested to develop a new method for calculating allocations and submit it to the Executive Board at its 115th session in January 2005 and then to the Fifty-eighth World Health Assembly.

Ms KONGSVIK (Norway) commended the proposed implementation of programming, budgeting and reporting in accordance with a results-based model. The current model, based on global objectives, gave scant guidance on prioritization in resource allocation. Objective criteria were needed, with approval by the governing bodies. Pending such consideration, apparently the current model would be applied for the forthcoming biennium. She endorsed the views already expressed regarding the need for fairness and transparency; the countries in greatest need should enjoy the highest priority. Why should the population factor be a major issue? WHO was concerned chiefly with capacity building and the provision of technical assistance for that purpose. The least developed countries were the key group – a factor that should be taken into account when elaborating criteria and making allocations.

Dr NORDSTRÖM (Assistant Director-General), responding to questions raised, said that he had noted the request to develop the current model to ensure more efficient use of resources. That was in line with the Secretariat's search for greater efficiency and its drive to achieve a stronger headquarters, as well as stronger regional offices and results in countries. It was not the Director-General alone who determined the needs; there was more of a "bottom-up" approach to planning and identifying requirements, in terms of financial resources and of health needs. Costing was partly based on targets thought to be achievable. Resources previously termed "extrabudgetary" currently constituted more than 60% of WHO's resources and were integrated into the budget. The level of resources was relatively stable. There were 10 to 20 major donors that had provided appreciable financial resources in recent years, and with which valuable discussions were held about improving predictability and aligning resources with the priorities requested by Member States; in fact, the totality of the budget was being discussed with them. Those partners had expressed their wish to work more closely with WHO to ensure that voluntary contributions matched needs, which would allow improved planning and monitoring for both assessed and voluntary contributions. The governing bodies had an important role to play in that context.

With regard to specific figures, the level of the regular budget to which resolution WHA51.31 applied was important for the regions, as it provided stability for the Organization. The amounts for each region were small in relation to total resources over recent bienniums. In the European Region, for example, the need for an additional US$ 20 million from the previous biennium compared with the current one had been mentioned: the target envisaged was to augment resources from US$ 125 million to US$ 158 million, an even greater increase. The Region of the Americas had been disadvantaged by the application of the model and had received few voluntary resources: however, the targets presented for that Region at the Executive Board in January 2004 showed an increase of 92%. Although regular budget allocations had decreased, extrabudgetary resources for the Western Pacific Region had risen

from US$ 35 million to US$ 59 million. Progress was being made in considering all resources within an integrated budget. Member States should be empowered to decide how resources should be spent.

The need for clear criteria and guiding principles for resource allocation had been referred to by Member States, and there was a recognition that the current model was not adequate. His view was that such criteria and principles would not only ensure that resources went to the geographical areas where they were most needed, but also that they targeted the most important health priorities, which were perhaps also political priorities. There were strong commitments to HIV/AIDS and to tuberculosis and malaria; the Health Assembly might wish to indicate other priority areas where it deemed resources to be most needed. Better assessment mechanisms were also needed to make sure that the resources allocated were achieving their ends. There were inequities at present; allocation was not always completely logical, and Member States' input to the discussion was welcome. He was sure that more clear and transparent criteria would be determined as a basis for further discussion.

The CHAIRMAN suggested that the agenda item remain open for further consultation.

It was so agreed.

(For continuation of the discussion and adoption of a decision, see summary record of the fourth meeting, section 3.)

The meeting rose at 12:25.

FOURTH MEETING

Friday, 21 May 2004, at 14:45

Chairman: Dr Jigmi SINGAY (Bhutan)
later: Professor N.M. NALI (Central African Republic)
Dr S. AL KHARABSEH (Jordan)

1. **PROGRAMME AND BUDGET MATTERS:** Item 16 of the Agenda (continued)

Programme budget 2002-2003: Item 16.2 of the Agenda (Document A57/25)

Ms MIDDELHOFF (Netherlands) welcomed the summary report of initial findings, which demonstrated the benefits of results-based management. She encouraged WHO to continue to improve transparency and accountability and increase internal consultations. The lessons learnt should guide all the work of the Organization. The Netherlands looked forward to publication of the full report, to be discussed by the Executive Board at its 115th session.

Ms BLACKWOOD (United States of America), commenting that any budgeting and programming system was an ongoing process, noted that WHO was committed to maximizing the usefulness of its results-based budget and programme management system, and looked forward to receiving the full assessment report in time for the 115th session of the Board.

It was important for WHO to get its expected results and indicators right from the start. Failure to do so could cause problems. The report identified the differences between global and country priorities and between generalized and specific results, and the difficulty of measuring results formulated in abstract terms. It rightly indicated the issues that were critical for Member States, which provided financial resources for the Organization's work. For the United States, those issues comprised having a clear purpose, setting strategic priorities, ensuring integrity and accountability at all levels of resource management, and achieving results. The results should reflect a real improvement in health. Thorough monitoring and evaluation helped in assessing whether that was being achieved, and in building a culture of accountability. The lessons learnt in implementing the programme budget were particularly useful, and WHO should build on them for future budget planning cycles.

Mr MACPHEE (Canada) expressed Canada's strong support for results-based budgeting and congratulated WHO on having pioneered its introduction. It was important to adopt clear baseline data for reference, and to select and refine performance indicators for quantitative assessment of results. The measures planned were encouraging, and he awaited the full report to be submitted to the Board in January 2005 in advance of the session.

Mr SAWERS (Australia) commended the timely release of the report, which should allow any lessons learnt in the previous biennium to be applied in the current one. It would also encourage greater involvement on the part of Member States when the report was discussed by the Board at its 115th session.

Mr LOZINSKIY (Russian Federation), emphasizing the value of the report on performance assessment and the results-based approach, expressed regret that it had not been possible to publish the final version. Ideally, the Health Assembly should have been able to consider it during the current session with the financial reports for the same period. The same view was expressed in paragraph 47

of the report of the External Auditor.[1] He drew attention to the importance of the interrelationship between the different levels of the Organization. The link between strategic and operational planning should be improved, as explained in paragraphs 37 and 38 of the same report.

In the columns showing indicators in the programme budget, the performance of WHO in individual countries could be judged better if countries were mentioned by name. The goals for the previous biennium should also have been stated, rather than the goals for 2010. In addition, expenditure for the previous accounting period should be broken down according to individual goals.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) endorsed the remarks of the delegates of the Netherlands, the United States of America, Canada and Australia, and looked forward to discussions on the full report in the Board at its 115th session.

Mr SAHA (India) said that, having obtained a copy of the initial draft of the full report, he had been impressed by the clear and concise way in which it described the essential features of the programmes and subprogrammes and answered most of the queries a reader might have about WHO. However, it would be helpful to include a glossary of abbreviations.

Ms ALONSO CUESTA (Spain) noted with appreciation the improvements in the programme budget, including the integrated approach to regular and extrabudgetary resources and the greater emphasis on results-based budgeting. However, she would like to see more detail in the indicators and more information about the extent to which individual programmes had achieved the expected results. It would be preferable not to combine activities and programmes. It appeared, for example, that in the biennium 2002-2003 the execution of programmes on immunization, emergency response and health promotion had achieved a level of more than 100%, while those on child and adolescent health, HIV/AIDS and women's health had performed 50% below the budgeted level. However, immunization should be treated as largely a matter of child health, and health promotion activities should be included in the programmes on women's health and HIV/AIDS. Those aspects should be refined in future programme budgets. She also expressed concern that the vertical structure of the programme budget could lead to a duplication of work across the Organization and an inefficient use of resources.

Dr NORDSTRÖM (Assistant Director-General) confirmed that the full report was due to be discussed at the 115th session of the Board in January 2005. He agreed with the delegate of the Russian Federation that it would have been preferable to have considered it in conjunction with the financial report, but the process of developing the systems to do that was still ongoing. However, the draft report was available to Member States, whose comments were invited. Reporting back on the financial outcome at the level of expected results should become possible for the performance assessment report for the 2004-2005 biennium. With regard to the budget's vertical structure, as part of the work on the next proposed programme budget, for 2006-2007, measures were being taken to ensure that there were clear links between different areas of work and that Member States were aware of their complementarity. The lessons learnt in the performance assessment process had been absorbed in the planning stage for 2006-2007.

The Committee noted the report.

[1] Document A57/20.

2. THIRD REPORT OF COMMITTEE B (Document A57/43)

Mrs JAKAB (Hungary), Rapporteur, read out the third report of Committee B.

The report was adopted.[1]

3. PROGRAMME AND BUDGET MATTERS: Item 16 of the Agenda (resumed)

Regular budget allocations to regions: Item 16.1 of the Agenda (Documents A57/24 and A57/INF.DOC./4) (continued from the third meeting, section 3)

The CHAIRMAN said that, in the light of the extensive discussions that had already taken place, the Committee might wish to approve the following draft decision.

> **Decision:** The Fifty-seventh World Health Assembly, after considering the Secretariat's report contained in document A57/24, noting the recommendations contained in paragraph 21 of the report, decided to request the Director-General to develop guiding principles to be applied in the allocation of all resources of funds, taking into account equity and support to countries in greatest need, in particular, least developed countries, and to report thereon to the Executive Board at its 115th session.

Professor PAKDEE POTHISIRI (Thailand) recalled that resolution WHA51.31 requested the Director-General to present a thorough evaluation of the model to the Fifty-seventh World Health Assembly. Document A57/24 did not provide such an assessment.

Two WHO regions had had a substantial increase in their budget allocations for three consecutive bienniums (2000-2005), while four other regions had had their programme budgets reduced. He requested a report to the Executive Board at its 115th session and to the Fifty-eighth World Health Assembly on the performance of the two regions that had seen an increase in their regular budget over the three bienniums, taking account of both budgetary and extrabudgetary funding, and also on the effect of the budget reduction on the performance of the four other regions, as well as the nature of their coping mechanisms, both budgetary and extrabudgetary. Such information would be crucial for a policy decision by the Health Assembly on future regional allocations. There had been some significant cumulative increases in extrabudgetary resources, as indicated in Table 1 of document A57/24, but the Western Pacific Region had received a mere US$ 34 million in 2000-2003. He drew attention to the enormous resources provided by the Global Fund to Fight AIDS, Tuberculosis and Malaria and other global initiatives to combat those diseases. Given the massive flows of resources into some regions, the Health Assembly should question whether programmes were being delivered efficiently and whether they represented good value for money. The four regions whose allocations had been reduced favoured discontinuing use of the model at the end of the six-year period. In the draft decision, he suggested adding the word "regional" before "allocation" and the words "efficiency and performance, as well as" after "equity".

Mr NAKAZAWA (Japan), supported by Dr TAHA BIN ARIF (Malaysia), accepted the draft decision, but, in view of the concerns of Member States, proposed inserting the words "in consultation with Member States and the regions" after "guiding principles".

---

[1] See page 241.

Mr GUNNARSSON (Iceland) said that the Executive Board should have an opportunity to consider the recommendations of the Director-General. He suggested amending the draft decision in that light.

Ms BLACKWOOD (United States of America) said that the Secretariat should look at all the resources, including those allocated to headquarters. She could accept the proposed amendments, apart from the insertion of "regional".

Professor PAKDEE POTHISIRI (Thailand) said that he had no objection to that suggestion.

Mr JØRGENSEN (Denmark) suggested inserting the words "based on objective criteria" after "guiding principles".

Dr NORDSTRÖM (Assistant Director-General) read out the decision, as amended.

Decision: The Fifty-seventh World Health Assembly, after considering the Secretariat's report contained in document A57/24, noting the recommendations contained in paragraph 21 of the report, decided to request the Director-General to develop guiding principles based on objective criteria in consultation with Member States and regions, to be applied in the allocation of all sources of funding, taking into account equity, efficiency and performance, and support to countries in greatest need, particularly least developed countries, and to be considered by the Executive Board at its 115th session.

Mr SAHA (India) asked whether the Director-General would merely be enunciating the principles to be followed, postponing until later a decision on the formula for deciding the precise allocations.

Dr NORDSTRÖM (Assistant Director-General) said that he had noted a general agreement on the need to improve the present allocation mechanism. There was also a need to set clear principles and criteria for allocating resources in specific countries and circumstances. However, it was too soon to say whether the solution would consist of a formula alone or would include some other means of ensuring that WHO was acting in accordance with its priorities.

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

4. STAFFING MATTERS: Item 17 of the Agenda

Human resources: annual report: Item 17.1 of the Agenda (Document A57/26)

Dr YIN Li (representative of the Executive Board) said that the fifth annual report updated the previous report submitted to the Board at its 113th session in January 2004. It provided complete data on WHO's staffing profile as at 31 December 2003, including overall staff numbers and associated costs, and breakdown by age, sex and location, length of service and temporary appointment. Information was also provided on distribution of the workforce by occupational group, internal and external recruitment and national professional officers.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA57(10).

Mr NAKAZAWA (Japan) stressed the importance of equitable representation. Many countries were still unrepresented or underrepresented, and he urged WHO to take steps to improve the situation.

Mr MACPHEE (Canada), acknowledging the well-prepared report, noted with pleasure progress in numerous areas, including geographical representation and distribution by sex. His Government strongly favoured the goal of a 50:50 gender balance throughout the Organization, including at senior levels. Canada was also a strong supporter of multilingualism within the United Nations system, and WHO should pay careful attention to promoting it. The report was a useful tool, providing a statistical basis for improvements in that and other areas. He looked forward to the development of the strategies required, which should be reflected in the objectives set in the programme budget, together with appropriate indicators for evaluating progress in the human resources field.

Mr SAHA (India) referred to resolution WHA56.35 on equitable geographical representation of staff. Significant improvements had since taken place, as shown in paragraph 9 of the report. He asked whether deliberate policies had been adopted to reduce the number of appointments from overrepresented countries, except in the case of special qualifications, while increasing those from underrepresented ones. He did not favour a ban on recruitment from overrepresented countries, but such appointments should require approval at the highest level. He noted the high cost of appointing headquarters-based staff to the regions, and asked whether WHO had any policy on the reappointment of retired staff members as expatriate consultants. In the interest of cost-effectiveness, it would be preferable to give priority to national candidates wherever possible.

Mr SAWERS (Australia) agreed with the views expressed by the delegate of Canada. He welcomed the improvements in geographical representation recorded in the report, as well as the adoption of a comprehensive strategy for improving regional representation and gender balance. WHO should continue to seek ways of improving the numbers of women at managerial level.

Ms AUER (France) agreed with the remarks of the delegate of Canada on multilingualism. WHO ought to be taking that factor into consideration in its recruitment policy, but was not doing so. Indeed, WHO was paying less attention to multilingualism, with severe consequences both for the daily life of the Organization and for the concepts that it was supposed to embody.

Mr HE Jinguo (China), expressing his country's keen concern about the geographical representation of the staff, noted that there were still 12 underrepresented countries and 44 countries that were not represented. In view of the fact that a target had previously been set for 60% of professional staff to be from underrepresented or unrepresented countries, he asked what had been done to meet that target.

Ms BLACKWOOD (United States of America), referring to paragraph 13, noted that in 2003, 30.8% of professional appointments had gone to nationals of unrepresented or underrepresented countries. What was the corresponding percentage for overrepresented ones? She would appreciate having the figure for the year 2003, and suggested that the figure be provided in future reports.

Mr LEE (Republic of Korea) requested information on measures taken to improve geographical distribution and gender balance.

Dr NORDSTRÖM (Assistant Director-General), responding to delegates' remarks, said that the report should be considered in the broader context of the priority currently being given to staff and human resources, as they were the key to implementing a results-based management policy. Various reforms were under way, including the introduction of a competence module to be used for

recruitment; a long-term planning system for human resources; greater investment in staff development and learning, including a programme for management and leadership development; the piloting of rotation and mobility; and greater investment in performance assessment of individual staff members, linked to the work of the Organization as a whole.

In reply to the question by the delegate of India, he said that in general WHO did not reappoint retirees except in special circumstances. With regard to the balance between national and international staff, he said that, given that WHO was an international organization, requiring both integrity and certain competences from its staff, it needed international staff but was encouraging rotation and mobility in order to maximize the spread of knowledge within the Organization. Within countries, international staff were needed for certain duties, especially in financial management. It was a matter of striking a balance between cost and what the Organization hoped to achieve.

Mr NOLAN (Recruitment, Placement and Classification), responding to specific questions, said that a report on recruitment strategy integrating gender and geographical balance had been submitted to the Executive Board in January 2004.[1] The strategy was set out under four broad headings: forecasting human resources needs; reaching out; investing for the future; and strengthening the organizational context for diversity. Forecasting called for an improvement in the planning of human resources within the Organization; that had been started by introducing a more comprehensive form of human-resources planning into the 2006-2007 proposed programme budget process. Reaching out meant broadening the sources of recruitment, which was being done through contact with the WHO collaborating centre network, schools of public health, nursing associations and other health-related associations. In addition, in response to a suggestion made at the Board, permanent missions in Geneva had been approached for help in bringing vacancy notices to wider audiences. WHO had also entered into a trial relationship with the world's largest online recruitment database in search of nationals from underrepresented countries. The Director-General also sought to identify possible candidates when he visited those countries. He also considered personally all recruitment of nationals from overrepresented countries.

With regard to investing for the future, a mobility and rotation scheme was under way, a staff development and learning fund had been initiated and a review of young-professional schemes had been undertaken, with a view to making more considered use of internships as possible sources for new recruits. In the fourth area, strengthening the organizational context for diversity, the Director-General had established targets that he had conveyed to the Regional Directors, reflecting the targets set for the Organization as a whole in resolution WHA56.35.

A more detailed report would be submitted to the next Health Assembly on progress made in implementing the human resources strategy, incorporating the suggestion made by the delegate of the United States of America to include data on the number of nationals recruited from overrepresented countries in 2004.

Dr AHSAN (Bangladesh) asked for clarification about what action was being taken to increase recruitment from underrepresented or unrepresented countries.

Mr HASHMIR (Pakistan) asked how the range was calculated. In the Region of the Americas, for instance, three countries were unrepresented and one underrepresented, and yet they were still considered to be within the desirable range.

Dr NORDSTRÖM (Assistant Director-General) replied that the question of representation was being taken extremely seriously. The Organization needed the best possible level of competence, but also recognized the value of diversity in terms of both languages and geographical background.

---

[1] Document EB113/18.

Because it was difficult to locate the right kinds of competence, WHO was in dialogue with several countries, with a view to helping the best candidates in underrepresented countries to apply.

Mr SAHA (India) said that India was keenly aware of the need to recruit only competent people. There was a feeling in many developing countries that competence was compromised by trying to fill the large numbers of staff posts allotted to developed countries. Able candidates from underrepresented countries were not being appointed as often as they should, because there seemed to be a link between a country's representation and its contributions.

The Committee took note of the report.

Appointment of representatives to the WHO Staff Pension Committee: Item 17.3 of the Agenda (Document A57/27)

The CHAIRMAN invited the Committee to appoint one member and one alternate member to the WHO Staff Pension Committee in accordance with the rotational schedule explained in document A57/27. In the absence of objections, he would take it that the Committee wished to convey the following draft decision to the plenary:

> **Decision:** The Fifty-seventh World Health Assembly appointed Dr J. Larivière, delegate of Canada, as a member of the WHO Staff Pension Committee, and Dr A.A. Yoosuf, delegate of Maldives, as an alternate member, the appointments being for a three-year period. It nominated Dr L. Waqatakirewa, delegate of Fiji, to replace Mr L. Rokovada for the remainder of the latter's term of office, namely until May 2005.

The draft decision was approved.[1]

Professor Nali took the Chair.

5. LEGAL MATTERS: Item 18 of the Agenda

Agreement with the *Office International des Epizooties*: Item 18.1 of the Agenda (Documents A57/28 and A57/28 Add.1)

Mr HASHMIR (Pakistan) pointed out that the first paragraph of document A57/28 referred to the *Office International des Epizooties* as an intergovernmental organization having 165 member countries. It was in fact an international organization, did not have 165 members, and furthermore one of its members was not a sovereign State as defined in the WHO Constitution. Supported by Ms GONZÁLEZ FRAGA (Cuba), he said that document A57/28 should be amended accordingly, and in the annexed Agreement the term "Member Countries" should be replaced by "Members".

Mr NAKAZAWA (Japan) said that zoonotic diseases such as bovine spongiform encephalopathy, severe acute respiratory syndrome and avian influenza were becoming a threat to human health. Having suffered the health and socioeconomic impacts of those diseases in recent years, Japan welcomed the close collaboration between the two organizations.

---

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as decision WHA57(11).

Dr BODZONGO (Congo) recalled that, in the past three years, his country had suffered three epidemics of Ebola virus haemorrhagic fever, often originating from human contact with animals found dead in the forest. Although the human epidemic had been halted, animals were continuing to die in the forests of the western Congo basin. That was a matter of grave concern, as the people living in that area subsisted only from hunting. His country therefore welcomed the agreement between the two organizations and its consolidation. Paragraph 2 of document A57/28 could have included a reference to Ebola virus haemorrhagic fever.

Mr TOPPING (Legal Counsel) took note of the observations made about the status and membership of the *Office International des Epizooties*. A revised version of document A57/28 would be issued.[1] As for the proposed amendment to the Agreement itself, he suggested that time would be saved if the operative paragraph of the draft resolution contained in document A57/28 Add.1 were amplified by the phrase: "subject to replacement of 'Member Countries' by 'Members' wherever this phrase appears." The Secretariat would then contact the *Office International des Epizooties* in order to revise the Agreement accordingly.

Ms BLACKWOOD (United States of America) said that she could not yet agree to the suggested amendment. She proposed leaving the matter in abeyance until later in the meeting.

It was so agreed.

Rules of Procedure of the World Health Assembly: amendment to Rule 72: Item 18.2 of the Agenda (Resolution EB112.R1; Document A57/29)

Dr FALL (Senegal), speaking on behalf of the African Region, recalled that its 46 Member States had previously suggested that the Director-General should be elected by a qualified majority of two thirds of the Health Assembly. Such a change would reconfirm the position of the Health Assembly as WHO's supreme body, with the mandate to ratify the important decisions of the Executive Board. It would also redress the balance between the Health Assembly and the Board, and would place the election of the Director-General on the same level as the adoption of conventions or agreements, amendments to the Constitution, or budgetary decisions. At the same time, the Director-General would enjoy greater legitimacy and authority, both of which were necessary for the correct performance of his duties. The African group of countries unreservedly supported the proposed amendment to Rule 72.

The CHAIRMAN invited the Committee to approve the draft resolution.

The draft resolution was approved.[2]

Dr Jigmi Singay resumed the Chair.

6. COLLABORATION WITHIN THE UNITED NATIONS SYSTEM AND WITH OTHER INTERGOVERNMENTAL ORGANIZATIONS: Item 20 of the Agenda (Document A57/31)

Mr MACPHEE (Canada) said that he was encouraged by the positive steps taken by WHO to work closely with other organizations in the United Nations system. There was a great need to resist

---

[1] Document A57/28 Rev.1.

[2] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA57.8.

"mandate creep", and Canada was working with other donor countries to ensure better coordination by donors with agencies and on the ground. The issue of HIV/AIDS was so important that effective coordination within the United Nations system was absolutely essential, to prevent unnecessary competition for funds or for pre-eminence in that issue. Canada welcomed the collaboration by WHO with UNAIDS, and it also wholeheartedly supported the work of the Global Outbreak Alert and Response Network in dealing with emerging and new communicable diseases.

Mr BURKART (IAEA) said that, while the Agency had been widely recognized for its work in verifying international safeguards agreements, it was less well known for its statutory objective of accelerating and enlarging the contribution of nuclear applications to peace, health and prosperity. The Agency contributed to sustainable development through its programmes on human health, food and agriculture, water resources and protection of the environment. It was also the only international organization authorized by statute to establish standards of safety for the protection of health from the effects of ionizing radiation, some of which had been cosponsored by WHO.

The Agency had worked with WHO since 1959, and cooperation continued to grow. It wished in particular to contribute to the issue of cancer. In 2003, against a background of high and increasing rates of cancer in the developing world, WHO and the International Union Against Cancer had issued a call for concerted action by all sectors to prevent and control cancer throughout the world. The Agency had been developing its Programme of Action for Cancer Therapy, which was predicated on the fundamental role of radiation therapy in cancer treatment and its favourable cost-effectiveness ratio. Developing countries needed help to develop their radiotherapy techniques and integrate them into their cancer control programmes. Under the Programme, expertise and equipment would be transferred to them.

In the field of nutrition, WHO and the Agency were cooperating in the preparation of a strategy to reduce low birth weight in developing countries, and in the use of isotope techniques in nutrition intervention programmes related to HIV/AIDS in Africa. In the fight against malaria-transmitting mosquitoes, the Agency was conducting research into the use of the sterile insect technique. It continued to work with a number of agencies, including WHO, to create zones free from tsetse flies. In developing countries limited resources must be used to the best effect, and the Agency stood ready to support WHO with the technologies at its disposal.

Dr NYENZI (WMO) said that his Organization contributed to the welfare of humanity by providing weather-related and climate-related information and products. In addition, it monitored greenhouse gases, aerosols, other pollutants and long-term atmospheric changes. An ongoing challenge for the international community was to ensure that all countries had access to information and communication techniques to enable them to benefit from advances in applying information about weather and climate. He outlined the many different ways in which climate and climate extremes affected human health, noting that climatic variation could have a profound impact, for example by affecting the spread of vector-borne diseases or the quality of air in urban environments. The importance of the link had been emphasized in a working arrangement between WHO and WMO approved at the Fifth World Health Assembly in 1952. That collaboration had proved to be very useful, for example, during the 2003 heat wave in Europe. WMO appreciated its existing collaboration with WHO, and wished to see it continue to prosper.

Warning systems were being developed for use by national meteorological services, in collaboration with the health sector, to provide public warnings of coming heat waves. Other examples of collaboration between the meteorological and health sectors included warning systems in cities to alert vulnerable communities to impending climate-related disasters. WMO was expanding its knowledge, in partnership with WHO, of the effects of climate variability and climate change on human health, through workshops organized in different parts of the globe.

In the area of malaria prevention, early-warning systems relied heavily on climate input to help the health sector prepare for anomalous patterns of climate-related disease outbreaks.

The Committee took note of the report.

7. POLICY FOR RELATIONS WITH NONGOVERNMENTAL ORGANIZATIONS: Item 21 of the Agenda (Decision WHA56(10); Document A57/32)

Dr YOOSUF (Maldives), speaking on behalf of a representative of the Executive Board, said that, in accordance with decision WHA56(10), the Board at its 113th session had reconsidered a proposal for a policy for relations with nongovernmental organizations. Before a discussion by the full Board, it had been decided that the interested Board members should meet informally with a view to reaching a consensus on suggested amendments to the proposal. Reporting to the Board, the facilitator of the informal meetings had said that, although the atmosphere had been constructive, it had not been possible to reach a consensus, as some amendments warranted fuller consideration and consultation. The Board had concurred with that view and had decided to request the Director-General to convene a consultation mechanism and report on the outcome to the Fifty-seventh World Health Assembly. In early February 2004, Member States had agreed on the text of a draft resolution and policy, as set out in document A57/32, although, despite extensive discussion, it had not been possible to reach a consensus on the wording in paragraph 5 of the draft resolution and in paragraphs 9, 14, 17 and 18 of the draft policy.

Mr M.A. KHAN (Pakistan) suggested that the brackets around the word "consistent" in paragraph 9 of the draft policy should be removed. Article 71 of the WHO Constitution clearly stated that "the Organization may, on matters within its competence, make suitable arrangements for consultation and cooperation with nongovernmental international organizations and, with the consent of the Government concerned, with national organizations, governmental or nongovernmental". Similarly, in paragraph 14, a choice must be made between the two bracketed texts, or between both of them and the footnote, in order to bring out the meaning that all collaboration on policy should be in consultation with the governments concerned.

Ms GONZÁLEZ FRAGA (Cuba) pointed out that the guidelines to govern the relations of WHO with nongovernmental organizations had still not been clearly defined. Cuba appreciated the excellent contribution of nongovernmental organizations to the work of WHO, but considered that the item should not be decided without a thorough evaluation of all the consequences of any change, and in particular without a clear definition of the guidelines governing the new relationship. The present system of relations with nongovernmental organizations, while it might have limitations, had been working well. Any change would entail challenges that would need to be evaluated carefully, and it would be advisable to allot the necessary time to the task. For those reasons, she suggested that the matter should be deferred until the Director-General had submitted clear guidelines to the Executive Board at its 115th session. She did not consider it appropriate to include in the resolution questions relating to the interaction of WHO with commercial companies. In line with Article 71 of the Constitution, collaboration with nongovernmental organizations should take place solely with the consent of the Government concerned. She suggested that the Board's Standing Committee on Nongovernmental Organizations should report to the Board on the updated list of nongovernmental organizations in relationship with WHO.

Mr MACPHEE (Canada) said that Canada had consistently favoured revising WHO's policy on relations with nongovernmental organizations, but in a way that would bring about greater flexibility and be in tune with the evolving role of nongovernmental organizations in the health sector. While the negotiations had resulted in progress in many respects, there were still some parts of the text that Canada could not accept, because they would make the current policy more inflexible and the Organization less open to nongovernmental organizations. He pointed out that the report of the United Nations Secretary-General's panel of eminent persons on civil society and relationships of the United Nations with it, which might provide inspiration and guidance to WHO's efforts in that area, was due to be released in a month's time.

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland), recalling her country's support of the revised policy submitted to the Executive Board in January 2004, said that her delegation had since then been involved in lengthy negotiations to resolve the outstanding issues for the sake of consensus.

In paragraph 9 of the draft policy, she suggested deleting any further references to Article 71 of the WHO Constitution simply because paragraph 1 clearly stipulated that all arrangements would be subject to Article 71. She likewise suggested deleting all text between square brackets in paragraph 14, and the bracketed paragraphs 17 and 18.

Ms ALOPAEUS-STÅHL (Sweden) said that her country was known for its open relationship with nongovernmental organizations. Although she considered it unnecessary to include a rule on consulting with national governments on the relations between local nongovernmental organizations and international organizations, Sweden would, as a member of an intergovernmental organization, always comply with WHO rules.

Mr YANG Xiaokun (China), welcoming the contribution of nongovernmental organizations to the health and well-being of the world's peoples, said that his country had actively participated in reviewing the policy and had made constructive suggestions. Document A57/32 was therefore the fruit of those consultations. He considered that paragraphs 9 and 14 of the draft policy were similar and, having probably been extracted from the WHO Constitution, should be retained. He disagreed with the proposal by the delegate of the United Kingdom to delete paragraphs 17 and 18, which he considered important. Furthermore, other entities had a policy provision similar to that contained in paragraph 17, including the United Nations Economic and Social Council. Paragraph 18 covered the Director-General's report to the Executive Board on WHO's cooperation with other organizations, on which point he argued that Member States were entitled to receive information on cooperation between WHO and nongovernmental organizations.

Mr HOHMAN (United States of America) said that his country had been actively engaged in the discussions following the Board's session in January 2004 with a view to reviewing the policy on collaboration with nongovernmental organizations. Much progress had been made and only a few difficulties remained, as reflected in the bracketed texts. He consequently endorsed the proposals made by the delegate of the United Kingdom regarding the deletion of that text in the document. A few months earlier, he had proposed a simple formulation of paragraph 9 to read: "Regional committees shall be responsible for decisions regarding the accreditation to them of nongovernmental organizations". He supported the comments of the delegate of China on the importance of the Director-General reporting to the Board on implementation of the collaboration policy, and his country would be flexible on the alternatives proposed in paragraph 18.

Ms MIDDELHOFF (Netherlands) endorsed the proposals made by the delegate of the United Kingdom, adding that careful consideration should be given to the criteria used for accrediting nongovernmental organizations. She observed, however, that the ultimate goal was to foster constructive and effective collaboration between WHO and nongovernmental organizations.

Dr BRONNER (International Special Dietary Food Industries), speaking at the invitation of the CHAIRMAN, expressed her appreciation for the United Nations community's recognition of the nongovernmental organizations representing industry as important stakeholders and partners, adding that such entities offered a valuable source of knowledge, technology and resources. She affirmed her organization's commitment to further collaboration with WHO and its willingness to improve nutritional health by sharing scientific expertise and research.

WHO's policy on relations with nongovernmental organizations should be based on two principles: non-discrimination to ensure equal treatment of all nongovernmental organizations; and

transparency and accountability to ensure that all nongovernmental organizations adhered to the same high standards to avoid potential conflicts of interest.

For the sake of clarity, precision and transparency and to avoid any misinterpretation, she recommended that all ambiguous language regarding nongovernmental organizations' implementation of resolutions should be clarified. WHO resolutions were recommendations to Member States, and nongovernmental organizations should not, in their capacity as third parties, be seen as arrogating their authority. She also suggested deleting any language implying that WHO held nongovernmental organizations responsible for the actions of individual members possibly acting on their own behalf.

As public-private partnership would continue to be crucial to delivering positive outcomes in public health, WHO must ensure that its policies recognized and treated all nongovernmental organizations equally.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, the People's Health Movement and the International People's Health Council, welcomed the policy review, initiated two years earlier by the Civil Society Initiative. She was pleased that the review emphasized three main areas identified by public-interest nongovernmental organizations: the underrepresentation of civil society organizations from the south and east at meetings of WHO governing bodies; the need to review and improve mechanisms to guard against conflicts of interest in WHO's interactions with commercial interests; and the request that any or all business-linked organizations be classified as the private, for-profit sector rather than the civil society/nongovernmental organization category.

Satisfactory progress had been made in the first area. In the matter of safeguards, she urged Member States to remove all bracketed text in the proposed resolution. Regarding the third area, the policy continued to identify commercial entities positively as nongovernmental organizations. That would make it difficult for Member States to safeguard the integrity of WHO and protect it from the undue influence of business interests.

The draft policy shied away from what could have been an important contribution to building WHO mechanisms for detection and proper management of conflicts of interest. Moreover, it ran counter to the existing criteria for the admission of nongovernmental organizations into official relations, specifying as they did that the activities of those organizations should concentrate on development and be free of commercial interests.

Regarding concerns expressed about discrimination against business entities not classified as nongovernmental organizations, she recalled the guidelines for relations with commercial enterprises that had been introduced by the Executive Board at its 107th session, with their singling out of "associations representing commercial enterprises" and "foundations not at arm's length from their sponsors". Those definitions could be made more inclusive. In the interest of democratic governance, the accreditation of not-for-profit organizations that represented or were closely linked with commercial interests should not be automatic. That matter could be further addressed in broad, public discussions.

Dr BALE (International Federation of Pharmaceutical Manufacturers Associations), speaking at the invitation of the CHAIRMAN, said that he represented a non-profit nongovernmental organization working in the public health interest, with more than 30 years of official relations with WHO. Representing the research-based pharmaceutical industry, but also a number of companies producing generic and self-medication products, his Federation had played a significant role in facilitating cooperation between WHO, other United Nations organizations and agencies, and pharmaceutical companies. It was a co-founder of major public-private partnerships involving WHO and the pharmaceutical industry, such as the Global Alliance for Vaccines and Immunization and the Medicines for Malaria Venture. As a legitimate representative of an important stakeholder, the Federation had always been a transparent, non-profit nongovernmental organization involved in discussions with WHO.

The private sector, and the pharmaceutical companies in particular, played an increasingly important role in global public health, contributing invaluable resources, expertise and know-how for its improvement worldwide. In the area of HIV/AIDS, the private sector had contributed significant resources to developing new medicines and vaccines to fight the disease and accelerating access to existing therapies in developing countries, currently reaching over 150 000 patients in Africa alone.

The need for close collaboration between WHO and the Federation was obvious in the provision of vaccines for poliomyelitis eradication and medicines to fight leprosy, trachoma, mother-to-child transmission of HIV and many other diseases and conditions.

Millions of people had benefited directly and indirectly from those programmes, and the pharmaceutical industry was responsible for developing the vast majority of life-saving vaccines and medicines so far developed.

It was in the interest of public health and of WHO to promote alliances with the pharmaceutical industry. The issue of what form such collaboration would take should not hinge on a private-sector versus public-sector dichotomy. Rather, the issue was how to strengthen partnerships to fight diseases. Transparency, not exclusion, was the solution. He condemned the false distinction that had been made between public interest and so-called "business interest" nongovernmental organizations, which would only cause confusion. He noted the excellent work done by the World Health Professions Alliance, the International Council of Nurses, the World Medical Association and the International Federation of Pharmacists in support of WHO goals. His Federation was not a business but a non-profit nongovernmental organization that represented biomedical innovation for patients. He looked forward to continuing productive collaboration with WHO for the benefit of people worldwide.

Mrs OULTON (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that she represented six health professional organizations – the International Confederation of Midwives, the International Council of Nurses, the International Pharmaceutical Federation, the World Confederation for Physical Therapy, the World Dental Federation and the World Medical Association – which worked closely with WHO. They contributed technical and policy advice, financial and human resources to projects, acted as advocates for WHO and disseminated information on its behalf. They were committed to effective, efficient and transparent governance and had supported a modern, streamlined system of accreditation from the outset. On several occasions, they had requested that health professionals' associations should be categorized separately from other nongovernmental organizations and had called for more regular consultations between WHO and such entities. WHO policy could not be effectively implemented without the support of health professionals.

She expressed concern that the current proposal was more restrictive than those reviewed over the past year. The policy and report addressed administrative processes only, thereby creating more work for nongovernmental organizations and more rules for WHO.

The case for international accreditation had been made, but several questions surrounded regional accreditation. For instance, if a problem occurred within a country, it seemed that WHO was intending to hold the international or regional group accountable, which was unfair. She considered the wording of paragraph 13 of the draft policy unclear and requested clarification on a possible appeal process.

The CHAIRMAN invited the Committee to postpone consideration of the policy to give the Director-General more time to consult with all interested parties with a view to reaching a consensus. In response to Mr HOHMAN (United States of America), he confirmed that the matter would be submitted to a future Health Assembly through the Executive Board.

It was so decided.

8. LEGAL MATTERS: Item 18 of the Agenda (resumed)

Agreement with the *Office International des Epizooties*: Item 18.1 of the Agenda (Documents A57/28 and A57/28 Add.1) (resumed)

Mr HOHMAN (United States of America) said that his delegation was able to accept the proposed amendment to the draft resolution contained in document A57/28 Add.1, namely to replace "Member Countries" with "Members" throughout.

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

Dr Al Kharabseh took the Chair.

9. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda

Quality and safety of medicines: regulatory systems: Item 12.12 of the Agenda (Document A57/15)

Ms NELLTHORP (United Kingdom of Great Britain and Northern Ireland) welcomed WHO's continued focus on medicines policy and its emphasis on access to high-quality medicines, including those for HIV, tuberculosis, malaria and other high-priority diseases. Her country strongly supported WHO in its key role of promoting the rational selection and use of safe, effective, and quality-assured medicines. As noted in the report, ensured access to quality medicines called for an adequate drug regulatory capacity; that function needed to be strengthened in many countries. There, too, WHO had a key role to play, including the issue of appropriate guidelines such as the United Nations Pilot Procurement, Quality and Sourcing Project.

Dr KASAI (Japan) said that Japan highly commended WHO's role as a liaison body among drug regulatory authorities from developed and developing countries. It supported the three main frameworks of recommendations made at the Eleventh International Conference of Drug Regulatory Authorities (Madrid, 16-19 February 2004) which should be fully implemented. Japan had contributed to WHO projects to combat counterfeit medicines and promote good manufacturing practice, and had provided bilateral training programmes for drug regulators and inspectors, stressing that compliance with good manufacturing practice was a prerequisite for access to quality medicines. Given its experience of fast-track approval for "orphan" medicines, Japan welcomed the discussions held at the Conference on the need for a suitable development mechanism; it was also interested in the discussions launched by the Commission on Intellectual Property Rights, Innovation and Public Health. Japan wanted good clinical practice, which it had made a statutory requirement in pharmaceutical matters, to be widely promoted in Member States. WHO should support the establishment of an effective drug regulatory system, and continue to be an interface for drug regulatory authorities through the International Conferences of Drug Regulatory Authorities.

Mrs MODISE (Botswana) agreed that regulatory authorities should cooperate in strengthening regulatory systems to ensure that the manufacture of, trade in and use of medicines were controlled in a way that promoted and protected public health. In Botswana, the quality and safety of medicines came under the Drugs and Related Substances Act and complied with the national drug policy, which governed drug registration as a precondition of marketing, in addition to trade, control and inspection,

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA57.7.

laboratory testing, post-marketing surveillance and the approval and monitoring of clinical trials. She welcomed the report.

Mr SEKOATI (South Africa) said that his Government had noted the steps taken by WHO to help Member States to close the regulatory gaps existing in various countries. Different regulatory models existed around the world, reflecting the size of the relevant pharmaceutical market, availability of resources and public health issues. WHO had played a significant role in promoting the harmonization initiatives of different regions. South Africa supported that work and called on Member States to facilitate implementation of guidelines and establish appropriate structures. It continued to support WHO's role in global standard-setting and its steps to improve the quality of medicines. It urged WHO to disseminate information on counterfeit and substandard medicines, with a view to a swift reduction of potential risks. It called for a partnership to combat counterfeits and for heightened efforts by WHO to promote and monitor safety in medicines, including antiretroviral agents, by assisting countries in integration of pharmacovigilance. WHO was urged to take the lead in ensuring that clinical trials, particularly in developing countries, met the standards of good clinical practice, and to step up efforts to support the introduction of national measures to control and regulate complementary and traditional medicines. Given the changed global pharmaceutical landscape, access to safe, good-quality medicines must be strengthened with a view to achieving maximum benefit at affordable cost.

Dr QI Qingdong (China) endorsed the report. China was ready to cooperate with WHO, regional organizations and Member States' regulatory authorities; and it was keen to apply regulatory strategies in order to safeguard the quality of medicines, to step up clinical research on the testing of new medicaments, to monitor marketing and to carry out quality control with a view to ensuring the application of universally recognized standards, thereby improving the efficiency of medicines.

Dr KRIT PONGPIRUL (Thailand) strongly supported the report but had two comments. First, a targeted standard of medicine quality, although crucial, should be applicable to the context of each country and not used as a barrier for generic drug manufacturing. Secondly, although improved quality might result in a higher price, value for money should be maintained and low-income groups should not be denied access to such medicines. Improved regulatory systems would, it was hoped, eventually eradicate both bad medicines and bad use of medicines.

Dr AGARWAL (India) said that successful health-care delivery depended on availability of safe, efficacious and high-quality medicines. His Government's policy sought to ensure that availability, at reasonable prices, tightening the quality control of drug production and promoting rational use of drugs, thus fostering a climate for further investment in the production of new technologies and new drugs. The report highlighted the need for international cooperation and harmonization, and the potential enabling role of a drug regulatory agency. In India, various initiatives had been taken recently to upgrade the regulation of medicine quality, safety and efficacy, including a project, with World Bank assistance, to establish a nationwide pharmacovigilance programme. Quality of medicinal products was intrinsically linked to good manufacturing process, which required updating from time to time. In India, the good manufacturing practice schedule had been improved, to include measures such as stricter environmental control. The schedule of the Drugs and Cosmetics Act had likewise been completely overhauled. That and other measures would complete a major phase of the Government's initiative.

Mr KYEREMATENG (Ghana) said that, as a developing country, Ghana recognized the importance of networking and cooperation among regulatory authorities. To that end, its drug regulatory authority, the Food and Drugs Board, had attended the African Drug Regulatory Authority Network meeting held in Hong Kong in June 2001 during the Tenth International Conference of Drug Regulatory Authorities, which had been followed by a successful subregional meeting in Ghana in

December 2002. Various harmonization efforts had been made by the then West Africa Pharmaceutical Federation. In addition, a binational fast-track approach had facilitated various meetings between Ghana's Food and Drugs Board and Nigeria's National Agency for Food and Drink Administration and Control. The meetings had been attended also by representatives from Chad, Côte d'Ivoire, Sierra Leone and Togo, with a mission to integrate and harmonize the various drug regulatory activities through exchange of information, coordinated programmes and sharing of resources. One strategy was to build the capacity of drug regulatory authorities through subregional training in good manufacturing practice, pharmacovigilance, evaluation, registration and inspection. Proposals would be submitted to the West African Health Organization accordingly.

Dr MAHJOUR (Morocco) said that, given its policy of improving access to high-quality medicine, Morocco had strict rules for production in keeping with universally accepted standards. The output of 34 pharmaceutical companies supplied 70% of national requirements. The relevant national legislation had three complementary components: the systematic monitoring of all medicines in the country; a systematic registration system; and a pharmacovigilance system that embraced all national participants in the public and private sectors. He encouraged WHO to disseminate information not only on all poor-quality medicines, but also about where good products could be acquired.

Ms MAHLANGU (Zimbabwe) said that her country particularly appreciated the sterling work of WHO in setting standards for medicine quality, safety and efficacy. It applauded WHO's efforts in support of the prequalification process, and trusted that other regulatory agencies would find it equally helpful. She noted WHO's intention to address the regulatory capacity gap in developing countries for assessing medicines for diseases with a marked effect on the population; it was hoped that the developing countries' regulatory agencies would be appropriately involved so as to acquire sufficient capacity, thereby helping to close the gap. She asked for assistance to Member States in promoting national quality-control laboratories.

Mr HAN Sok Chol (Democratic People's Republic of Korea) expressed pleasure that WHO had launched the pharmaceutical strategy and made progress in its implementation. However, the goal of ensuring access to essential medicines of guaranteed quality, safety and efficacy, and achieving their rational use, was far from being attained. Member States must draw up and implement pharmaceutical policies that took account of the countries' respective economic, social and political characteristics. In recent years his Government, having encountered difficulties in providing medicines and medical care, had devoted particular attention to traditional, or koryo, medicine. It was important to engage in scientifically-based therapeutical practices, combine traditional and modern medicine, and establish the scientific basis of popular therapies. WHO should continue to apply its strategy on traditional medicine, and do more to encourage scientific and technical cooperation, regionally and internationally.

Dr ABREU CATALÁ (Venezuela) said that her country was striving to apply best manufacturing practice as part of its policy of access to medicines, and to recognize the efforts of other developing countries to produce their own medicines, with a view to promoting technology in those countries. It supported the modernization of national regulatory systems, which meant making use of all possible strategies to ensure best practice in manufacturing, clinical practice, raw material monitoring and other relevant fields. That called for improved legal measures, better-trained human resources and, when necessary, the setting up of international collaboration and surveillance networks. Venezuela was striving to develop and implement regulatory concepts and principles. However, national regulatory systems had to relate to the national policy of access to medicines, particularly in the developing countries. Therefore, rather than aiming for conformity to international standards which might be at variance with a national health policy or be influenced by commercial interests, WHO should focus on appropriate technical standardization enabling Member States, especially the developing countries, to enhance their own technical ability to monitor quality of medicines and

thereby safeguard health. Establishing best practice would require investment, which for some developing countries might mean diverting funds from other objectives. There was also the need to avoid divulging to third parties information that might fall into the hands of competitors or sow doubts among potential users.

Ms AUER (France) supported any steps towards regulation to uphold the quality and safety of medicines – an aim reflected in the agreement on cooperation signed by France and WHO in November 2003, which reflected France's adhesion to the principle of making high-quality medicines and blood products available to the population in line with best practice recommendations and at suitable cost. The relevant French institutions would continue to support the Organization and the activities of its Member States. Paragraph 5 of the report suitably summarized the tasks that united national authorities, particularly with regard to evaluation, pharmacovigilance and inspection. France also approved WHO's efforts, including measures relating to rational use of medicines, and welcomed the developing cooperation with the European Agency for the Evaluation of Medicinal Products, which would soon be in a position to provide scientific expertise relating to the evaluation of medicines to be marketed outside the European Union at the request of WHO. France could also support WHO on two points: the importance of easier access to high-quality medicines, with priority given to essential medicines, including antiretroviral agents; and the establishment of a link between WHO's pharmaceutical strategy and the WTO agreement relating to generic medicines in poor countries. She shared the concern voiced by previous speakers about counterfeits and the importance of quality control at the market level.

Dr SOEPARAN (Indonesia) expressed satisfaction that the global implications of advanced technology, increased international trade and the opening of borders had been raised. The existence of a strong, independent national regulatory system became ever more important in ensuring public health, particularly as inferior products might become increasingly available. The awareness of limited capacity in developing countries should encourage assistance in assessing safety, efficacy and quality from countries with a developed regulatory system. Indonesia stressed the need for intercountry collaboration, facilitated by WHO. The problem of substandard medicines and counterfeit products caused growing concern in many countries with insufficient regulatory capacity. Since political commitment to combating counterfeits was often lacking, Member States had to start drawing up a framework convention on combating counterfeit drugs; he recommended discussion of that issue at a future Health Assembly. He fully supported the recommendation contained in paragraph 5 of document A57/15, but considered that the need also to apply good manufacturing practices in medical procedures, including tissue transplant products, should be stressed explicitly.

Dr TAHA BIN ARIF (Malaysia) said that his country fully supported the recommendations put forward at the Eleventh International Conference of Drug Regulatory Authorities, and WHO's efforts to ensure the quality, efficacy and safety of medicines for domestic use and international trade. Malaysia continued to collaborate closely with WHO and other regulatory agencies. His country's National Pharmaceutical Control Bureau had been redesignated as a WHO Collaborating Centre for Regulatory Control of Pharmaceuticals for a further period of four years; it would continue to provide training for WHO fellows in drug regulatory matters, participate in audits of other regulatory agencies and provide consultancy services, especially to developing countries, in order to bridge the gap in drug regulatory standards. It continued to maintain good working relationships with the Uppsala Monitoring Centre, Sweden, in monitoring the safety of pharmaceuticals and herbal medicines.

WHO had been instrumental in helping Malaysia chair the Pharmaceutical Product Working Group and other bodies of ASEAN, and ASEAN quality guidelines had been developed and adopted by member countries. Such measures, in addition to assistance through partnerships such as that between the European Commission and ASEAN, were helping to bridge the regulatory gap.

Dr FAOURI (Jordan) said that in his country an independent body was in charge of food and medicines and 18 drug-production centres. He emphasized the importance of WHO's role in the domain. With pharmaceutical companies intending to undertake clinical trials in developing countries, he urged that good clinical practice and the Helsinki Agreement and other similar agreements be adhered to.

Mr GUNNARSSON (Iceland) welcomed the report, expressed agreement with most of its content and endorsed the comments of previous speakers, acknowledging the huge variations in drug regulatory bodies among Member States. In fact, a mere third of all Member States were considered to have advanced regulatory systems, with another third having virtually no regulatory system. He confirmed the regulatory gap between the developed and developing countries, and identified the weaknesses of an ineffective regulatory capacity, including, inter alia, the irrational consumption and prescription of drugs, and the role of substandard or counterfeit drugs. With a view to bridging that gap, WHO had been supporting many Member States, particularly developing countries, in building up their drug policy and regulatory infrastructure. Experts from developed Member States had also provided technical assistance. He fully supported those efforts, recalling that the drug policy had first been highlighted at the Eleventh International Conference of Drug Regulatory Authorities. Despite the significant progress that had since been made in the availability and affordability of high-quality essential drugs, he understood the concerns raised by many States and the pharmaceutical industry owing to the lack of any effective regulatory structure, particularly with respect to blood and plasma products.

Ms BLACKWOOD (United States of America), applauding the priority given to the quality and safety of medicines, including blood products, stressed the importance of strong regulatory capacity at the country level, particularly for the implementation of such programmes as the "3 by 5" initiative and President Bush's Emergency Plan for AIDS Relief. She urged WHO and all Member States to collaborate to safeguard the quality and safety of drugs.

She strongly supported WHO action to promote the availability of safe blood throughout the world by promoting national blood transfusion services. She also encouraged the Organization to pursue initiatives such as the development and updating of blood standards and its participation in the Global Collaboration for Blood Safety, noting PAHO's leadership role in the Americas regarding safe blood.

She commended WHO's leadership in combating counterfeit and substandard drugs, which were being sold in increasing quantities over the Internet. In the light of the discussion at the Eleventh International Conference of Drug Regulatory Authorities, she underscored WHO's role in reinforcing partnerships with stakeholders and forging new working alliances with regulatory bodies, inspection agencies and other interested parties.

She supported the emphasis on updated standards guidance, stronger mechanisms for the timely exchange of information, and greater capacity building and training in regulatory functions. Those elements were critical to strengthening the regulatory control of medicines given the growing number of initiatives to combat HIV/AIDS, tuberculosis and malaria worldwide. She urged WHO to encourage national drug regulatory bodies to adopt and implement best practices and standards.

She expressed concern over the misuse of the Defined Daily Dose/Anatomical Therapeutic Chemical pharmaceutical classification guideline system, which had been established as a tool to measure drug use and not therapeutically equivalent doses of different drugs for reimbursement and pricing purposes. Indeed, recent changes to those guidelines actually promoted such misuse. Her country had asked WHO to re-examine recent amendments to the guidelines and recommend further changes to promote the guidelines' original scientific and technical purpose.

Ms ALONSO CUESTA (Spain) welcomed the discussion of the subject by the Executive Board at its 113th session in the interest of ensuring the quality and safety of drugs and blood products. She also commended the inclusion in the document of the recommendations of the Eleventh International

Conference of Drug Regulatory Authorities. The whole document, rather than a summary, should be presented to the Health Assembly in the future.

She urged the continued encouragement of countries to establish national drug regulatory bodies to coordinate national drug policies and strategies and to enforce laws on pharmaceutical products, particularly those on the authorization of medicines, including blood products. Measures facilitating access to safe and high-quality essential medicines should also be taken, in keeping with the medicines strategy presented to the Board at its 113th session, which, she suggested, should be presented to the next Health Assembly.

Mrs DE LA MATA (European Commission) said that the European Commission was aware of the existing regulatory gap between developed and developing countries and recognized that regulatory bodies in the latter were limited in their capacity to ensure safe and high-quality medicinal products. The recently published revision of the European pharmaceutical legislation, the Pharma Review, identified measures to address that very issue. The new regulatory framework, already in force, authorized the European Medicines Agency to give its scientific opinion, in collaboration with WHO, in the context of evaluating certain medicinal products for human use intended exclusively for markets outside the European Union. That scientific assessment would be based on the same standards on drug safety, quality and efficacy as were applied throughout Europe.

WHO, the European Commission and the European Medicines Agency had already started collaboration to implement the provisions of that framework. However, certain issues, particularly adoption of the scientific opinion by countries and the potential impact of the WHO certification scheme, remained to be addressed. That would require enhanced collaboration between the stakeholders. The European Commission looked forward to even closer future cooperation with WHO in the interest of global public health.

Dr LEPAKHIN (Assistant Director-General) thanked delegates for their comments, which had been noted and would be taken into account in WHO's efforts to strengthen drug regulatory capacity. He also acknowledged the support for WHO activities aimed at strengthening drug regulatory authorities, particularly in developing countries, in the interest of public health. Medicines saved lives, alleviated suffering and improved health only if they were of good quality, safe, available, affordable and used rationally.

Noting that most issues raised were contained in the WHO medicines strategy for 2004-2007,[1] he assured delegates that WHO would continue its work of providing effective assessments to countries in need, particularly developing countries.

Stressing the importance of active collaboration with countries and various organizations, he welcomed the initiative by the European Commission to work with WHO in that area.

WHO considered the Eleventh International Conference of Drug Regulatory Authorities, attended by 113 regulatory authorities, to have been a landmark event that had identified regulatory matters requiring urgent attention. He thanked the Government of Spain for hosting that meeting.

The Committee took note of the report.

Eradication of dracunculiasis: Item 12.16 of the Agenda (Document A57/33)

The CHAIRMAN invited the Committee to consider the following draft resolution, proposed by the Sudan:

[1] Document EB113/10 Add.1.

The Fifty-seventh World Health Assembly,

Having considered the report on eradication of dracunculiasis;[1]

Noting with satisfaction the excellent results achieved by the endemic countries in decreasing the number of dracunculiasis cases from an estimated 3.5 million in 1986 to 32 000 reported cases in 2003;

Noting also that only 12 countries are endemic, all in sub-Saharan Africa,

1. CONGRATULATES Member States, the Organization and partner bodies, particularly UNICEF and the Carter Center, for increasing the availability of safe and potable water, improving surveillance for case detection, strengthening interventions and expanding public awareness of the disease;

2. CONGRATULATES the 168 countries and territories that have been certified free of dracunculiasis transmission since the International Commission for the Certification of Dracunculiasis Eradication was established in 1995;

3. URGES the remaining endemic countries to intensify their eradication efforts, including active surveillance and prevention measures;

4. URGES Member States, the Organization, UNICEF, the Carter Center and other appropriate entities to capitalize on current successes and opportunities by continuing their commitment, collaboration and cooperation, to ensure political support at the highest level, and to assure that the much-needed resources are mobilized for rapid completion of eradication;

5. RECOMMENDS the Director-General to ensure that the full resources required are mobilized for eradication of dracunculiasis, taking into account the disproportionate increase of cost by case detected during the last steps of eradication, and to enable the International Commission to intensify its verification and certification activities for a world free of dracunculiasis.

Professor HOMIEDA (Sudan) said that the draft resolution proposed by his country, where 76% of all cases of dracunculiasis in the world occurred, had been cosponsored by Benin, Côte d'Ivoire, Ethiopia, Ghana, Niger and Uganda. Since the start of the initiative to eliminate the disease in 1982, enormous progress had been made. Reported cases had dropped by 96%, from 800 000 to under 32 000 in 2003. Furthermore, 168 countries and territories considered endemic in 1990 had been certified free of dracunculiasis.

Despite the ongoing civil war in the Sudan, guinea-worm eradication had progressed significantly since the ceasefire of 1995. More villages where dracunculiasis was endemic had been accessed, 82% of them having received health education and 70% household filters. The total number of such villages had fallen by 62% for the period January-July 2003 as against the same period of 2002. The total number of cases for the same period in 2003 had fallen by 65% compared with 2002. The northern states of the Sudan, which had reported 36 endogenous cases for the period January-August 2002, had reported only four cases for the same period in 2003. Transmission was therefore believed to have been interrupted in the north of the country. In spite of the war, an 89% reduction in the total number of cases in the south of the country had been achieved and he thanked the Sudan's partners, the Carter Center, WHO, UNICEF and all those who had supported the programme.

The race to end the disease was in its last lap, calling for one final spurt of energy. It was the most difficult part, one that would require intensifying efforts, recruiting more donors and retaining

[1] Document A57/33.

traditional donors. With the Sudan committed to eradicating the disease, he urged WHO to continue providing resources.

In the draft resolution, he suggested adding a new paragraph 3 to read: "RECALLING that ministers of health from the remaining endemic countries signed at the Fifty-seventh World Health Assembly the Geneva Declaration for the Eradication of Dracunculiasis by 2009". Subsequent paragraphs would be renumbered. He proposed adding the words "by 2009" at the end of existing paragraph 4. He suggested replacing former paragraph 5 with a new paragraph 6 to read:

> "RECOMMENDS the Director-General to support the efforts taken to ensure that adequate resources required are mobilized for the eradication of dracunculiasis during the last steps of the programme and for its verification and certification activities for a world free of dracunculiasis."

Professor AKOSA (Ghana), commending WHO's continued support for the eradication of dracunculiasis, said that Ghana had the unenviable distinction of being the country with the second-highest prevalence of the disease, and the President himself had called on the Ministry of Health to rededicate efforts to its eradication. Although improved surveillance had shown an increased number of cases for 2003, further efforts had seen a drop in cases in the first quarter of 2004.

Ghana had engaged in multisectoral collaboration, particularly with the district assemblies and community water and sanitation authorities. The initiative had benefited from increased funding by the Ministry of Finance and the support of partners such as Global 2000, UNICEF and WHO.

In addition to an increased water supply in areas highly endemic for the disease, the distribution of filters had been expanded, as had active surveillance by community-based volunteers. However, with more funding urgently needed, he expressed his gratitude to all partners for their support and requested continued assistance.

Ghana had signed the Geneva Declaration on the Eradication of Dracunculiasis during the current Health Assembly and had pledged to eradicate the disease as soon as possible. It had cosponsored the draft resolution. He accepted the proposed amendments and called on other Members to support the draft resolution.

Dr NABAE (Japan) said that his country continued to support dracunculiasis-control activities under the Hashimoto Initiative and expressed his support for the draft resolution.

Mrs RIZZO (Italy) expressed her appreciation for the assistance provided by the Organization to the endemic countries for the control of the disease. She also welcomed the excellent results achieved, noting that those efforts had led to the final stages of eradicating the guinea worm from the 12 endemic countries. She supported the draft resolution presented by the Sudan and other sponsors, including the new target date of 2009. She stressed the need to provide adequate financial resources to the endemic countries and to WHO to stop the transmission of the disease and undertake certification activities.

Ms VALDEZ (United States of America) appreciated the tabling of the draft resolution by the delegation of the Sudan and other sponsors. Although the eradication of dracunculiasis was close, it had not been fully achieved. For one thing, a huge gap in resources remained to be filled; for another, it seemed that the surveillance process remained somewhat fragmented, calling for increased contributions in terms of resources and leadership.

The United States could support the text and the proposed amendments but, bearing in mind that most of the resources came from private sources, she suggested that the opening phrase of the text just read out should be modified to read "RECOMMENDS the Director-General to support mobilization of adequate resources for eradication of dracunculiasis ...", with the remainder unchanged.

Dr FALL (Senegal) said that his delegation congratulated WHO and its partners, particularly UNICEF and Global 2000, and the Carter Center. Like all the endemic countries in the region, Senegal had initiated its programme in 1991, when 1341 cases had been recorded in the country. In 1998, when all the activities had been put in hand, the number of cases had been reduced to zero. Thus, in November 2003, Senegal had been re-certified for the eradication of dracunculiasis.

Mr GUNNARSSON (Iceland), speaking also on behalf of the delegations of Denmark, Finland, Norway and Sweden, said that the Nordic countries supported the draft resolution as proposed and amended by the delegate of the Sudan, and could support the amendment proposed by the United States.

Dr KRIT PONGPIRUL (Thailand) expressed appreciation of the efforts made by all stakeholders in the eradication of dracunculiasis, and supported the draft resolution.

Professor HOMIEDA (Sudan) accepted the text proposed by the delegate of the United States.

Dr KARAM (Secretary) said that, as a result of the accepted amendment, former paragraph 5, which would become paragraph 6, would read:

> "RECOMMENDS the Director-General to support mobilization of adequate resources required for the eradication of dracunculiasis during the last steps of the programme and for its verification and certification activities for a world free of dracunculiasis."

Following an observation by Professor HOMIEDA (Sudan), he said that the words "by 2009" would be added at the end of new paragraph 5.

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

The meeting rose at 18:40.

[1] Transmitted to the Health Assembly in the Committee's fourth report and adopted as resolution WHA57.9.

FIFTH MEETING

Saturday, 22 May 2004, at 09:20

Chairman: Dr Jigmi SINGAY (Bhutan)

1. FOURTH REPORT OF COMMITTEE B (Document A57/45)

Mrs JAKAB (Hungary), Rapporteur, read out the draft fourth report of Committee B.

The report was adopted.[1]

2. FINANCIAL MATTERS: Item 15 of the Agenda (continued)

Scale of assessments for 2005: Item 15.3 of the Agenda (Document A57/23) (continued from the third meeting, section 2)

The CHAIRMAN invited the Committee to resume consideration of the draft resolution.

Mr SAHA (India) said that his research into the method used to calculate the scale of assessments had revealed certain political factors. The adjustment mechanism did not differ greatly from the one applied in the United Nations and its specialized agencies, but the amounts available under it were insufficient to meet the needs of developing countries. Discussions on the matter, and on the draft resolution, should be postponed until the next Health Assembly in order to ensure that any shortfall in funds available under the mechanism did not lead to increases in contributions payable by developing countries.

Mr BÁRCIA (Portugal) said that he would be reluctant to agree to a reopening of the debate on the scale of assessments, given that a compromise had already been negotiated and accepted by consensus the previous year. India had participated actively in those negotiations, and the Committee should respect consensus decisions.

Ms MANGAN (Ireland), speaking on behalf of the European Union, reiterated her support for the draft resolution and pointed out that the adjustment mechanism had been agreed on only after extensive debate. To transfer more funds to the mechanism could be detrimental to health programmes. The European Union could not accept such an option, and she urged delegations to support the draft resolution, which fully reflected the previous consensus.

Ms BLACKWOOD (United States of America), supported by Mr SAWERS (Australia), shared that view. The Committee should approve the draft resolution without delay.

Mr SAHA (India) said that it was not the first time that the subject had been debated. The adjustment mechanism was an integral part of the compromise reached the previous year. There were alternatives to the arrangement outlined in paragraph 2 of the draft resolution whereby the amounts available under the mechanism would be proportionally reduced, if necessary, to ensure that the total claimed was fully covered by the amount appropriated. Reappropriating funds from other areas, which was common practice in the United Nations system, would guarantee that countries entitled to

---

[1] See page 241.

compensation would be able to claim it and ensure that the agreement reached the previous year providing for such a facility would not be undermined. The Committee was duty-bound to provide an adjustment mechanism, and should consider ways in which it could guarantee the availability of the required funds.

Mr MACPHEE (Canada) expressed support for the comments made by the delegates of Portugal, Ireland and the United States. His Government was strongly opposed to any form of mitigation, and considered that any funds set aside under Miscellaneous Income should be used solely to finance WHO programmes desperately in need of support. It was unlikely that every country entitled to claim under the adjustment mechanism would do so; furthermore, the amounts available under Miscellaneous Income were unpredictable. The package agreed by consensus the previous year after extensive debate should be adopted.

Mr LOZINSKIY (Russian Federation) and Mr NAKAZAWA (Japan) supported that view.

Ms WILD (Comptroller) recalled that the previous year's discussions had taken into account the fact that the total amount that could be claimed – if all Member States that were entitled to do so were to claim the adjustment mechanism – was significantly more than the US$ 12.3 million appropriated by the Health Assembly. As noted in document A57/23, the amount available in the Miscellaneous Income account was an estimate or projection, and it was currently estimated that there might not be sufficient funds in that account to meet all requirements, although the mitigation scheme would take priority when allocating the amounts available. However, despite the fact that at the beginning of the previous biennium a shortfall had been expected in the Miscellaneous Income account, by the end of that biennium adequate funds had been realized to meet all commitments approved.

She wished to reassure Member States that, when the financing of the programme budget for the biennium 2006-2007 was being considered, care would be taken to ensure that the proposals took account of the need to provide adequate funding for the adjustment mechanism.

Mr SAHA (India) argued that there was some room for accommodation. For example, if deferring implementation of the new scale did not meet with acceptance, reappropriation might be considered. If reappropriation was not approved, then at the very least a carry-over of unutilized mitigation could be an option, so that the 60-40-40-30 rule was not affected by non-availability of funds. The carry-over would essentially be in the form of percentages not used. If, for example, countries that had sought mitigation were able, owing to a shortage of funds, to use only 50% of their entitlement, the balance should be carried over to the next financial year. There were various other possibilities that might also be considered.

Ms WILD (Comptroller) said that the WHO Financial Regulations provided clear guidance with respect to the Miscellaneous Income account. Essentially, if the amount of miscellaneous income realized was greater than the amount authorized by the Health Assembly for use, the balance was carried forward for disposition in the following biennium by decision of the Member States. If the amount realized was less than the amount authorized, the Director-General was required to find areas where adjustments could be made in programme implementation in order to ensure that he did not overspend.

Mr SAHA (India) said that the point he wished to make was that under the existing 60-40-40-30 percentage formula, it might transpire that at the end of the first biennium the effective mitigation was 20, in which case the unused 20 should be carried forward to the following year, when it would be understood that for the next biennium the formula would be 60-30. There would be no budgetary implications.

Dr NORDSTRÖM (Assistant Director-General) recalled that the budget for 2004-2005 and the scale of assessments for 2004 had been decided. The scale of assessments for 2005 still had to be considered. A decision had also been taken at the previous Health Assembly on the adjustment mechanism, which had been strongly supported.

The budget process for 2006-2007 was still open, and it was up to Member States to decide how the priorities for that budget should be set. He suggested that the issue regarding percentages raised by the delegate of India should be considered in the course of that process, rather than at the current meeting.

The CHAIRMAN asked whether, in view of the fact that the majority of speakers had been opposed to a reopening of the debate, India would reconsider its position.

Mr SAHA (India) said that, provided it was understood that the 60-40-40-30 percentage formula would be considered again in the context of the budget negotiations in 2005, he could accept the draft resolution.

On that understanding, the draft resolution, as amended, was approved by consensus.[1]

3. TECHNICAL AND HEALTH MATTERS: Item 12 of the Agenda (continued)

Implementation of resolutions (progress reports): Item 12.15 of the Agenda (Documents A57/18 and A57/18 Add.1) (continued from the eighth meeting of Committee A, section 3)

- **Integrated prevention of noncommunicable diseases**

Mr JASKARI (Finland) wished to place on record the importance his country attached to the integrated prevention of noncommunicable diseases, which was closely related to the issues underlying the global strategy on diet, physical activity and health and health promotion and healthy lifestyles discussed earlier. Since noncommunicable diseases were rapidly becoming the chief component of the global burden of disease and were preventable, the two main aspects of the global strategy for prevention and control of noncommunicable diseases from the year 2000, namely, the need to take an integrated approach and to target the main lifestyle-related risk factors, including tobacco use, unhealthy diet and physical inactivity, were of particular relevance.

He stressed the value of the regional noncommunicable disease networks, such as the Countrywide Integrated Noncommunicable Disease Intervention Programme in Europe and the set of actions for the multifactorial reduction of noncommunicable diseases (CARMEN) in the Americas. The Global Forum on Integrated NCD Prevention and Control had become a very useful mechanism for sharing experiences and discussing joint actions. The regional networks were extremely useful instruments for helping Member States to implement important WHO strategies, such as the WHO Framework Convention on Tobacco Control, Move for Health and that on diet and physical health.

Dr LARIVIÈRE (Canada) suggested that the progress report did not accurately reflect the work already undertaken or the large amount still to be done. Reference was made in paragraph 18 of the report (document A57/18) to the global strategy for prevention and control of noncommunicable diseases submitted to the Fifty-third World Health Assembly in 2000. Although adoption of that strategy had been considered a positive step, several Member States, including Canada, continued to

[1] Transmitted to the Health Assembly in the Committee's fifth report and adopted as resolution WHA57.15.

await a comprehensive global strategy, together with a plan for implementation, as requested in resolution WHA51.18.

He expressed concern at the absence of any reference to mental illness or to musculoskeletal diseases in the progress report, an omission which meant that the strategy was neither comprehensive nor integrated. At a time when major challenges were posed by new infectious diseases, it was particularly important to adopt a comprehensive and inclusive approach to noncommunicable diseases.

Dr CUI Gang (China) said that, since the adoption by the Fifty-third World Health Assembly of the global strategy for the prevention and control of noncommunicable diseases, WHO had undertaken commendable pioneering work in tobacco control, mental health, and promoting healthy diet and physical activity. However, it should be remembered that most developing countries were subject to the dual burden of disease and lack of economic resources and particularly health personnel. Much needed to be done to ensure that sufficient emphasis was placed on the control of noncommunicable diseases. WHO should take integrated action on preventable biological and behavioural risk factors and initiate health education and health promotion activities.

The Global Forum on Integrated NCD Prevention and Control provided a platform for communication between all types of organization, and was also a useful vehicle for raising awareness of the initiative. In order to improve efficiency and achieve the objective of controlling noncommunicable diseases globally, a different theme should be identified for each forum, and policy development and work at national level should be promoted step by step to expand the forum's coverage and influence. WHO should undertake more research into identifying the relationships between socioeconomic development and noncommunicable diseases in order to establish a basis for policy-making. In 2002, China had launched a large-scale survey on nutrition and health which had revealed the impact of the socioeconomic situation of the 1990s on nutrition, and consequently on the incidence of high blood pressure, diabetes and obesity. Initial results had shown that noncommunicable diseases and economic development were closely linked. The findings of the survey would be published and policies developed in response to them.

Dr LE GALÈS-CAMUS (Assistant Director-General), responding to comments made, thanked Member States for their commitment to preventing and controlling noncommunicable diseases. Although the focus in recent years on tobacco control and on diet and physical health might have led to the belief that the issue of mental health was not receiving the attention it deserved, that was not the case, and in fact a technical briefing on mental health had been held in the course of the current Health Assembly. The approach to the issue should be as integrated as possible and respond closely to the needs expressed by countries.

Networks and forums had been recognized as being of importance in implementing integrated prevention measures. A new network had recently been established in the South-East Asia Region, and the Western Pacific Region would see the launch of a network for the prevention and control of noncommunicable diseases within the next few weeks. The next international forum would be held in November 2004, and she had noted the proposal made by the delegate of China. The priority goal was still to maintain and increase efforts to provide Member States with the advice and support they needed in formulating and evaluating the policies necessary for effectively and significantly reducing the incidence of noncommunicable diseases.

- **WHO Framework Convention on Tobacco Control**

Mrs HERNÁNDEZ (Venezuela) stated that her country would soon ratify the WHO Framework Convention on Tobacco Control, and urged all countries that had not already done so to sign and ratify it as soon as possible.

Mr McKERNAN (New Zealand), noting that tobacco use was increasing worldwide and was one of the major public health challenges of the times, said that his country was committed to the Framework Convention, which it had signed and ratified. New Zealand had embarked on a number of initiatives to reduce the harm caused by tobacco use and called on other Member States to ratify the Framework Convention.

Mrs ALLEN-YOUNG (Jamaica) said that, having participated in drawing up the Framework Convention, her country was well on the way to ratification. Several activities had been initiated, such as the banning of tobacco advertising and sponsorship, increased taxation of tobacco products and the formulation of relevant legislation. She encouraged countries that had not yet signed the Framework Convention to do so.

Mr SAWERS (Australia) said that his country was a strong supporter of international efforts to combat tobacco use and commended WHO's efforts to secure ratification of the Framework Convention. It was hoped that States would participate in the Open-ended Intergovernmental Working Group, to be held the subsequent month, to work out procedures for the Conference of the Parties to the Framework Convention, final decisions on those matters being the province of the Conference itself. Australia would look to the Conference of the Parties to define the role of WHO in relation to the Framework Convention, recognizing the efficiencies that would result from using the existing infrastructure where possible.

Dr CUI Gang (China) said that the Framework Convention would doubtless be a milestone in the annals of public health. It was the result of difficult negotiations and constituted the basis for action and strategic measures on tobacco control the world over. Countries should take the Framework Convention as a new departure point and promote action for the sustainable development of tobacco control. China had launched a number of policies and practical activities to control tobacco use and create a healthy environment. It was also considering action to make the Olympic Games in China in 2008 tobacco-free. The Chinese Ministry of Health, with the support of WHO, was implementing a tobacco-control capacity-building programme in China, using various means to mobilize public participation and to raise social awareness of the hazards of smoking.

Dr SHANGULA (Namibia) said that his country was proud to have been involved in the negotiations leading to the adoption of the Framework Convention. In 1998, the Government of Namibia had adopted a policy on tobacco, including a ban on tobacco smoking in all public places and on the promotion of tobacco products. Namibia had signed the Framework Convention and was currently finalizing tobacco-control legislation. It was also engaged in consultations with States that had adopted such legislation in order to identify possible loopholes. Once the legislation process was concluded, Namibia would ratify the Framework Convention.

Dr NABAE (Japan) strongly supported WHO's commitment to the Framework Convention, the first step in promoting global tobacco control. His country was expanding national control through education on the health effects of tobacco and the prevention of passive smoking. Japan had signed the Framework Convention in March 2004 and was about to deposit its instrument of ratification. It was ready, once the Convention entered into force, to enhance control through coordination among ministries. He urged WHO to continue its efforts to encourage ratification and hence implementation of the Framework Convention.

Mr DE CASTRO SALDANHA (Brazil) said that his Government intended to ratify the Framework Convention within a matter of days, and called on other States to sign and ratify it as soon as possible. Brazil would participate actively in the forthcoming Open-ended Intergovernmental Working Group, as it had in the negotiations. On 31 May, World No Tobacco Day, major events highlighting tobacco control would be held in Brazil.

Dr PAVLOV (Russian Federation) said that his country had taken a very active part in formulating the Framework Convention and was conducting intensive internal consultations on the subject, which he hoped would be concluded by the deadline for signature.

Dr TSHABALALA-MSIMANG (South Africa) said that the South African Government had signed the Framework Convention in June 2003 and was currently preparing an instrument of ratification which it expected to submit to Parliament before the end of 2004. At the same time, more stringent tobacco legislation and regulations were being introduced. Public response to the proposed amendments had been overwhelmingly positive. As the tobacco industry consciously targeted developing countries, placing an intolerable burden on their health resources, she was pleased to report that, since tough legislation had come into force in 2001, there had been a significant decrease in the prevalence of smoking, especially among young people. In addition to legislative measures, health promotion drives and research were being conducted. With the help of the Swedish Government, a comprehensive smoking-cessation programme, with special emphasis on pregnant women, was soon to be launched.

Mr SHARMA (India) said that his country had ratified the Framework Convention on 5 February 2004. Comprehensive tobacco-control legislation had been enacted in 2003 and rules banning smoking in public places, direct and indirect advertising, and sales of tobacco products to under-18 year olds had come into effect in 2004. Further rules were being adopted and measures to control tobacco use had been intensified.

Dr NYIKAL (Kenya) said that his Government strongly supported the Framework Convention and was placing restrictions on many tobacco-promotion activities, such as advertising, sports sponsorship and sales to young people. All government buildings in Kenya had been declared tobacco-free areas. It planned to sign the Framework Convention before the June 2004 deadline and to ratify it shortly thereafter. A bill on tobacco control was currently before Parliament.

Mr DEBRUS (Germany) said that after the preparation, with other German-speaking countries, of an official translation of the Framework Convention into German, ratification procedures had begun in the German Parliament and he was confident that they would be accomplished in good time.

Ms RØINE (Norway) said that the epidemic of tobacco use could be brought to a halt only through an instrument such as the Framework Convention, which Norway had been the first country to ratify. She strongly urged other countries to join in making the Framework Convention operational as soon as possible. Her country was looking forward to participating in the forthcoming Open-ended Intergovernmental Working Group, in the belief that it would produce a constructive, operational basis for the first Conference of the Parties.

Dr ABEBE (Nigeria) reported that the Permanent Representative of Nigeria to the United Nations in New York had been instructed to sign the Framework Convention on behalf of the Nigerian Government. Nigeria had enacted tobacco-control legislation in 1990, focusing principally on passive smoking, but a review process to expand its scope had been stalled for more than three years. The Framework Convention should provide the necessary impetus for real progress, and a vigorous effort would be made to encourage the National Assembly to ratify it. She urged countries that had not yet done so to sign the Framework Convention.

Dr ZAHER (Egypt) expressed full support for the Framework Convention, which should have a substantial impact on the global burden of noncommunicable diseases. Egypt had been one of the first countries to sign the Convention and was taking the necessary steps to ensure prompt ratification.

Ms GILDERS (Canada) said that Canada was taking the necessary steps to ratify the Framework Convention at the earliest opportunity and would continue to provide support through its participation in the Open-ended Intergovernmental Working Group.

Dr OLIVEROS (Philippines) said that the Philippines had signed the Framework Convention in September 2003 and had started the ratification process. The Government had enacted legislation, reflecting the Framework Convention's provisions on advertising, promotion and sponsorship, which had come into force in April 2004. The Philippines supported the work of the Open-ended Intergovernmental Working Group and suggested that regional intergovernmental working groups might also be established to ensure a wide representation of Member States.

Dr KHAIRI BIN YAKUB (Malaysia) said that Malaysia had signed the Framework Convention in September 2003 and was currently establishing the necessary tools and infrastructure to meet the requirements for ratification. The adoption of amendments to the tobacco-products regulations under the Food Act had been completed. A separate tobacco-control act that was consistent with the provisions of the Framework Convention was being prepared and a permanent local secretariat for the Framework Convention was being established within the Ministry of Health to oversee implementation of its obligations. The draft amendments to the tobacco-products regulations and tobacco-control bill included a total ban on all forms of tobacco-product promotion, standard packaging for cigarettes with warning labels and the extension of smoke-free public areas. Malaysia was also exploring the idea of establishing a health promotion foundation, to be funded through tobacco and alcohol taxation. The Government of Malaysia placed public health and the health and well-being of the population above commercial gain.

Dr SADRIZADEH (Islamic Republic of Iran) said that a national summit would be held in Tehran in June 2004 to increase awareness of the Framework Convention, generate the necessary political will and support for ratification and pave the way for its smooth implementation. A tobacco-control bill had been prepared for enactment by Parliament. It was important for all Member States to make the necessary preparations for timely implementation of the Convention. Full and effective implementation would require high-level political commitment, strong intersectoral collaboration and active community involvement through activities directed at the various population groups.

Dr SOMBIE (Burkina Faso) said that Burkina Faso had signed the Framework Convention in 2003 and expected to be able to ratify it in 2004. The Convention should provide a starting point for enhancing existing tobacco-control measures.

Dr YOOSUF (Maldives) said that, having successfully controlled the major infectious diseases, Maldives had been increasingly troubled by the emergence of noncommunicable diseases. It was to be hoped that the Framework Convention would have an impact on their prevalence. His country had already introduced several of the recommended measures, but many areas still needed attention. Maldives had already signed and ratified the Framework Convention and encouraged other Member States to follow its example so that the Convention could enter into force.

Mr KYEREMATENG (Ghana) said that his country had signed the Framework Convention in February 2004 and set the ratification process in motion. Various activities had been carried out in the meantime, including public awareness campaigns, and the banning of smoking in and around the Health Ministry and all health facilities.

Ms BLACKWOOD (United States of America) said that the United States had signed the Framework Convention, which it regarded as an important basis for improving public health worldwide. The next step would be its submission to the Senate.

Dr AHSAN (Bangladesh) said that the Government of Bangladesh had approved ratification of the Framework Convention, and a tobacco-control bill, and had introduced several programmes to facilitate implementation of the Convention's provisions. They included raising public awareness of the harmful impact of tobacco use on health, banning advertising in government-sponsored media outlets and incorporating an operational plan into the three-year health, nutrition and population sector programme.

Mr LEE (Republic of Korea) said that his country had signed the Framework Convention in July 2003 and was preparing for ratification. Controlling tobacco use required a synchronized effort by all Member States. He therefore urged those countries that had not yet done so to show the same commitment as they had demonstrated in adopting the Framework Convention and sign it as a matter of priority.

Mr MANGUELE (Mozambique) observed that his country had taken part in all international efforts to control tobacco consumption in order to curb the harmful effects of tobacco use on public health. Mozambique had signed the Framework Convention and was taking steps to expedite ratification.

Dr TANGI (Tonga) said that the small Pacific island countries had consistently and strongly supported development of the Framework Convention and three of them, including Tonga, had already signed it. Tobacco-control efforts in the future should focus, inter alia, on the pervasive and highly damaging influence of smoking by actors in films and on television.

Dr AL-JABER (Qatar) said that Qatar had been one of the first countries to sign the Framework Convention in June 2003 and its ratification was imminent. Qatar had enacted stringent legislation against smoking and was one of seven Gulf States in favour of imposing a tax on tobacco to discourage young people from smoking.

Mrs DIALLO (Senegal) said that her country strongly supported the Framework Convention, given its importance in preventing noncommunicable diseases. Senegal had signed the Convention in June 2003 and had initiated the ratification process.

Dr EL ISMAILI LALAOUI (Morocco) expressed his country's full support for the Framework Convention. Morocco had promulgated a law against smoking in public places in 1995 and had signed the Convention in April 2004. The process of ratification was under way.

Dr KUARTEI (Palau) said that in his country tobacco was chewed rather than smoked, so that the attendant risks were different. Palau had been one of the first countries to sign and ratify the Framework Convention and he encouraged other Member States to do likewise.

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked Member States for their support in tackling smoking issues and, in particular, those that had already signed or ratified the Framework Convention. The number of signatories had increased from the 100 mentioned in the report to 115, together with the European Union, and ratifications had risen to 16. The 78 Member States which had not yet done so were urged to sign the Convention as soon as possible. It would be open for signature until 29 June 2004. Beyond that date, States would still be able to accede. The minimum number of ratifications required for entry into force was 40, and in the light of statements made, she was optimistic that that goal would be reached.

She looked forward to welcoming all Member States to the first session of the Open-ended Intergovernmental Working Group, which was to be convened in Geneva from 21 to 25 June 2004. Most of the documents were already available. WHO was ready to provide Member States with any technical support in implementing tobacco-control measures or policies. She urged countries to participate in World No Tobacco Day celebrations on 31 May 2004, on the theme of "tobacco and poverty, a vicious circle".

Ms VIAUD (World Medical Association), speaking at the invitation of the CHAIRMAN and also on behalf of the International Council of Nurses, the International Pharmaceutical Federation, and the World Federation of Public Health Associations, said that those organizations together represented more than 20 million physicians, nurses, pharmacists and public health professionals worldwide. Alarmed by the increasingly widespread use of tobacco products, they welcomed WHO's leadership in tobacco control in general and the Framework Convention in particular. Yet it was a matter of great concern that the tobacco industry continued to target young people, women and developing countries in order to expand its markets. Health professionals hailed the Framework Convention as a major public health revolution. She urged States and regional economic integration organizations to ratify it as a matter of urgency. The four associations she represented, for their part, were making every effort to encourage governments to sign and ratify the Convention. They had collaborated with WHO and nongovernmental organizations in developing a tobacco code of practice for health professional organizations. Furthermore, they were conducting a survey of members to obtain data for anti-tobacco activities and had drawn up guidelines to improve the competencies of their members. The four associations saw the Framework Convention as a force with the potential to change the behaviour of the tobacco industry. They were committed to working together with other sectors in implementing the Convention and to reducing the burden of tobacco-related disease and death.

Mr MISRA (International Organisation of Consumers Unions (Consumers International)), speaking at the invitation of the CHAIRMAN and also on behalf of the Global Federation of Consumer Organizations, saluted the Member States that had ratified or signed the Framework Convention. As five million consumers would already have died of tobacco-related diseases since the adoption of the Framework Convention, every day was crucial, and he appealed to all signatories to ratify the Convention at the earliest opportunity, and not to allow themselves to be influenced by the tobacco industry's vested interest in delaying the process.

At the 17th Consumers International World Congress, held in Lisbon in 2003, a resolution had been unanimously adopted to combat tobacco use and production, urging governments to stop subsidizing tobacco production and exports and to promote the production of alternatives. India's ratification of the Framework Convention and its complete ban on advertising and smoking in public places, which had come into effect on 1 May 2004, had been warmly welcomed. India should continue its efforts and adopt further measures, as industry would always find excuses to mislead governments and consumers for the sake of profit and self-enrichment. Developing countries should take the lead in persuading Member States to ratify the Convention without delay. All Member States should work to secure ratification by at least 40 Members by 29 June 2004. Consumers International pledged its full support to work together with governments concerned for consumers and their rights in implementing the Framework Convention.

Ms MULVEY (Infact), speaking at the invitation of the CHAIRMAN, said that the adoption of the Framework Convention had been a major step forward in the movement challenging irresponsible and dangerous corporate actions around the world. Its implementation would save millions of lives and change the way the tobacco industry operated globally, by introducing measures to protect public health policies from interference by tobacco corporations, encourage cooperation among countries on issues related to liability, and prioritize health over the tobacco industry's commercial interests. The Framework Convention set new standards for the international regulation of industries that threatened health, the environment and human rights. Infact was currently participating in the worldwide

celebrations to mark the sixth international week of resistance to tobacco transnationals. Large multinational tobacco companies had attempted to derail the framework convention process from the outset and it was therefore more vital than ever to resist their attempt to undermine the treaty at the present stage. She congratulated Member States that had ratified the Framework Convention and those that had announced plans to join them. Infact urged all other governments to follow suit swiftly, since the sooner the treaty entered into force, the more lives would be saved.

Mr CUNNINGHAM (International Union Against Cancer), speaking at the invitation of the CHAIRMAN, said that the global pandemic of tobacco-related diseases was entirely preventable. Five million people died needlessly each year, a total that would climb to 10 million annually by the year 2030. The Framework Convention was a crucial and effective instrument to combat the increasing use of tobacco. He congratulated the 115 signatories and the 16 countries that had ratified the Framework Convention and urged all countries to sign and ratify by the deadline. Since legislation would be required only at the ratification stage, taking the initial step of signature might make ratification easier. As there was no reason for countries not to sign, he called on all Member States to take that initial step towards the prevention of disease, disability and death and to ensure a smoke-free future for the next generation.

Dr LE GALÈS-CAMUS (Assistant Director-General) thanked the nongovernmental organizations for their role in tobacco control and their contributions to the Framework Convention. She called on them to sustain their efforts to introduce effective tobacco-control measures at national level.

The CHAIRMAN said that he took it that the Committee wished to take note of the progress reports on integrated prevention of noncommunicable diseases and the WHO Framework Convention on Tobacco Control.

The Committee took note of the reports.

4. FIFTH REPORT OF COMMITTEE B (Document A57/46)

Mrs JAKAB (Hungary), Rapporteur, read out the draft fifth report of Committee B.

The report was adopted.[1]

5. CLOSURE

After the customary exchange of courtesies, the CHAIRMAN declared the work of Committee B completed.

The meeting rose at 11:30.

---

[1] See page 242.

PART II

REPORTS OF COMMITTEES

The text of resolutions and decisions recommended in committee reports and subsequently adopted without change by the Health Assembly have been replaced by the serial number (in square brackets) under which they appear in document WHA57/2004/REC/1. The verbatim records of plenary meetings at which these reports were approved are reproduced in document WHA57/2004/REC/2.

COMMITTEE ON CREDENTIALS

First report[1]

[A57/37 – 18 May 2004]

The Committee on Credentials met on 18 May 2004. Delegates of the following Member States were present: Austria, Belize, Canada, Djibouti, Gambia, India, Italy, Kenya, Mali, Myanmar, Papua New Guinea.

The Committee elected the following officers: Dr J. Larivière (Canada) – Chairman; Dr A. Misore (Kenya) – Vice-Chairman; Dr F. Cicogna (Italy) – Rapporteur.

The Committee examined the credentials delivered to the Director-General in accordance with Rule 22 of the Rules of Procedure of the World Health Assembly.

The credentials of the delegates of the Member States listed at the end of this report were found to be in conformity with the Rules of Procedure as constituting formal credentials; and the Committee therefore proposes that the Health Assembly should recognize their validity.

The Committee examined notifications from the Member States and the Associate Member listed below, which, while indicating the names of the delegates concerned, could not be considered as constituting formal credentials in accordance with the provisions of the Rules of Procedure. The Committee therefore recommends to the Health Assembly that the delegates of these Member States and the representative of the Associate Member be provisionally seated with all rights in the Health Assembly pending the arrival of their formal credentials: **Member States** – Andorra, Azerbaijan, Finland, Ghana, Honduras, Liberia, Micronesia (Federated States of), Mongolia, Nigeria, Romania, Tonga, Turkmenistan and **Associate Member** – Puerto Rico.

States whose credentials it was recommended should be recognized as valid (see fourth paragraph above)

Afghanistan, Albania, Algeria, Angola, Antigua and Barbuda, Argentina, Armenia, Australia, Austria, Bahamas, Bahrain, Bangladesh, Barbados, Belarus, Belgium, Belize, Benin, Bhutan, Bolivia, Bosnia and Herzegovina, Botswana, Brazil, Brunei Darussalam, Bulgaria, Burkina Faso, Burundi, Cambodia, Cameroon, Canada, Cape Verde, Central African Republic, Chad, Chile, China, Colombia, Congo, Cook Islands, Costa Rica, Côte d'Ivoire, Croatia, Cuba, Cyprus, Czech Republic, Democratic People's Republic of Korea, Democratic Republic of the Congo, Denmark, Djibouti, Dominican Republic, Ecuador, Egypt, El Salvador, Equatorial Guinea, Eritrea, Estonia, Ethiopia, Fiji, France, Gabon,

[1] Approved by the Health Assembly at its fifth plenary meeting.

Gambia, Georgia, Germany, Greece, Grenada, Guatemala, Guinea, Guinea-Bissau, Guyana, Haiti, Hungary, Iceland, India, Indonesia, Iran (Islamic Republic of), Iraq, Ireland, Israel, Italy, Jamaica, Japan, Jordan, Kazakhstan, Kenya, Kiribati, Kuwait, Kyrgyzstan, Lao People's Democratic Republic, Latvia, Lebanon, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Madagascar, Malaysia, Malawi, Maldives, Mali, Malta, Marshall Islands, Mauritania, Mauritius, Mexico, Monaco, Morocco, Mozambique, Myanmar, Namibia, Nepal, Netherlands, New Zealand, Nicaragua, Niger, Norway, Oman, Pakistan, Palau, Panama, Papua New Guinea, Paraguay, Peru, Philippines, Poland, Portugal, Qatar, Republic of Korea, Republic of Moldova, Russian Federation, Rwanda, Saint Lucia, Saint Kitts and Nevis, Saint Vincent and the Grenadines, Samoa, San Marino, Sao Tome and Principe, Saudi Arabia, Senegal, Serbia and Montenegro, Seychelles, Sierra Leone, Singapore, Slovakia, Slovenia, Solomon Islands, Somalia, South Africa, Spain, Sri Lanka, Sudan, Swaziland, Sweden, Switzerland, Syrian Arab Republic, Thailand, The former Yugoslav Republic of Macedonia, Timor-Leste, Togo, Trinidad and Tobago, Tunisia, Turkey, Tuvalu, Uganda, Ukraine, United Arab Emirates, United Kingdom of Great Britain and Northern Ireland, United Republic of Tanzania, United States of America, Uruguay, Uzbekistan, Venezuela, Viet Nam, Yemen, Zambia, Zimbabwe.

Second report[1]

[A57/40 – 21 May 2004]

On 20 May 2004, the Bureau of the Committee on Credentials examined the formal credentials of the delegations of the following Member States, who had been seated provisionally in the Health Assembly pending the arrival of their formal credentials: Andorra, Azerbaijan, Finland, Honduras, Micronesia (Federated States of), Mongolia, Turkmenistan.

These credentials were found to be in conformity with the Rules of Procedure of the World Health Assembly, and the Bureau therefore proposes that the Health Assembly recognize their validity.

COMMITTEE ON NOMINATIONS

First report[2]

[A57/34 – 17 May 2004]

The Committee on Nominations, consisting of delegates of the following Member States: Bahrain, Brunei Darussalam, Burkina Faso, China, Democratic Republic of the Congo, Eritrea, Estonia, France, Guyana, Israel, Mexico, Micronesia (Federated States of), Monaco, Mozambique, Nicaragua, Peru, Russian Federation, Sri Lanka, Swaziland, Thailand, Tunisia, Uganda, United Kingdom of Great Britain and Northern Ireland, and Uruguay, and Dr Khandaker Mosharraf Hossain (Bangladesh) (ex officio), met on 17 May 2004.

In accordance with Rule 25 of the Rules of Procedure of the World Health Assembly and respecting the practice of regional rotation that the Health Assembly has followed for many years in

[1] Approved by the Health Assembly at its seventh plenary meeting.

[2] Approved by the Health Assembly at its first plenary meeting.

this regard, the Committee decided to propose to the Health Assembly the nomination of Mr Muhammad Nasir Khan (Pakistan) for the Office of President of the Fifty-seventh World Health Assembly.

Second report[1]

[A57/35 – 17 May 2004]

At its first meeting, held on 17 May 2004, the Committee on Nominations decided to propose to the Health Assembly, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations:

Vice-Presidents of the Health Assembly: Dr M.E. Tshabalala-Msimang (South Africa), Mrs Ann David-Antoine (Grenada), Mr S. Bogoev (Bulgaria), Dr Rui Maria de Araujo (Timor-Leste), Dr Chua Soi Lek (Malaysia);

Committee A: **Chairman** – Dr Ponmek Dalaloy (Lao People's Democratic Republic);

Committee B: **Chairman** – Dr Jigmi Singay (Bhutan).

Concerning the members of the General Committee to be elected under Rule 31 of the Rules of Procedure of the World Health Assembly, the Committee decided to nominate the delegates of the following 17 countries: Botswana, Chad, Chile, China, Cuba, France, Ireland, Kazakhstan, Liberia, Libyan Arab Jamahiriya, Niger, Nigeria, Russian Federation, Trinidad and Tobago, United Kingdom of Great Britain and Northern Ireland, United States of America and Yemen.

Third report[2]

[A57/36 – 17 May 2004]

At its first meeting held on 17 May 2004, the Committee on Nominations decided to propose to each of the main Committees, in accordance with Rule 25 of the Rules of Procedure of the World Health Assembly, the following nominations for the Offices of Vice-Chairmen and Rapporteur:

Committee A: Vice-Chairmen: Dr D. Slater (Saint Vincent and the Grenadines) and Mrs A. Van Bolhuis (Netherlands);
Rapporteur: Professor M. Mizanur Rahman (Bangladesh);

Committee B: Vice-Chairmen: Professor N.M. Nali (Central African Republic) and Dr S. Al Kharabseh (Jordan);
Rapporteur: Mrs Zsuzsana Jakab (Hungary).

---

[1] Approved by the Health Assembly at its first plenary meeting.

[2] See summary records of the first meetings of Committees A and B (pp.17 and 153, respectively).

GENERAL COMMITTEE

Report[1]

[A57/38 – 19 May 2004]

Election of Members entitled to designate a person to serve on the Executive Board

At its meeting on 19 May 2004, the General Committee, in accordance with Rule 102 of the Rules of Procedure of the World Health Assembly, drew up the following list of 12 Members, in the English alphabetical order, to be transmitted to the Health Assembly for the purpose of the election of 12 Members to be entitled to designate a person to serve on the Executive Board: Australia, Bahrain, Bolivia, Brazil, Jamaica, Kenya, Lesotho, Libyan Arab Jamahiriya, Luxembourg, Romania, Thailand, Tonga.

In the General Committee's opinion these 12 Members would provide, if elected, a balanced distribution on the Board as a whole.

COMMITTEE A

First report[2]

[A57/39 – 20 May 2004]

On the proposal of the Committee on Nominations,[3] Dr D. Slater (Saint Vincent and the Grenadines) and Mrs A. Van Bolhuis (Netherlands) were elected Vice-Chairmen, and Professor M. Mizanur Rahman (Bangladesh) Rapporteur.

Committee A held its first meeting on 18 May 2004 and its second and third meetings on 19 May 2004 under the chairmanship of Dr Ponmek Dalaloy (Lao People's Democratic Republic). During the third meeting Dr D. Slater (Saint Vincent and the Grenadines) later took the chair *ad interim*.

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of the two resolutions and one decision relating to the following agenda items:

12. Technical and health matters
    12.2 Surveillance and control of *Mycobacterium ulcerans* disease (Buruli ulcer) [WHA57.1]

---

[1] See document WHA57/2004/REC/2, verbatim record of the seventh plenary meeting, section 3.

[2] Approved by the Health Assembly at its seventh plenary meeting.

[3] See the third report of the Committee on Nominations, above.

12.3 Control of human African trypanosomiasis [WHA57.2]
12.15 Implementation of resolutions (progress reports)
Intellectual property rights, innovation and public health [WHA57(9)]

Second report[1]

[A57/44 – 22 May 2004]

Committee A held its fourth, fifth, sixth and seventh meetings on 20 and 21 May 2004. The fourth and fifth meetings were under the chairmanship of Dr Ponmek Dalaloy (Lao People's Democratic Republic) and the sixth and seventh meetings were under the chairmanship of Mrs A. Van Bolhuis (Netherlands).

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of five resolutions relating to the following agenda items:

12. Technical and health matters
12.7 Road safety and health [WHA57.10]
12.9 Family and health in the context of the tenth anniversary of the International Year of the Family [WHA57.11]
12.10 Reproductive health
Reproductive health: strategy to accelerate progress towards the attainment of international development goals and targets [WHA57.12]
12.13 Genomics and world health: report of the Advisory Committee on Health Research
Genomics and world health [WHA57.13]
12.1 HIV/AIDS
Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS [WHA57.14]

Third report[1][c1]

[A57/47 – 22 May 2004]

Committee A held its eighth meeting on 22 May 2004 under the chairmanship of Dr Ponmek Dalaloy (Lao People's Democratic Republic).

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of four resolutions relating to the following agenda items:

12. Technical and health matters
12.8 Health promotion and healthy lifestyles [WHA57.16]
12.6 Global strategy on diet, physical activity and health [WHA57.17]
12.14 Human organ and tissue transplantation [WHA57.18]
12.11 Health systems, including primary health care
International migration of health personnel: a challenge for health systems in developing countries [WHA57.19]

[1] Approved by the Health Assembly at its eighth plenary meeting.

COMMITTEE B

First report[1]

[A57/41 – 20 May 2004]

Committee B held its first meeting on 20 May 2004 under the chairmanship of Dr Jigmi Singay (Bhutan).

On the proposal of the Committee on Nominations,[2] Professor N.M. Nali (Central African Republic) and Dr S. Al Kharabseh (Jordan) were elected Vice-Chairmen, and Mrs Z. Jakab (Hungary), Rapporteur.

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of one resolution relating to the following agenda item:

19. Health conditions of, and assistance to, the Arab population in the occupied Arab territories, including Palestine [WHA57.3]

Second report[3]

[A57/42 – 21 May 2004]

Committee B held its second meeting on 20 May under the chairmanship of Dr Jigmi Singay (Bhutan).

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of one resolution relating to the following agenda item:

15. Financial matters
    15.1 Financial report on the accounts of WHO for 2002-2003; report of the External Auditor and comments thereon made on behalf of the Executive Board [WHA57.4]

Third report[3]

[A57/43 – 22 May 2004]

Committee B held its third meeting on 21 May under the chairmanship of Dr Jigmi Singay (Bhutan).

---

[1] Approved by the Health Assembly at its seventh plenary meeting.

[2] See third report of the Committee on Nominations, above.

[3] Approved by the Health Assembly at its eighth plenary meeting.

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of two resolutions relating to the following agenda items:

15. Financial matters
    15.2 Status of collection of assessed contributions, including Member States in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution
        Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution [WHA57.5]
        Arrears in payment of contributions: Ukraine [WHA57.6]

Fourth report[1][c2]

[A57/45 – 22 May 2004]

Committee B held its fourth meeting on 21 May under the chairmanship of Dr Jigmi Singay (Bhutan), Professor N.M. Nali (Central African Republic), and Dr S. Al Kharabseh (Jordan).

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of three resolutions and three decisions relating to the following agenda items:

18. Legal matters
    18.1 Agreement with the Office International des Epizooties [WHA57.7]
    18.2 Rules of Procedure of the World Health Assembly: amendment to Rule 72 [WHA57.8]
12. Technical and health matters
    12.16 Eradication of dracunculiasis [WHA57.9]
16. Programme and budget matters
    16.1 Regular budget allocations to regions
        Budget allocations to regions [WHA57(10)]
17. Staffing matters
    17.3 Appointment of representatives to the WHO Staff Pension Committee
        United Nations Joint Staff Pension Fund: appointment of representatives to the WHO Staff Pension Committee [WHA57(11)]
21. Policy for relations with nongovernmental organizations [WHA57(12)].

Fifth report[1]

[A57/46 – 22 May 2004]

Committee B held its fifth meeting on 22 May under the chairmanship of Dr Jigmi Singay (Bhutan).

[1] Approved by the Health Assembly at its eighth plenary meeting.

It was decided to recommend to the Fifty-seventh World Health Assembly the adoption of one resolution relating to the following agenda item:

15. Financial matters
    15.3 Scale of assessments for 2005 [WHA57.15].