



WORLD HEALTH ORGANIZATION

EXECUTIVE BOARD

115TH SESSION

GENEVA, 17-24 JANUARY 2005

SUMMARY RECORDS

GENEVA
2005



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ABBREVIATIONS

Abbreviations used in WHO documentation include the following:

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

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

PREFACE

The 115th session of the Executive Board was held at WHO headquarters, Geneva, from 17 to 24 January 2005. The proceedings are issued in two volumes. The present volume contains the summary records of the Board's discussions, list of participants and officers, and details regarding membership of committees and working groups. The resolutions and decisions and relevant annexes are published in document EB115/2005/REC/1.

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¹ As adopted by the Board at its first meeting (17 January 2005).

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LIST OF DOCUMENTS

EB115/1 Rev.1	Agenda ¹
EB115/1(annotated)	Provisional agenda (annotated)
EB115/1 Add.1	Supplementary provisional agenda
EB115/2	Report by the Director-General to the Executive Board at its 115th session
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EB115/4	Revision of the International Health Regulations
EB115/5 and Corr.1	Achievement of the health-related Millennium Development Goals: status report
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¹ See page ix.

² See document EB115/2005/REC/1, Annex 1.

EB115/16	Status of collection of assessed contributions including Members in arrears to an extent which would justify invoking Article 7 of the Constitution
EB115/17	Assessed contributions. Assessments for 2006-2007
EB115/18	Appointment of the Regional Director for Africa
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EB115/23	Reports of the Joint Inspection Unit and related matters. Previous JIU reports: implementation of recommendations
EB115/24	Reports of the Joint Inspection Unit and related matters: recent JIU reports
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¹ See document EB115/2005/REC/1, Annex 5.

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EB115/33	Human resources. Report of the International Civil Service Commission
EB115/34	Nongovernmental organizations: Reconsideration of two applications for admission into official relations with WHO
EB115/35	Commission on Social Determinants of Health
EB115/36	Global smallpox vaccine reserve
EB115/37 and Corr.1	Public health problems caused by alcohol
EB115/38, Corr.1, Corr.2 and Add.1	Confirmation of amendments to the Staff Rules ¹
EB115/39	eHealth
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EB115/41	Proposed programme budget for the financial period 2006-2007. Real Estate Fund ²
EB115/42	Programme budget 2002-2003: performance assessment report
PBPA/2002-2003	Programme budget 2002-2003: performance assessment report
EB115/43	Amendments to the Financial Regulations and Financial Rules ³
EB115/44 and Corr.1	Influenza pandemic preparedness and response
EB115/45	Report of the first meeting of the Programme, Budget and Administration Committee of the Executive Board
PPB/2006-2007	Proposed programme budget 2006-2007
PPB/2006-2007 Add.1	Proposed programme budget 2006-2007. Linkage tables

¹ See document EB115/2005/REC/1, Annex 3 and Annex 4.

² See document EB115/2005/REC/1, Annex 6.

³ See document EB115/2005/REC/1, Annex 2.

Information documents

EB115/INF.DOC./1	Statement by the representative of the WHO staff associations
EB115/INF.DOC./2	Reproductive cloning of human beings: status of the debate in the United Nations General Assembly
EB115/INF.DOC./3	Reflection in Proposed programme budget 2006-2007 of achievement in, and obstacles to, implementing Health Assembly resolutions: assessment for 2001-2004
EB115/INF.DOC./4	Proposed programme budget 2006-2007. Comparison with the Programme budget 2004-2005
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International Catholic Committee of Nurses and Medico-social Assistants

Mrs D. ROSIERS

International College of Surgeons

Professor P. HAHNLOSER
 Professor N.S. HAKIM
 Dr R. DIETER
 Professor LEE Chun-Jean
 Mr M. DOWNHAM

International Confederation of Midwives

Mrs K. HERSCHDERFER
 Mrs R. BRAUEN
 Mrs J. BONNET

International Council for Control of Iodine Deficiency Disorders

Mr J.C. LING
 Dr H. BURGI
 Dr M. ZIMMERMANN

International Council of Nurses

Dr J.A. OULTON

International Council of Women

Mrs P. HERZOG
 Dr A. KING

International Epidemiological Association

Dr R. SARACCI

International Federation of Business and Professional Women

Ms M. GERBER
 Ms G. GONZENBACH

International Federation of Gynecology and Obstetrics

Dr R. KULIER

International Federation of Medical Students' Associations

Mr A. RUDKJØBING

International Federation of Oto-rhino-laryngological Societies

Professor J.J. GROTE

International Federation of Pharmaceutical Manufacturers Associations

Dr H. BALE
 Dr E. NOEHRENBURG
 Mr B. AZAIS
 Ms O. MORIN
 Mrs R. KRAUSE
 Mr M. GAJEWSKI
 Mrs K. ELEMESOVA
 Mr T. SANO
 Ms A.-L. BOFFI
 Ms L. JANSSON
 Ms P. CARLEVARO
 Mr S. BRUPBACHER
 Ms S. CROWLEY
 Ms A. VILA
 Mr M. OJANEN
 Mr J. PENDER
 Mr P. HEDGER

International Hospital Federation

Professor P.-G. SVENSSON
 Mr D. MOE
 Miss S. ANAZONWU

International Lactation Consultant Association

Ms M. LEHNERS-ARENDT

International League of Dermatological Societies

Professor J.-H. SAURAT

International Organization for Standardization

Mr K. MCKINLEY
 Mr T. HANCOX

International Pharmaceutical Federation

Mr T. HOEK
Ms S. SIISKONEN
Ms T. ALVES

International Pharmaceutical Students' Federation

Ms T. WULIJ
Mr S. DALGLIESH
Mr J. MEULENAAR
Ms L. ZWICKER
Ms M. LESKO
Ms Y. NGUYEN
Mr M.N. FORS

International Society for Preventive Oncology

Dr H.E. NIEBURGS

International Special Dietary Foods Industries

Dr A. BRONNER
Mr M. DE SKOWRONSKI
Mr K. DE JONG
Ms J. KEITH
Mr D. HAWKINS
Ms C. DROTZ-JONASON
Mr THIEN LUONG VAN MY
Mr M. MIRANDA
Ms H. MOUCHLY WEISS
Ms K. BOLOGNESE
Ms S. RIBAS
Mr R. CLARKE
Ms M. CREEDON
Ms D. MALONE
Mr H. SCHOLICK
Mr C. BURCKY
Mr D. SPEIGEL

International Union of Architects

Mme S. CHATZICOCOLI-SYRAKOU
Mme A.C. SYRAKOY

La Leche League International

Ms H. KUONEN-GOETZ

Rotary International

Mr G. COUTAU
Mr R. HÖRNDLER

Soroptimist International

Ms I.S. NORDBACK

The International Association of Lions Clubs (Lions Club International)

Mr G.E. CANTAFIO

The Network: TUFH

Dr P. KEEKI

The Save the Children Fund

Ms R. KEITH
Ms J. LAMBO

The World Federation of Acupuncture-Moxibustion Societies

Professor NGUYEN TAI THU

World Association of Societies of Pathology and Laboratory Medicine

Dr U. MERTEN

World Federation for Medical Education

Dr H. KARLE
Professor L. CHRISTENSEN

World Federation for Mental Health

Dr S. FLACHE
Mrs M. LACHENAL

World Federation of Hydrotherapy and Climatotherapy

Professor N. STOROZHENKO
Professor U. SOLIMENE
Ms E. MINELLI

World Heart Federation

Ms J. VOÛTE
Ms H. ALDERSON
Ms D. GRIZEAU-CLEMENS

World Medical Association

Dr D. HUMAN
Dr O. KLOIBER
Dr Y. COBLE
Professor J. WILLIAMS

Dr Y. BLACHAR
Dr J.L. CALLOC'H

World Self-Medication Industry

Dr D. WEBBER

World Vision International

Dr M. AMAYUN

COMMITTEES AND WORKING GROUPS¹

1. Programme, Budget and Administration Committee

Ms J. Halton (Australia), Dr N.A. Haffadh (Bahrain), Mr I. Shugart (Canada), Dr Yin Li (China), Professor B. Fišer (Czech Republic), Professor W. Dab (France), Dr M. Camara (Guinea), Mr D.Á. Gunnarsson (Iceland, member ex officio), Dr M. Phooko (Lesotho), Dr A.A. Yoosuf (Maldives, member ex officio), Dr H.N. Acharya (Nepal), Mr M.N. Khan (Pakistan), Mrs Sudarat Keyuraphan (Thailand), Dr W.R. Steiger (United States of America)

First meeting, 12-14 January 2005: Dr A.A. Yoosuf (Maldives, Chairman), Ms J. Halton (Australia, Vice-Chairman), Dr A.W.M. Abdul Wahab (Bahrain, alternate to Dr N.A. Haffadh), Mr D. MacPhee (Canada, alternate to Mr I. Shugart), Dr Qi Qingdong (China, alternate to Dr Yin Li), Mr M. Bouček (Czech Republic, alternate to Professor B. Fišer), Dr J.-B. Brunet (France, alternate to Professor W. Dab), Dr M. Camara (Guinea), Mr T.J. Ramotsoari (Lesotho, alternate to Dr M. Phooko), Dr H.N. Acharya (Nepal), Dr Suwit Wibulpolprasert (Thailand, alternate to Mrs Sudarat Keyuraphan), Ms A. Blackwood (United States of America, alternate to Dr W.R. Steiger)

2. Standing Committee on Nongovernmental Organizations

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

Meeting of 18 January 2005: Dr F. Huerta Montalvo (Ecuador, Chairman), Dr A.A. Yoosuf (Maldives), Dr F. Lamata Cotanda (Spain), Mrs I.I.M. Elamin (Sudan, alternate to Dr A.B. Osman), Mrs Le Thi Thu Ha (Viet Nam)

3. Léon Bernard Foundation Committee

The Chairman and Vice-Chairmen of the Executive Board, and Dr D. Hansen-Koenig (Luxembourg)

Meeting of 19 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Dr Yin Li (China), Dr F. Huerta Montalvo (Ecuador), Dr A.A. Yoosuf (Maldives), Dr I.M. Abdulla (Sudan, alternate to Dr A.B. Osman), Dr D. Hansen-Koenig (Luxembourg)

4. Jacques Parisot Foundation Committee

The Chairman and Vice-Chairmen of the Executive Board, and Professor M. Cinteza (Romania)

Meeting of 19 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Dr Yin Li (China), Dr F. Huerta Montalvo (Ecuador), Dr A.A. Yoosuf (Maldives), Dr I.M. Abdulla (Sudan, alternate to Dr A.B. Osman), Dr L. Sanda (Romania, alternate to Professor M. Cinteza)

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

5. Ihsan Dogramaci Family Health Foundation Selection Panel

The Chairman of the Executive Board, the President of Bilkent University (Ankara) or his or her appointee, and a representative of the International Children's Centre (Ankara)

Meeting of 20 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Professor M. Bertan (representative of the President of Bilkent University), Ms N. Grasser (representative of the International Children's Centre)

6. Sasakawa Health Prize Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board

Meeting of 20 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Professor K. Kiikuni (representative of the founder), Dr V. Tangi (Tonga)

7. United Arab Emirates Health Foundation Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region

Meeting of 18 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Mr N.K. Al Budoor and Mr A.H. Al Humood (representatives of the founder), Dr A.W.M. Abdul Wahab (Bahrain, alternate to Dr N.A. Haffadh)

8. State of Kuwait Health Promotion Foundation Selection Panel

The Chairman of the Executive Board, a representative of the founder, and a member of the Executive Board from a Member State of the WHO Eastern Mediterranean Region

Meeting of 19 January 2005: Mr D.Á. Gunnarsson (Iceland, Chairman), Dr A. Al-Saif (representative of the founder), Mr M.N. Khan (Pakistan)

SUMMARY RECORDS

FIRST MEETING

Monday, 17 January 2005, at 09:35

Chairman: Mr D.Á. GUNNARSSON (Iceland)

- 1. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (Documents EB115/1 and EB115/1 Add.1)

The CHAIRMAN declared open the 115th session of the Executive Board.

- 2. EXPRESSION OF SYMPATHY AND SOLIDARITY WITH PEOPLE AND COUNTRIES SUFFERING AS A RESULT OF THE EARTHQUAKE AND TSUNAMI IN SOUTH ASIA**

At the invitation of the CHAIRMAN, the Board observed a minute of silence in memory of all who had lost their lives in the tragic events in south Asia.

- 3. OPENING OF THE SESSION AND ADOPTION OF THE AGENDA:** Item 1 of the Provisional agenda (resumed)

The CHAIRMAN proposed, following consultations among Board members from the African Region, that Dr Ndong (Gabon) be elected as Rapporteur for the current session, replacing Dr Nyikal (Kenya) who was unable to attend.

It was so agreed.

The CHAIRMAN, turning to the provisional agenda (document EB115/1), said that in view of the large number of items already on the agenda, some of the items proposed by Member States had had to be deferred to the Board's 116th session. Document EB115/1 Add.1 contained a proposal by the United States of America to include, under Rule 10 of the Rules of Procedure of the Executive Board, a supplementary agenda item of an urgent nature on influenza pandemic preparedness and response. If the Board so agreed, the item would be considered under agenda item 4, Technical and health matters.

Dr ANTEZANA ARANÍBAR (Bolivia) suggested, in the light of that proposal, that discussion of agenda item 5, Programme and budget matters, be brought forward so that the objectives and strategies decided on could be borne in mind when considering item 4.

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) supported the proposal for the supplementary agenda item, in view of the increasing burden of new and emerging infectious diseases, including avian influenza and severe acute respiratory syndrome (SARS). Improvement of epidemiological surveillance systems was urgently needed to allow rapid

identification and prompt control of any outbreak, given the strong possibility of a genetic reassortment of avian and human influenza viruses during epidemics.

The CHAIRMAN said that, in the absence of any further comments, he took it that the inclusion of the supplementary agenda item was acceptable.

The agenda, as amended, was adopted.¹

4. ORGANIZATION OF WORK

In view of the interest expressed by Member States in assessing the effects of the recent tsunami in south Asia and WHO's response to it, the CHAIRMAN proposed that subitem 4.3, Responding to health aspects of crises, should be taken up as the first subitem under item 4, Technical and health matters. Further timetable adjustments might have to be made later on in line with the Board's deliberations and daily developments. Referring to the proposal by the member for Bolivia, he suggested that, since such a change would inconvenience several members of the Board whose experts on budget issues were not due to attend the session until later in the week, the Board might agree to holding a short discussion on the budget immediately after discussion of agenda item 3, Report of the Programme, Budget and Administration Committee.

He took it that the proposed changes were acceptable.

It was so agreed.

The CHAIRMAN pointed out that in compliance with Rule 7 of the Rules of Procedure of the Executive Board, subitems 7.1 and 7.2, concerning appointments of Regional Directors, would be considered in an open meeting. He proposed that, as in the Board's 113th session, the reports of the awards Selection Panels should be considered and recipients of the awards be determined in public session, under subitem 7.5, Reports of the foundation committees. The reports of the Selection Panels for the prizes to be awarded in 2005 would continue to be circulated as restricted documents to Board members. Should a member of the Board feel that the proposals in those reports should be considered in a forum other than a public meeting, a proposal to change the nature of the meeting could be made and considered by the Board at the opening of the item.

He took it that the Board agreed to those proposals.

It was so agreed.

(For continuation of the discussion, see the summary record of the second meeting, section 1.)

5. REPORT BY THE DIRECTOR-GENERAL: Item 2 of the Agenda (Document EB115/2)

The DIRECTOR-GENERAL said that the tsunami disaster had devastated countries bordering the Indian Ocean and had claimed the lives of more than 160 000 people. While the world's attention had been focused on the countries most badly hit, it should not be forgotten that communities much further away had also been affected.

¹ See page ix.

During his recent visit to Indonesia and Sri Lanka, he had been impressed by the work being done by the surviving local health workers in caring for the many thousands of injured people, and by survivors already rebuilding their homes and communities.

Much had been achieved through the massive international and national relief effort. An early warning and control system for epidemics had been set up, and no outbreaks had yet been reported. Assessments of health services, which would also help to determine reconstruction needs, were being carried out in the affected areas. Health system supply chains were being restored and public health services re-established. WHO was establishing ways of meeting the immediate and longer-term mental health needs of the survivors, their families and carers, and was also supporting national authorities in coordinating the work of those responding to the disaster, namely, local and national staff and health workers with intergovernmental and nongovernmental agencies.

He interrupted his speech for a video conference with Dr Rob Holden, Operations Manager for the South Asia Crisis Assessment Team; Dr Wayan Widaya, Communicable Disease Specialist, Centre of Diseases Control Research and Development, Indonesia; Rear-Admiral Crowder, Commander, Naval Forces of the Combined Support Forces; Dr Eigil Sorensen, Special WHO Representative for Disaster Relief and Coordination in Indonesia; and Dr Georg Petersen, WHO Representative, Indonesia, who described their work in supporting the health and rehabilitation needs of the victims of the disaster.

Resuming his address, he confirmed that the emergency phase was rapidly becoming one of rehabilitation and self-reliance. The long-term aim was to ensure that people were protected from health threats by an effective global system of alert and response. The transition from relief to reconstruction had to be given sustained support to ensure that communities did not languish for many years in a state of dependence, with high levels of disease and mortality, as rebuilding the physical infrastructure might take several years. It would also be essential to invest in people, as thousands of health workers and other public service employees had been killed.

The disaster had seriously set back the social, economic and health development gains of recent years within the region. It was imperative that both immediate and long-term needs were met and that international support was adequate, effective and sustained, but such support must be led and coordinated by the affected countries themselves.

Of the US\$ 67 million requested the previous week by WHO as part of the United Nations Flash Appeal, two thirds had already been pledged. The generous international response to the disaster and the resilience shown at local and national levels gave hope for rapid recovery and reconstruction. It was essential, however, that the resources pledged were used effectively, without reducing support for other areas of need in the world. The launch by the United Nations of "A practical plan to achieve the Millennium Development Goals", which showed the investment needed to reach those goals by 2015, would help to maintain the momentum of those global efforts. To mark the launch of that plan, an event focusing on its health components would be held at WHO headquarters the following day.

The world's response to the tsunami emergency had shown the willingness of governments and the public to support communities that were suddenly afflicted by disaster. The United Nations and its specialized agencies had been established as a result of a similarly clear view of global need and of the decision to meet it with an effective, long-term system of support and cooperation. The recently released report of the United Nations Secretary-General's High-Level Panel on Threats, Challenges and Change underlined WHO's indispensable role in ensuring international security. Its invitation to the Health Assembly to consider the recommendation that it increase resources for global monitoring and response to emerging infectious disease signalled the importance of ensuring that WHO had an adequate regular budget in future bienniums.

The demand for global public health activities, against both infectious and noncommunicable diseases, had grown rapidly in recent years. The danger of a pandemic, for example of SARS, avian influenza or influenza, required rapid response systems to be in place. The need to tackle the social determinants of health was also increasingly apparent. All of that was in addition to the need to be prepared for unforeseeable disasters, such as the tsunami in south Asia.

Those were just some of the concerns of Member States that were reflected in the Proposed programme budget for 2006-2007 which recommended an overall increase of 12.8%; the proposed increase in the regular budget component was 9%. The Proposed programme budget also included measures to reduce costs by increasing efficiency and accountability. The goodwill represented by voluntary funding, which had continued to be a major resource for WHO, was much appreciated but an increase in assessed contributions was nevertheless being proposed to enable the Organization to fulfil its triple obligation to act decisively, consistently and impartially.

World Health Day 2005 had as its theme "Make every mother and child count". Every year, more than 10 million children died, 40% of them in the first month of life, and half a million women died from pregnancy-related causes. Nearly all those deaths, which could be greatly reduced if the resources needed to attain the Millennium Development Goals were made available, occurred in developing countries. Tackling that problem would be a major focus of work in 2005.

The WHO Commission on Intellectual Property Rights, Innovation and Public Health would complete its work and submit its report during 2006, and the WHO Commission on Social Determinants of Health would be launched in Santiago in March 2005. Human resources for health development would be a major focus of work during 2005 and would constitute the theme of *The world health report 2006* and World Health Day 2006.

With unprecedented attention on health needs, WHO had not only to respond rapidly to emergencies, but also to maintain prevention and control work. To meet those obligations, it had to evolve to reflect the world's changing health situation.

The CHAIRMAN observed that WHO's rapid response to the tsunami disaster showed how important it was to have a strong Organization that could respond to such emergencies as quickly as possible.

It was so agreed.

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

Responding to health aspects of crises: Item 4.3 of the Agenda (Document EB115/6)

The CHAIRMAN invited the Regional Director for South-East Asia to take the floor before the Secretariat briefed the Board on the current situation with a view to discussion of WHO's work in general.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that the events of 26 December 2004, the brunt of which had been borne by countries of his Region, would remain forever in the world's memory. The countries least affected had been Bangladesh and Myanmar, but India, Indonesia, Maldives, Sri Lanka and Thailand had been hard hit. To respond to the crisis, a tsunami task force and operations room had been established and were working around the clock. The task force was acting in close coordination with headquarters and the various countries affected in monitoring public health conditions, mobilizing resources and coordinating information. A Regional Office web site, established on the second day, provided situation reports and access to a range of key guidelines for emergency management. Coordination was enhanced by daily teleconferences between the affected countries, headquarters and the Regional Office. In addition, satellite communication had been established with Aceh, Indonesia, Maldives and Sri Lanka, and WHO operational units were being established in Indonesia and Sri Lanka.

In the early stages, priority had been given to the provision of technical advice. WHO emergency staff and field staff from other programmes had been deployed in the affected areas. Vital medical supplies had been provided. WHO had also responded speedily to a request for technical

advice and guidance to tackle the psychosocial consequences. The Regional Office's main task, however, had become coordination with other international agencies in assessing health infrastructure damage, restoring basic health services and advising on rehabilitation plans. A tsunami health bulletin would be issued regularly, and a strategy for health action during the first 100 days was in place, focused on five key areas: disease surveillance and response, including early warning systems; coordination of health activities in relief operations; access to essential health care; provision of technical guidance on critical public health issues and improved routine health services; and coordination of efforts to restore medical supply chains.

To respond to the affected countries' immediate needs, WHO had mobilized more than 60 professional staff to work in Indonesia, 20 in Maldives, 50 in Sri Lanka and 27 in Thailand. In addition, epidemiologists and other experts were on standby to be deployed as and when required. Additional supplies and equipment, such as a mobile laboratory, had also been made available, with the support of many countries.

Teams of senior staff would visit the affected countries in order to ensure efficiency of work, provide on-the-spot assessment and ensure coordination among WHO staff and those of other international agencies. The use of financial resources would also be closely monitored to ensure transparency and accountability. A rehabilitation strategy plan had also been developed and would be implemented, as the second phase was entered, in close consultation with the World Bank and other key partners.

Most of WHO's efforts, although impressive, were modest compared to the response from many countries. The scale of the catastrophe was beyond any single organization's capacity to cope with alone, and the contribution of all participants was greatly appreciated. Never before, however, had the United Nations system demonstrated the ability to react to a crisis with such unity, professionalism and speed. The response had been unprecedented. He thanked the Director-General and all Regional Directors for their sympathy, concern and solidarity in helping the South-East Asia Region through such a difficult time.

Every disaster presented an opportunity to enhance emergency preparedness capacity. WHO's efforts, therefore, should also be aimed at helping to rebuild and strengthen the health infrastructure that existed before the tsunami struck. The challenge was immense, but he was convinced that the efforts would succeed and thus promote long-lasting benefits.

The CHAIRMAN expressed the Board's appreciation of the regional efforts, and wondered whether there was any action that the Board itself could take to help.

Dr SAMLEE PLIANBANGCHANG (Regional Director for South-East Asia) said that further enhancing global solidarity could undoubtedly help. It was of the utmost importance to support all efforts in the field through the mobilization of human resources, supplies and equipment. The second phase would provide a good opportunity to enhance the capacities of individual countries, and to make them sustainable.

Dr NABARRO (Representative of the Director-General for Health Action in Crises), summarizing cooperation with other agencies and countries and WHO's ongoing response to humanitarian crises everywhere, said that WHO's involvement was essential in all crises because, whatever the causes, there were always substantial numbers of people whose health was threatened by resultant sickness as well as by the event itself. It provided guidance and expertise through staff on the spot, headquarters, regional offices and collaborating centres. Its advice was increasingly sought through the Internet as well as in global and local media.

The destruction in Aceh, Indonesia, and elsewhere in the region had been immense. More than 160 000 people had been killed and millions more had been affected; vital water, food, care and sanitation services had been disrupted; and many areas remained inaccessible even three weeks after the event. Health workers had been among the first to respond to the disaster, focusing on the most vulnerable groups and giving priority to protecting life and providing clean water and sanitation, while

devoting attention to hygiene and a healthy environment. Efforts had been made at all times to keep families together and to help communities. A wide range of countries had been affected, with loss of life and other grave consequences, and deaths among people from many other parts of the world present in the region at the time.

As the scale of the emergency became clear, WHO had begun to coordinate the relief offered by various groups: for example, within a few hours of the disaster its staff in Sri Lanka had been helping to provide life-saving care, move supplies from warehouses, assess needs, supply public-health expertise and coordinate assistance. Some 120 members of staff in the region had been deployed to support those who were having to cope with the crisis. Medical supplies for more than two million people had been delivered, together with one million cholera kits, and suboffices with functioning telecommunications had been established in the affected communities, despite sometimes dire weather conditions. Thanks to the generosity of Member States and the willingness of the Director-General to release funds from the reserves, money had reached countries within days. Progress was being assessed daily, communicable diseases early-warning surveillance systems were already some 75% operational, and 70% of public health strategies were in place. The greatest success, however, had been achieved in coordinating health actions. Staff had teamed up with national health ministries, the World Bank and the Asian Development Bank to ensure that health-sector issues were properly taken into account during repair and rehabilitation, above all in India, Indonesia, Maldives, Sri Lanka and Thailand.

Although the initial response had been rapid, it had sometimes been hampered by logistical complications. However, the Strategic Health Information Centre in Geneva and the operations room set up at the Regional Office for South-East Asia had permitted close cooperation between all concerned, and the recently established operational platforms were currently making it possible to work effectively in each country. All WHO regions had provided staff and expertise. All departments at headquarters and in the Regional Office for South-East Asia had offered administrative and technical support, and many members of staff had foregone annual leave in order to volunteer for the relief effort. The communicable diseases response groups, already tested by the SARS crisis, had played a key role, and the Global Outbreak Alert and Response Network, which drew on professionals in many Member States, had been activated, with good effect.

The pattern of WHO support differed from country to country. The Indian Government had responded rapidly to the dramatic impact of the tsunami on the southern and eastern coasts of the country and on the Nicobar and Andaman Islands, where injured survivors had required medical treatment. Priority had been given to safe drinking-water, sanitation, infrastructure and hygiene, and the existing disease surveillance network had been strengthened. The Government had provided substantial assistance to neighbouring countries, and had worked closely within the framework of existing partnerships with WHO and UNICEF to prioritize mental health, disease surveillance and measles immunization.

In Indonesia, the massive destruction of infrastructure meant that assessments were still being carried out, and pockets of people in need were still being found. Half the health staff were reportedly dead or missing. Tetanus cases had been reported, and there was a risk of malaria, diarrhoea and dengue fever. Cooperation between the civil and military authorities was exemplary and the quality of supply systems was being improved by tailoring responses to meet assessed needs. The systematic assessments being undertaken in conjunction with military personnel and with the USS *Abraham Lincoln* as a base, were yielding extremely useful reports, which were being posted immediately on web sites.

Malaysia and Myanmar had both suffered significant casualties and had been working with WHO to respond to the catastrophe.

Although the death toll in Maldives had been relatively low, the country's infrastructure had been severely damaged and, unless ports and piers were repaired quickly, the long-term impact on its economy, social services and government was likely to be substantial. Communicable disease threats were being investigated with care. There was a shortage of drinking-water, but disease surveillance had been established and health facility assessments were being conducted.

In Somalia, where 30 000 people had been affected, 4000 displaced and more than 150 people had died, WHO had worked jointly with the Ministry of Health to collect surveillance data, measure disease, assess needs, distribute emergency health kits, coordinate the health sector and send in emergency response teams.

In Sri Lanka, where a narrow coastal belt had been devastated, assistance to displaced persons had been prompt. A disease surveillance system had been launched. There had been no significant outbreak of diarrhoeal or other serious diseases. All the hospitals were currently functioning, and repair work was under way.

In the six disaster-stricken provinces on the west coast of Thailand, the first, most pressing need had been to ensure safe drinking-water, sanitation and hygiene facilities for displaced people and to identify the dead. The Thai Government had quickly ensured that disease surveillance was in place and there had in fact been no outbreaks of disease. A major programme of mental health and psychological support had been initiated, and rapid action taken to rehabilitate fishing and other communities in the affected region.

Discussions with communities on the ground had indicated that there would be need to look beyond emergency relief and to help rebuild lives, livelihoods, and governmental and social service infrastructures. For that reason, the relief endeavour must underpin recovery and the reconstruction of health systems, as well as economic repair. At the same time, it would be vital to strengthen local capacity for preparedness and response, so that no natural disaster could ever again wreak such havoc.

The Secretariat, a major contributor to the coordinated efforts of United Nations bodies, had sought at all times to liaise closely with Member States. It had relied heavily on close cooperation with both the civil and military authorities of the affected countries and those of Australia, France, Germany, Singapore and the United States of America. It was already involved in repair and reconstruction, and in the coming months would be turning its attention to the recovery of vital systems. The capacity to contain outbreaks already existed and a major epidemic was therefore unlikely.

The tsunami response would have implications for future efforts to improve performance in crisis situations, which were currently affecting some 40 Member States, chiefly as a result of long-term conflict. Even before the tsunami, the Secretariat had been busier than ever responding to the needs of communities suffering from conflict and natural disaster, and had introduced a strategy for scaling up action by raising fresh resources from Member States and engaging all parts of the Organization in a performance improvement programme.

In helping Member States prepare for, and respond to crises, WHO had four core functions: assessing health status, coordinating action, filling gaps and strengthening local systems and capacities. Thanks to the experience gained, in three years' time its response to crises should be more competent and sensitive, with better cooperation with other United Nations agencies and key partners, and upgraded and effective administrative procedures. In turn, enhanced effectiveness would make the Organization better equipped to meet the challenges of HIV/AIDS and to deal with issues of gender, women's health, mental health and health systems in communities at risk because of crises, to promote post-conflict recovery and to facilitate attainment of the Millennium Development Goals by countries with fragile economies and systems of governance.

Dr YOOSUF (Maldives) said that his country consisted of 1200 small islands, 200 of them inhabited, with a population of only 280 000 people. The tsunami had devastated the whole country. The country's poverty had made it more difficult to respond adequately to the crisis. There was very little safe drinking-water and most of the topsoil had been washed away, destroying the country's agriculture. Some 15 000 people had been made homeless. Fishing boats and harbour facilities had been destroyed, and in any case the fishermen were too busy rebuilding their homes to go fishing. The tourist industry had been badly affected: 25% of tourist resorts were still closed, and bookings were down because people did not wish to visit a disaster zone, or feared the possible health risks. The impact on the country's three main sources of income – tourism, fishing and agriculture – would affect the people's nutritional status for a long time to come. Many survivors, particularly children, needed

psychosocial support, which was being provided by nongovernmental organizations and intergovernmental agencies.

What lessons could be learnt from the disaster? The first was that WHO could not respond to such a situation alone: many other partners, national and international, civil and military, must be involved. Protocols and procedures must be established for the various partners to follow, so that the number of lives lost could be minimized and reconstruction more effectively organized.

There was currently no early-warning system for natural disasters in southern Asia. The tsunami had struck Sri Lanka a full hour before it reached Maldives, but it had not been possible to issue a warning. WHO's Strategic Health Information Centre, with its potential for round-the-clock surveillance at headquarters and constant contact with the regional offices, might usefully be adapted to take on that responsibility.

He thanked WHO, the International Federation of Red Cross and Red Crescent Societies and United Nations, intergovernmental and bilateral agencies for their goodwill and relief efforts, and hoped for their continued support. However, offers of personnel, equipment and medicines must be properly coordinated. With the assistance of the international community, his country hoped to regain as soon as possible the level of development it had enjoyed before the tsunami.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) agreed that a round-the-clock operations room was required to coordinate health needs, particularly in the case of natural disasters. Later that day, his Minister of Health would present a cheque for US\$ 500 000 to the Director-General as a contribution to the financing of the Strategic Health Information Centre.

Dr PHOOKO (Lesotho), speaking on behalf of the African group, also commended the response of WHO and other international organizations to the disaster. The most vulnerable groups, particularly women and children, had been the worst affected, and he emphasized the need to guard against exploitation and trafficking of members of such groups at times of crisis.

The African Region, with the largest number of least developed countries of all regions, suffered from constant crises, both natural and man-made. Famine in Eritrea and Ethiopia; armed conflict in Central African Republic, Democratic Republic of Congo, Liberia, and Sudan; outbreaks of disease and locust infestations were just a few examples. Thousands of lives were lost in Africa every day from those and other causes, including complications of pregnancy and childbirth, HIV/AIDS, malaria, tuberculosis and noncommunicable diseases, compounded by poverty and underdevelopment. He applauded the global commitment to and solidarity with the disaster in south Asia, but urged the international community not to forget Africa.

There was an urgent need for early-warning systems to counter the effects of natural disasters. The health sector must improve its global disease outbreak preparedness and response system. The current revision of the International Health Regulations was none too soon.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries, Romania and Turkey, said that the health threats facing the thousands of people displaced and made homeless after the tsunami made the work of WHO highly topical. The Organization's effective and rapid response to the disaster, the availability of its staff and the relevance of the analyses undertaken were to be commended.

There had been an unprecedented show of solidarity by the European Union in the wake of the disaster: Member States had provided €1500 million of public aid, and civil society, too, had made an exceptional financial commitment. The European Union had involved WHO in its crisis planning, and appreciated the coordination that had resulted and the quality of WHO's cooperation, including its participation in the meeting of the Council of the European Union on the disaster (Brussels, 7 January 2005). It was more important than ever for WHO to have the institutional capacity to mobilize, centralize and act in such crisis situations. Despite the unprecedented humanitarian response, it should not be forgotten that long-term rehabilitation and reconstruction would be a major challenge for the international community, but that should not eclipse other humanitarian needs elsewhere in the world.

Although the first responsibility to the survivors was to provide assistance and to give hope, the international community still had an obligation to consider ways of preventing the consequences of natural disasters, including health-related consequences. At the imminent World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005) the European Union would be supporting the strengthening of measures for prevention, early warning and disaster preparedness in coordination with the United Nations. It was also studying possibilities for the development of a rapid response capacity of its own, which would have both a medical and a social dimension.

Natural disasters were most devastating in poorer countries with lower levels of health, since HIV/AIDS, tuberculosis, malaria and other threats to health made populations more susceptible. Raising the health status of populations would thus not only achieve WHO's primary objective, but would constitute a significant step towards making nations and communities more able to resist the potential detrimental effects on health of crisis situations.

Professor CİNTEZA (Romania) said that his Government had provided about €400 000 worth of aid to different countries affected by the tsunami. A forthcoming challenge was to help those countries to plan for long-term reconstruction and to prepare for disasters, and Romania supported initiatives such as the World Conference on Disaster Reduction.

He welcomed the three-year programme aimed at enhancing WHO performance in crises, which was a global framework for action and a unified work plan, and emphasized the importance of the forum on health action in crises, which would provide Member States with information on progress and developments with respect to work in crisis and disaster situations. If WHO was to meet the health needs of all populations in disaster and crisis situations it should be given the basic tools to do so. It should not be forgotten that there were many other vulnerable people in crisis situations, including women and children, the elderly, and people suffering from acute trauma, chronic illnesses, mental health problems or disabilities.

He called on the Director-General to ensure the necessary technical support for the health elements of national disaster preparedness and response systems; mobilize adequate resources for the Emergency preparedness and response area of work; streamline the administrative, financing and personnel procedures; and mobilize additional resources to maintain WHO's improved performance.

Dr ACHARYA (Nepal) expressed his deepest sympathy to those affected by the tsunami, and commended WHO's work, particularly that carried out under the leadership of the Regional Director for South-East Asia. He hoped that immediate problems such as water and sanitation, control of epidemics, psychological after-effects and long-term rehabilitation would be dealt with successfully.

Dr YIN Li (China) said that WHO's extremely rapid response to the tsunami disaster proved that the Organization was indispensable, since its role in disease control and prevention in the disaster-stricken areas could not have been undertaken by any other international organization.

The Chinese Government had provided 500 million renminbi to disaster-stricken countries and 20 million for relief operations. It had also dispatched five health and DNA testing teams to Indonesia, Sri Lanka and Thailand. He himself had visited four of the countries affected by the tsunami, and believed that WHO should play a leadership and coordinating role in all disaster relief and disease prevention efforts. For the future, WHO's goal should be to strengthen emergency preparedness and response capacity, and create greater global awareness of the need for international cooperation in dealing with public health problems.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

The meeting rose at 12:30.

SECOND MEETING

Monday, 17 January 2005, at 14:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

1. ORGANIZATION OF WORK (continued from the first meeting)

The CHAIRMAN said that, following representations by the member for Sudan and discussions with members for other Member States in the Eastern Mediterranean Region regarding working arrangements on the Muslim religious holiday of Eid el-Adha, it was proposed that the Board should not meet on the morning of Thursday, 20 January 2005.

Dr LARIVIÈRE (alternate to Mr Shugart, Canada) said that the issue of sensitivity to religious practices had been raised in the past and the Board had adopted a decision on the subject. As the various major religions of the world had holy days at different times of the year, observing all of them would drastically reduce the Organization's working days. The arrangement proposed by the Chairman risked establishing a precedent whereby all similar requests would have to be honoured in future. He did not object to the arrangement proposed, but wished to sound a note of caution.

The CHAIRMAN said that, if there were no objections, he would take it that the Board agreed to the proposed change in the working arrangements for its current session, on the understanding that no precedent would be created thereby.

It was so agreed.

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

Responding to health aspects of crises: Item 4.3 of the Agenda (Document EB115/6) (continued from the first meeting)

Dr AHMED (Ghana) expressed his country's deep sympathy and condolences for the victims of the recent tsunami. The President of Ghana had launched an appeal for aid and private institutions and individuals had donated materials and funds, an effort which was being coordinated locally by UNDP.

Ghana commended WHO's vision in attempting to appraise the emergency through the Strategic Health Information Centre which, having been tested by the disaster and found to be efficient, should be maintained in order to monitor any future disasters.

Dr STEIGER (United States of America) said that having been closely involved in much of the planning and implementation of the response to the tsunami, the United States considered that it was probably the most effectively coordinated international relief effort seen in many years. Much of the credit for the health-related aspects of the response went to the leadership at WHO. His country was proud to be working in partnership with WHO, the other agencies in the coalition and the governments concerned. The United States had already disbursed about US\$ 100 million of the US\$ 350 million pledged by President Bush.

The coordination of the relief effort had been of such high quality that it presented a good model for use by WHO in the future. It was encouraging that the investment made by his Government and others in the Strategic Health Information Centre had paid benefits during the crisis in ensuring better

links between headquarters, the regional offices, donors and Member States. The video link established earlier in the day had illustrated the excellent relationship that existed between United States military and civilian forces on the ground and the international agencies – a level of cooperation that was almost unprecedented.

He thanked the many staff members of WHO who were working so hard in response to the tsunami and expressed the hope that following the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005) WHO would be able to apply the lessons learnt to its future efforts, as well as to its daily work.

Mrs LE THI THU HA (Viet Nam) said that her Government had decided to grant US\$ 450 000 in aid and goods, including medicine and vaccines, to disaster-stricken countries. It had welcomed the Special ASEAN Leaders' Meeting on the Aftermath of the Earthquake and Tsunami (Jakarta, 6 January 2005) and the pledge by world leaders to set up an Indian Ocean early warning system, which could save lives in the event of a repetition of the disaster.

Viet Nam commended WHO's prompt action in providing guidance to national authorities, other United Nations agencies and nongovernmental organizations to ensure that the public health needs of people in the tsunami-affected areas were met. It welcomed WHO's efforts to establish an early warning system for disease outbreak, with strong disease surveillance and laboratory support in the affected areas. It fully supported WHO's appeal for US\$ 67 million to prevent disease outbreaks in the affected areas of south-east Asia and the related public health emergency strategy focusing on five key objectives to ensure the rapid recovery and rehabilitation of public health services.

The disaster had taught a lesson about early warnings, sent a signal to countries that it was time to examine their means of coping with future natural disasters, and revealed the need to maintain an effective information system. Regional and international cooperation in disaster preparedness should be further strengthened. Her country supported further enhancement of WHO's capacity to respond to crises and natural disasters.

Mrs GILDERS (alternate to Mr Shugart, Canada) commended WHO's response in areas where it clearly had a comparative advantage in coordinating health activities. As the video link with Indonesia had shown, the close collaboration with agencies on the ground and the combined expertise of specialists from many countries would help to relieve immediate suffering and assess longer-term needs.

Canadians had contributed some US\$ 425 million to the tsunami-affected countries, much of which would be directed towards humanitarian relief and rehabilitation. Canadian reconstruction efforts would be targeted to longer-term recovery so that communities could again stand on their own feet. Preparedness was a precondition for effective response; and the experience of PAHO in that regard offered an example that could inform and strengthen WHO's activities. The painful lessons learnt from the recent disaster could be applied to the Organization's work in a broad range of crisis areas.

Dr BUSS (Brazil), speaking on behalf of the countries of MERCOSUR, commended the rapid and effective response of WHO's leaders and technical teams to that terrible challenge. Also worthy of note was the heart-warming show of solidarity on the part of governments and individuals throughout the world through the donations made to the suffering populations. The one positive aspect of the whole tragic episode was the realization that people throughout the world retained a sense of compassion and solidarity with others.

Mr PIROGOV (alternate to Mr Skotnikov, Russian Federation) said that the tragedy in south Asia had graphically demonstrated the need to develop appropriate and effective mechanisms to respond to every challenge to human health, including natural disasters. The Secretariat's intention to devote new efforts to preparing for action in emergency situations was therefore welcome. He was grateful for the provision of first-hand information on the efforts undertaken in the affected areas and

commended WHO's efforts to overcome the consequences of the tsunami, efforts in which his country was ready to take an active part.

Rescue workers and paramedics from his country had been among the first to arrive in the affected countries. Dozens of air shipments, thousands of tons of humanitarian aid and teams of Russian physicians, epidemiologists and rescue workers had been sent to the afflicted regions. The Government had decided to allocate US\$ 22 million to disaster relief, US\$ 3.5 million of which would be channelled directly to WHO. The Russian Federation was providing not only financial and in-kind contributions, but also the means of delivering Russian goods and those offered by other nations directly to the victims. That activity would be pursued.

Professor FIŠER (Czech Republic) said that, although earthquakes could not be forecast, the extent of the ensuing damage could be accurately predicted. Prevention was better than cure; and it had to be said that the early warning system had not functioned properly. International solidarity, including the involvement of his compatriots and Government in relief operations, was encouraging and important, but it was not enough. Although such disasters were likely to occur once in every 100 years, statistics showed that random events were most likely to occur at very short intervals. Another catastrophe could therefore be expected in some part of the world in the near future.

Despite economic growth, governments of developing and developed countries alike were failing to provide budgetary resources to deal with such potential crises. A balance must be struck between promotion of economic growth and protection of the lives and health of the population. Solidarity after the completion of relief operations was also of the utmost importance. The developed countries could contribute funds and the scientific capacity to create an appropriate action plan for the prevention and management of disasters worldwide.

Ms HALTON (Australia) said that the key role played by WHO and its partners in the response effort should not be overlooked; the outstanding contributions made by individuals in both their personal and professional capacities must also be acknowledged.

Total official Australian contributions to direct relief and reconstruction efforts stood at Aus\$ 1060 million, comprising a five-year Australian-Indonesian partnership for reconstruction and development, together with Aus\$ 60 million for immediate humanitarian and emergency response activities in the affected countries. To date the Australian community had made individual contributions of more than Aus\$ 1 million to relief efforts. The Australian Defence Forces had deployed medical teams and provided air transport of relief supplies and engineering capacity, including the operation of a water-purification plant pumping up to 480 000 litres of clean water every day in Banda Aceh. The Australian Federal Police had provided more than 30 officers to assist with disaster victim identification.

The main focus of Australia's response had been to provide urgently-needed relief to the affected communities and avert secondary threats such as disease. The Aus\$ 60 million in emergency assistance was being delivered by Australian nongovernmental organizations, international bodies and United Nations specialized agencies, in such sectors as food aid, health, water and sanitation, shelter, education, protection of vulnerable people, preservation of the environment, support for logistical operations and coordination of aid.

The crisis had highlighted the importance of WHO's contribution as part of the international community's assistance to the health sector. WHO should continue its efforts to ensure the integration of Indonesian, Sri Lankan and other governments' action in the health sector and effective participation in United Nations responses. In addition to the immediate, short-term regional response to the disaster, a long-term agenda must be established, based on the lessons learnt and emphasizing enhanced emergency preparedness and coordination among United Nations specialized agencies and key partners.

Dr SUWIT WIBULPOLPRASERT (Thailand) welcomed the importance accorded by the Board to the tsunami disaster and on behalf of the Thai people, thanked all countries, international civil society and intergovernmental organizations for their strong solidarity and massive support for

emergency relief action. Two senior medical officers from Bangkok and Phuket who had been directly involved in dealing with the disaster were present at the session and could provide first-hand information to all those wishing to learn more.

Thailand had learnt many lessons from the crisis. Although the tsunami had struck the southern part of Thailand in the early morning, the first medical teams – recruited from all over the country to support local facilities – had arrived only after midnight, despite the fact that the Prime Minister had been present to take personal command of the operation. The first lesson was that people had to rely on their own resources at the beginning of a disaster, as external support took time to arrive. It was therefore essential to establish adequate health infrastructures throughout the country. WHO's programmes for the development of health services, basic health infrastructures and human resources for health in Member States should therefore be strengthened so as to enhance preparedness for future crises. That concern should also be given greater priority in the Proposed programme budget 2006-2007.

Despite criticism by senior government officials of the management of Thai relief efforts, expressions of appreciation had been received from all over the world, praising the emergency relief action by the Government and people of Thailand and the strong public spirit that had prevailed. Immediately after the disaster the Thai Ministry of Health had set up a central command centre in Bangkok and a provincial command centre at Phuket. Those centres would clearly have been able to do much more with a better level of emergency preparedness.

The national committee for avian influenza control had stressed that an influenza pandemic preparedness plan was urgently required, as there was a risk that Thailand might become a source of a new influenza pandemic. Such a situation might prove much worse than the tsunami disaster, as everyone, including close relatives and health personnel, would avoid the affected people rather than help them. It was therefore important to establish preparedness plans not only for natural disasters but also for other health-related crises. WHO's capacity to provide strong technical support to countries should consequently be enhanced.

Another lesson was that steps needed to be taken to counteract rumours that accompanied crisis situations, so as to prevent public panic. There had been rumours, for example, that the tsunami would return, and that the bodies would spread infectious diseases or contaminate water supplies and food. Prompt and accurate information from credible sources was essential, and WHO was the best organization to provide it. Furthermore, certain national and international organizations had emphasized the risk of epidemics. Although well intentioned, such statements had had negative effects. Effective public communication was essential in a crisis situation and needed to be handled professionally. WHO's capacity to provide prompt accurate and effective communication in time of crisis, which had been aptly demonstrated during the epidemic of severe acute respiratory syndrome (SARS), must be revitalized in order to cope with future crises.

Due to past investment in human resources and infrastructures, Thailand had been able to set up an extensive 24-hour epidemiological surveillance system immediately after the disaster, which had found no evidence of epidemics of cholera or other infectious disease. The international organizations, including WHO, and Member States should use the latest information available from such surveillance systems to update their travel warnings so that in future the situation in affected areas would not be unduly aggravated.

The tsunami disaster had also provided extensive experience in the management of the dead. As several thousand foreigners had died, there was a need for internationally acceptable procedures for recovery, identification and burial of bodies. Over 300 forensic doctors from more than 25 countries were currently working in Thailand, a situation that called for systematic professional management. Support in those areas had been provided by the Centers for Disease Control and Prevention (Atlanta, Georgia, USA) and by the Government of China. As WHO lacked expertise in those areas, it was important that they should be included in the Health Action in Crises programme.

The psychological and social impacts of the disaster called for the alleviation of post-traumatic stress disorders, a strong social network and mental health support. In that regard, he noted with regret that the budget allocation for mental health in the Proposed programme budget 2006-2007 was low.

The disaster had been followed by massive relief support, the coordination of which represented an immense additional burden. WHO could help in the coordination of foreign support to free local health officials for other tasks; in the early stages of the disaster, Thailand had had sufficient national capacity to help those affected and remained anxious that assistance and support should go to countries in greater need. The Regional Office had expressed interest in recruiting Thai teams to support other countries. Thailand was accordingly ready to volunteer to be the focal point for subregional coordination of health action in crises.

Experience of the disaster had shown that the first group to move in was local civil society followed by the national Government, then foreign governments and lastly the United Nations specialized agencies, including WHO. As a technical organization rather than an implementing agency, WHO's role in disaster situations should be focused mainly on emergency preparedness and recovery, apart from certain activities relevant to the immediate response period, particularly in relation to communicable disease prevention and control and environmental health support. However, the relevant area of work had a budget allocation of only about US\$ 105 million in the Proposed programme budget 2006-2007, almost all of which came from voluntary contributions allocated specifically to certain crisis areas. The regular budget allocation was only US\$ 8 million, and it was difficult to see how the Secretariat could be expected to provide support for long-term emergency preparedness with that meagre amount. He therefore urged all Member States to increase their contributions to the regular budget so as to enable more to be done. He also urged all donor countries to react promptly to WHO's request for US\$ 67 million for the tsunami disaster, for which only US\$ 40 million had so far been mobilized. He further requested all Member States to support WHO's emergency fund for health action in crises, which currently amounted to only US\$ 500 000 rather than the US\$ 10 million required. If more funds were forthcoming, it would be important to expedite their utilization and to provide clear accountability and indications of funding sources. It was also important to take advantage of the current sense of urgency to plan for any future disaster.

He therefore proposed that a formal drafting group should be convened to prepare a resolution with clear indications for action, for consideration by the Board at its present session and, subsequently, by the Health Assembly.

The CHAIRMAN recalled that some 30 years previously Iceland had learnt the hard way that a country must rely on itself for the initial work required after a natural disaster. The Nordic countries and those rescued had nothing but praise for the response of the Thai authorities to the tsunami.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that, although nothing could compensate for the lives lost, his country and others in Africa had spontaneously shown their solidarity and sympathy with the countries affected and made donations, however small, to help the victims. He expressed satisfaction at the way WHO and the international community had reacted and appealed to them to continue to be vigilant with regard to emergencies, whatever their cause, which involved suffering and loss of life.

Dr TANGI (Tonga) said that many small, low-lying countries in the Pacific had donated what they could afford to the relief effort. As there was little doubt that other tsunamis would occur, he emphasized the importance of preparedness for emergencies so that responses could be effective. The immediate response to the tsunami by various countries, including rich countries, was heart-warming and he hoped that lessons had been learnt that would prove useful in the future.

Mrs FERNANDO (Sri Lanka)¹ said that in her country over 35 000 lives had been lost and more than 15 000 people injured; 88 000 houses had been totally demolished and more than 800 000 people displaced. The Government was in the process of assessing the destruction of infrastructure, which included, it was estimated, more than 85 health institutions. Yet the tragedy had brought out the best in

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Sri Lanka's people had been a reminder that compassion was a pillar of her society; there had been an immediate surge of local support, without discrimination, for all victims, and government health systems had proved resilient. Within two hours of the disaster, medical teams had been deployed to all the affected areas and medical professionals had responded magnificently to the crisis, assisted by the national Red Cross and local nongovernmental organizations.

Furthermore, the response to her Government's appeal to the international community for assistance in meeting health and sanitation needs had been overwhelming. The response from WHO headquarters and the Regional Office for South-East Asia had been effective, in particular, the Director-General's rebuttal of certain rumours, for example about the contamination of fish. Sri Lanka greatly appreciated the vital supplies, cash donations, field hospitals, medical teams, ships and helicopters sent by the many foreign governments and nongovernmental organizations. The Government had been able to act in all affected parts of the country, thanks to the prevailing ceasefire with the Liberation Tigers of Tamil Eelam. According to the Regional Office, the medical infrastructure in the areas controlled by the Liberation Tigers was good, and millions of dollars' worth of medicine and relief supplies had been sent there. Moreover, the country's excellent health infrastructure had helped to prevent the spread of diseases and epidemics after the tsunami. WHO's work to provide clean drinking-water and sanitation and its initiation of a major counselling project to treat the trauma affecting thousands of displaced persons had been invaluable.

The people of Sri Lanka had shown courage and resilience in the face of the disaster and she trusted that the international community would continue its support, solidarity and generosity during the rehabilitation and reconstruction stages.

Dr AGARWAL (India)¹ said that in India the tsunami had wrought havoc in several areas. The death toll exceeded 10 700; nearly 6000 people were still missing; the lives of some three million people had been affected; there had been considerable damage to crops and dwellings; and the total cost of reconstruction was estimated at US\$ 1560 million, excluding the Andaman and Nicobar Islands, for which an equal amount would be required. The entire government apparatus in India had been mobilized for the relief effort: the armed forces, and medical and paramedical professionals, with special emphasis placed on mitigating the psychological impact of the catastrophe.

The situation had begun to stabilize except in the Andaman and Nicobar Islands. The focus was primarily on providing temporary housing and paid employment, restoring the infrastructure and rehabilitating the people. Fishing had resumed, shops and schools were reopening, there were no reports of scarcity of food or medicines, and the state governments were making efforts for early resumption of normal life. Hygiene was being maintained in relief camps and the health situation was being monitored. So far, there had been no reports of epidemics.

The way ahead, however, would be long and arduous as people attempted to rebuild their lives. His Government was extremely grateful for the offers of assistance it had received from the international community; so far, owing to its well-established, experience-based system, it had been able to take swift action and estimated that it could manage alone. It was therefore requesting that international efforts should be directed where they were most needed, while retaining the option to make requests for any specific assistance it might require. Many of the issues mentioned by previous speakers, such as the need to dispel unfounded rumours, were real and required professional handling.

India had contributed to international relief efforts by sending assistance to neighbouring countries that had experienced even greater damage and suffering. For Sri Lanka, a composite relief package worth US\$ 24 million had been announced. On the day the tsunami struck, an Indian aircraft carrying a medical team and supplies had landed in Colombo; 16 helicopters had been engaged in search and rescue operations and in assessing the damage; a mobile army field hospital with medical personnel had been air-lifted to Sri Lanka and was operating in the worst-affected areas, and a 45-bed hospital ship had been deployed. Army teams had helped to restore water and power supplies and to

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

repair some buildings and telecommunications systems. Help had also been provided the disposal of bodies and in sanitation operations.

For Maldives, relief equivalent to US\$ 1.15 million had been announced and some Indian aircraft had been made available there to transport supplies to remote areas and conduct search-and-rescue operations. Water containers had been sent and two naval vessels had set up medical camps and were providing transport to remote islands. Generators and telecommunications equipment were being repaired; a naval tanker and water-purification facilities were also in place.

In addition, aid in kind of US\$ 1 million to Indonesia, consisting of emergency shelter, medicine and food supplies, had been announced by the Indian Government. Immediately after the disaster, an Indian hospital ship had been sent to Aceh. For Thailand, aid in kind of US\$ 0.5 million had been approved.

The disaster had again highlighted the need for WHO to play an effective coordinating role in ensuring prompt response to the health aspects of such crises. He thanked WHO for the support to his country and affirmed that India would continue to extend all possible support to other affected countries in the region.

Dr SADASIVAN (Singapore)¹ said that, in the aftermath of the disaster, the world had responded rapidly and generously; WHO had coordinated with governments and organizations to provide aid, issued alerts on the risk of potential outbreaks of disease, provided public health guidance and ensured access to public health care. It had also helped to coordinate the delivery of medical supplies where required. His country's action represented only a small fraction of the global effort, but it was committed to supporting WHO and, in view of its proximity to the affected areas, had helped to ferry relief supplies to Aceh, Indonesia, offered the use of its air and naval bases for relief operations, and provided office, telecommunications and logistics facilities. One lesson learnt from the disaster was the importance of preparedness and capacity-building. The present need was to rebuild public infrastructure and capacity, a daunting task for which the global community would need to sustain its efforts, translating plans into action. WHO would have a critical leadership role in the months ahead, and he urged Member States fully to support that endeavour.

Dr TSHABALALA-MSIMANG (South Africa)¹ said that her Government had joined the United Nations-led initiative to provide unprecedented financial and material assistance, and had pledged over 9 million South African rand with the stipulation that half that sum be used in Africa. In addition, more than 3.5 million rand had been pledged by telephone donors, and a fund-raising concert organized by the Tourism and Leisure Association to heighten general disaster awareness was expected to raise over 10 million rand. South Africa had also donated over 40 tonnes of equipment and medicines to Maldives, deployed two helicopters, crewed by South African volunteers (including a medical doctor), to Indonesia to help to deliver supplies in remote areas at a cost of 4 million rand, and donated a further 180 tonnes of clothes and other supplies. South African Airways had pledged cargo space on scheduled flights to move donated goods as and when required. Thousands of South African volunteers from many sectors stood ready to help, a matter she hoped to discuss with the Director-General and his Representative for Health Action in Crises.

South Africa considered itself duty-bound, in the spirit of international solidarity, to respond as it had, despite being faced with its own internal disasters such as flooding and severe drought. Indeed, three South African provinces had suffered heavy flooding on the very day the tsunami had struck.

It was vitally important that the scope of the international community's response be extended to the affected communities in Africa: people who had been confronted with the untold hardship caused by floods, drought, civil war and famine suddenly had to contend with the additional effects of the tsunami without adequate infrastructure, human capital or financial resources. South Africa had sent a delegation to Somalia two weeks earlier to obtain information on the tsunami's impact. The

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

information that about 300 people had died, a further 54 000 were displaced and infrastructure destroyed had to be seen in the light of the political and conflict situation in that country, where the absence of a local assessment and response capacity made it hard to obtain accurate data; the true toll might be much higher. The disaster had highlighted the need to develop a global early warning system capable of reducing the potential consequences of disasters.

Dr FUKUDA (Japan)¹ expressed appreciation for WHO's timely and appropriate action in the wake of the tsunami, and for the updates on the situation in the countries affected made available on its web site. Japan had decided to contribute US\$ 500 million in cash to the relief effort, half of which would be directly allocated to the countries concerned, while the other half would be donated through international organizations such as WHO. The Japanese Diet had just allocated US\$ 6 million for WHO activities. Japan hoped to cooperate with WHO to prevent and control the spread of infectious diseases.

Dr KARAM (Lebanon)¹ commended WHO's immediate response. The reports by the Director-General, his staff and relief workers in the region had been reassuring, and the words of the member for Thailand revealing. WHO had played a pivotal and exemplary role in alleviating suffering, and still had a role to play in ensuring that help reached the people for whom it was intended and that the amounts pledged worldwide were forthcoming. He suggested that a ministerial-level committee of Member States not affected by the tsunami act as a consultative body to the Director-General for the duration of the crisis. Its terms of reference would be determined by the Director-General on the recommendation of the Executive Board, and should include support for the Secretariat's work, to ensure that pledges were met and that the field was not overcrowded.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the Group of Latin American and Caribbean countries, said that the countries in his region, despite their economic difficulties, had provided what aid they could. They, too, were vulnerable to natural disasters and endorsed any initiative seeking a long-term strategy to reduce disaster vulnerability. The Group applauded the prompt response of the Secretariat and encouraged it to pursue its work during the reconstruction and rehabilitation phase.

Dr BELLO DE KEMPER (Dominican Republic)¹ endorsed the statement by the previous speaker, the proposal of the member for Thailand that the Board should consider a draft resolution, and the comments relating to corpses and the spread of disease. A recent PAHO study should be made public. She suggested that the subitem under discussion should be placed on the agenda of the Fifty-eighth World Health Assembly to give Member States more information on WHO's activities in that field, the work of the United Nations Office for the Coordination of Humanitarian Affairs, civil-military cooperation in the event of natural disasters, and implementation of the Tampere Convention on the Provision of Telecommunication Resources for Disaster Mitigation and Relief Operations. It was to be hoped that the plan of action that would be considered by the World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005) would include the establishment of tsunami alert systems and awareness programmes for vulnerable groups.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the disaster had underlined the importance of a well-established, properly organized health system. An adequate response to disasters would be impossible without continuous improvement in health systems. He commended the Director-General's report² for its affirmation that primary health care was a vital means of attaining that goal.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Document EB115/2.

The following day's presentation on the global plan to achieve the Millennium Development Goals would be particularly useful as the Goals dealt with many topics raised indirectly in the present discussion and constituted major challenges for developing countries.

The Director-General had also highlighted the importance of World Health Day 2005, whose theme was "Make every mother and child count", which would provide an opportunity to link health for all to the Millennium Development Goals. The Director-General had also mentioned the report of the United Nations High-Level Panel on Threats, Challenges and Change and WHO's role as described therein. That report was also relevant to the discussion since it covered threats, whether natural or otherwise, the challenges they posed to health for all, and the changes to which the Organization would have to adapt.

In view of the importance attached by the Director-General to global public health activities, the Organization's financial resources, whether from the regular budget or voluntary contributions, must be used as efficiently as possible; the discussion of the Proposed programme budget 2006-2007 and the increases it contained would be of paramount importance.

Mr JUNOR (Jamaica) noted that the lessons being learnt by the countries affected by the tsunami confirmed the recent experience of many countries in the Caribbean. During his seven years as Minister of Health, he had been struck by the need for countries to have the capacity to respond to mass casualty situations. That capacity, as pointed out by the previous speaker, could only be based on a functional health system. The countries of the Caribbean were fortunate in that, through PAHO, they had developed a tremendous regional capacity to respond to each other's disasters. PAHO and WHO were to be thanked for their help in restoring a certain normality to the health sector, in particular.

Dr LHOTSKA (Consumers International), speaking at the invitation of the CHAIRMAN, and also on behalf of the International Baby Food Action Network, commended the relief efforts under way. The Network had a history of working in emergency situations and had contributed to a document on infant and young child feeding in emergencies and The Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response, which called for adherence to the International Code of Marketing of Breast-milk Substitutes and relevant Health Assembly resolutions. The Network was also a member of the Interagency Working Group on Infant and Young Child Feeding in Emergencies, which had developed two training modules providing practical technical guidance for emergency relief workers.

The risks associated with the use of milk products, breast-milk substitutes and infant feeding equipment in emergencies, together with poor hygiene, limited access to safe drinking-water and fuel, and overcrowding, included diarrhoeal diseases and other infections. Breastfeeding and protection and support for exclusive and continued breastfeeding were therefore particularly important as a source of sustainable food security and a means of child spacing in the absence of contraceptives. Breast-milk substitutes in emergencies should be provided after careful assessment to ensure distribution only to children needing them and for as long as that need continued, and to avoid their use as a sales inducement. Children separated from their mothers were better served by local products labelled in the correct language and distributed with appropriate training on safe use. That was especially relevant given current public health alerts concerning contaminated powdered infant formula and the international recall of some products.

Since the tsunami, Consumers International and the International Baby Food Action Network had been active in providing information, technical guidance and practical aid in affected countries and had launched a specific fund. They stood ready to continue that assistance. Colleagues in nongovernmental organizations working in the field had confirmed the value of the guidance materials provided. Member States should ensure that protection, promotion and support of breastfeeding were an integral part of their policies and programming for crisis preparedness, response and recovery.

Mr SUMIRAT (Indonesia)¹ expressed heartfelt gratitude to WHO for the extensive help and support given to his Government and people, especially those in Aceh province, since the Indian Ocean tsunami. Quality of health care for the survivors was a key criterion in the provision of relief, rehabilitation and reconstruction in the affected areas. There had so far been no reports of severe epidemics among survivors in Indonesia, but the threat of outbreaks of diarrhoeal diseases and malaria in the weeks ahead was a serious concern. The cooperation of WHO and other international organizations in the field was therefore most welcome.

Dr NABARRO (Representative of the Director-General for Health Action in Crises), summarizing the discussion, said that speakers had offered substantial guidance and had identified several as yet unresolved difficulties. Most had also commented on the importance of heeding health matters in times of crisis, whether caused by conflict or natural disasters. The discussion had highlighted the important role of health systems and health professionals. The capacity of national health systems clearly had a considerable impact on the health situation following emergencies. There was a need for effective early warning of disease outbreaks, strong public health guidance and practice, relevant measurement of unfolding events, and clear and strong advocacy by health professionals. All speakers had expressed their solidarity with the countries affected and had indicated generous offers of help in cash and in kind, some including military deployment. WHO was being asked to strengthen its help to countries in a number of ways: coordination of offers of help so that they met actual needs; coordination of unplanned help arriving in countries; support for the establishment of social networks to handle the psychological effects of the crisis; support in developing disaster preparedness and response programmes and policies, including the formulation of protocols and training exercises; and strong advocacy to dispel rumours and to remind the international community of the needs of other areas where disasters had failed to elicit such a generous response. The provision of such support was a complex matter calling for careful management to ensure more effective action in the United Nations system as a whole, in the donor community, and both nationally and locally.

Many speakers had commented on the value of the Strategic Health Information Centre, the Regional Offices and country offices in ensuring a more effective response. PAHO, in particular, possessed great expertise and was providing significant support in the present crisis. Further, many WHO staff and volunteers were actively engaged in current operations. It was essential, however, to direct those energies efficiently and effectively, for example through such activities as the three-year programme for enhancing WHO's performance in health action in crises and the Forum for Health Action in Crises. Several speakers had commented that Member States would need to provide greater support, including financial contributions, to increase preparedness activities and make WHO more effective in times of crisis.

Mr AITKEN (Director, Office of the Director-General) said that the Secretariat would work with interested parties to prepare a draft resolution for discussion later in the week.

The CHAIRMAN reiterated the condolences expressed by all speakers to those affected by the tsunami. He thanked the Director-General and his staff for their considerable efforts in response to the crisis, and welcomed the selfless spirit displayed. He suggested that the item be left open, pending consideration of the draft resolution.

It was so agreed.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

3. **REPORT OF THE PROGRAMME, BUDGET AND ADMINISTRATION**

COMMITTEE: Item 3 of the Agenda (Document EB115/45)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee of the Executive Board, introducing the report, said that the participants had considered the single committee to be an improvement over the previous arrangement, permitting fuller and broader discussions and resulting in a series of concrete recommendations to the Board.

Following extensive discussions on the areas of work of the Proposed programme budget 2006-2007, the Committee had recommended: the alignment of overall goals to ensure consistency; a review of expected results to ensure a consistent standard of quality throughout the programme budget document; a review of resource requirements to ensure that they were adequate to achieve stated outcomes; and a thorough review of the Emergency preparedness and response area of work. The Committee had expressed concern at the rapidly decreasing proportion of the overall WHO budget represented by the regular budget, and urged that measures be taken to tackle the undesired consequences of that trend. He would report on the views of the Committee on specific topics under the relevant items of the Board's agenda.

The next meeting of the Committee was scheduled for 13 May 2005, immediately before the opening of the Fifty-eighth World Health Assembly. It was suggested that the work of the new Committee should be evaluated after the completion of a full cycle of meetings in 2006.

The CHAIRMAN invited general remarks on the report, requesting members to reserve specific comments for the detailed discussion of the proposed programme budget.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the brevity of the comments in the report under the different budget headings, such as that on nutrition in paragraph 26, made it difficult to offer any constructive comment. The budget document itself (document PPB/2006-2007) was equally obscure in places: for example, it was impossible to judge, in the section on human resources management, how it was intended to implement the human resources module of the global management system, or how the management processes in key posts were being improved and simplified. The assumption throughout the budget document was that most of the spending would take place at country level; however, in some cases less than 20% of budget funds were allocated to countries. If the argument that much of the funding allocated to headquarters' activities would ultimately be spent in countries was valid, that should be made clear in the budget document.

Professor DAB (France) drew attention to the need to budget adequately for disaster preparedness and response. The tsunami crisis highlighted the indissoluble link between disaster or emergency situations and long-term action. The examples given earlier by the member for Thailand were vivid illustrations of that linkage. Adequate preparation for emergencies must be an essential item of the WHO regular budget, not just in the form of a set of budgets for specific actions. Moreover, a budget strategy that emphasized voluntary contributions to the detriment of regular ones risked jeopardizing the entire mission of the Organization. Whenever the Health Assembly made a recommendation to the Director-General, its budgetary impact should be evaluated first to ensure that the Secretariat was in a position to act on it.

The CHAIRMAN said the issues raised by the members for Bolivia and France could be discussed fully when the Board took up the question of the Proposed programme budget 2006-2007.

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

Revision of the International Health Regulations: update: Item 4.1 of the Agenda (Document EB115/4)

The CHAIRMAN explained that the report by the Secretariat summarized the discussions and outcome of the first session, in November 2004, of the Intergovernmental Working Group on Revision of the International Health Regulations.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries Croatia and Romania, welcomed the progress made in revising the Regulations through the regional consultations and the negotiations in the Intergovernmental Working Group. The European Union and its member states would continue to be active in the revision process, in order to make the Regulations consistent, binding and useful. There were still differences of opinion on some important matters, and a high degree of coordination was needed for consensus solutions. She urged WHO to enhance the effectiveness of its working methods so that a text acceptable to all could be completed at the forthcoming session of the Intergovernmental Working Group.

The European Union continued to favour an algorithm for Annex 2 to the Regulations as the best way of guaranteeing clear decisions, while making provision for the different characteristics and circumstances specific to each emergency situation. It was gratifying that WHO had convened an expert group on the subject, and the European Union undertook to play a constructive part in its work for the sake of a satisfactory compromise on Annex 2. She trusted that all concerned would show the necessary flexibility to overcome the remaining points of disagreement so that, in the interests of all Member States, the final text submitted to the Fifty-eighth World Health Assembly for adoption contained strong regulations.

Dr STEIGER (United States of America) expressed appreciation of the efforts of the Secretariat and the Intergovernmental Working Group to complete the revision process. He agreed with the previous speaker that a clear instrument for decision-making was needed in Annex 2, and he strongly favoured inclusion of a list of reportable diseases.

Dr CAMARA (Guinea) also welcomed the progress made on the revision and the pragmatic and participatory approach of all countries and regions. The Regulations must reflect a true consensus. The inclusion of specifics would make them less effective and harder to implement. Technical aspects must be kept apart from political ones, and the terms used clearly defined. He also emphasized the need to respect national sovereignty and the responsibility of health ministries for announcing public health emergencies. Attention must go to the provisions in the Regulations on ground transport and to the need, in the African Region, to make implementation of the Regulations part and parcel of integrated disease surveillance.

Professor CINTEZA (Romania), endorsing the remarks by the member for Luxembourg, expressed his country's full support for revision of the Regulations as a tool for international warning and response in the event of threats to public health. It was a priority for Romania to establish a national surveillance system to meet the requirements of the new Regulations and of the European Commission Decision of July 2003 (2003/542/EC) on the operation of dedicated surveillance networks. The Romanian system would have written procedures and policies, and its own budget. As the representative of WHO's European Region on the bureau of the Intergovernmental Working Group, Romania welcomed the opportunity to develop a regional position on the new textual proposal being prepared by the Chair of the Group.

Dr PREECHA PREMPREE (adviser to Dr Suwit Wibulpolprasert, Thailand) expressed appreciation for the management of the revision process, which had enabled all stakeholders to

participate actively. In the light of the increasing frequency of outbreaks of infectious disease in several regions, willingness to collaborate in revising the Regulations had been unprecedented. The collective spirit shown by members of the Board would, he was confident, produce a basis for adopting the revised Regulations at the Fifty-eighth World Health Assembly.

With regard to the inclusion of specific reportable diseases, Thailand was proposing that some major diseases be part of the reportable list, and that a participatory mechanism should be established to take the necessary decisions whenever new diseases had to be included in future. Referring to the composition and work of the emergency committee, he emphasized the importance of having knowledgeable members on the committee from the affected countries.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) welcomed the work done so far; considerable effort had gone into achieving consensus on the guiding principles of the revision, and a more balanced interpretation had emerged of the concept of an international health emergency. The result was a sound basis for implementing the revised Regulations with a view to maximizing epidemiological safety at minimum cost in terms of moving people and goods. Russian experts were prepared to play an active part in the second session of the Intergovernmental Working Group in order to reach consensus on all outstanding issues.

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

The meeting rose at 17:35.

THIRD MEETING

Tuesday, 18 January 2005, at 09:00

Chairman: Mr D.Á. GUNNARSSON (Iceland)

Following an open meeting at 09:00, the meeting resumed in public session at 10:05.

1. MANAGEMENT MATTERS: Item 7 of the Agenda

Appointment of the Regional Director for Africa: Item 7.1 of the Agenda (Document EB115/18)

Dr NDONG (Gabon), Rapporteur, read out the following resolution adopted by the Board during the open meeting:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of WHO;
Considering the nomination and recommendation made by the Regional Committee for Africa at its fifty-fourth session,²

1. APPOINTS Dr Luis Gomes Sambo as Regional Director for Africa as from 1 February 2005;
2. AUTHORIZES the Director-General to issue to Dr Luis Gomes Sambo a contract for a period of five years from 1 February 2005, subject to the provisions of the Staff Regulations and Staff Rules.

The CHAIRMAN congratulated Dr Sambo on his appointment.

At the invitation of the CHAIRMAN, Dr Sambo took the oath of office contained in Staff Regulation 1.10 and signed his contract.

Dr SAMBO (Regional Director elect for Africa) said that he was honoured to be appointed as Regional Director, and was most grateful to the Member States of the Region for nominating him. His participation in the Board's work and 15 years' experience within the Organization had given him valuable grounding, and Dr Samba's constant support during the period of their collaboration had helped to motivate him to carry out his new task.

He was aware of the grave health problems facing Africa, which were often linked to development issues, and notably to poverty. One challenge was the prevalence of communicable diseases, particularly HIV/AIDS, tuberculosis and malaria, the growing burden of noncommunicable diseases, the very high maternal death rates, and the high infant mortality rate, all of which led to a low life expectancy in the Region. HIV/AIDS was the public health problem that caused the greatest concern because of its effect in terms of morbidity and mortality, and its impact on the economic performance of Member States. Every effort was being made, with the support of partners, to achieve the goal of eradication of poliomyelitis. Another challenge was the fragility of health systems, especially in relation to the availability of human, financial and technological resources.

¹ Resolution EB115.R1.

² Resolution AFR/RC54/R1.

The commitment shown by African countries to achieving the health-related Millennium Development Goals provided an historic opportunity for governments and for WHO and its partners, which should recognize and strengthen that commitment. Special emphasis needed to be placed on promoting excellence at the technical and management levels, and particularly on management based on results, reporting and accountability.

Under the guidance of the Director-General, in cooperation with Member States and partners, and in collaboration with his fellow Regional Directors, his aim would be to strive for the realization of WHO's work programme with a view to raising the health status of all peoples to the highest possible level.

The DIRECTOR-GENERAL warmly welcomed the appointment of Dr Sambo, who had worked for WHO for a long period. The challenges he would face in Africa, especially in achieving the health-related Millennium Development Goals, were enormous. The technical support capacity and the administrative capacity of the Regional Office and country offices would need to be strengthened, as WHO's performance in the Region would be of crucial importance in the coming years. Dr Sambo would need to build on the impressive achievements of his predecessor, and he pledged him the Organization's support in that endeavour.

Dr NDONG (Gabon), Rapporteur, read out the following resolution adopted by the Board during the open meeting:¹

The Executive Board,

Desiring, on the occasion of the retirement of Dr Ebrahim M. Samba, Regional Director for Africa, to express its appreciation of his services to the World Health Organization;

Mindful of his lifelong devotion to the cause of international health, and recalling especially his 14 and 10 years of service respectively as Director of the Onchocerciasis Programme for West Africa and Regional Director for Africa,

1. EXPRESSES its profound gratitude and appreciation to Dr Ebrahim M. Samba for his invaluable contribution to the work of WHO;
2. ADDRESSES to Dr Ebrahim M. Samba on this occasion its sincere good wishes for many further years of service to humanity.

Dr SAMBA (Regional Director for Africa) recalled that Dr Sambo had been his colleague, supporter and adviser during all his years in office. He was grateful for the opportunity he had been given of working for WHO, and greatly valued the friendships that he had established within the Organization over the years. He particularly appreciated the friendship of the Director-General, whom he had known for nearly 20 years, and of Mr Gunnarsson, the member for Iceland.

Africa was a difficult continent to serve: the Board had the previous day discussed the impact of the Indian Ocean tsunami on Somalia, yet in Africa emergencies were a daily occurrence. He expressed his gratitude to the members of the Board for their support, to the Members of the African Region for having elected him to serve the Organization, and to his fellow Regional Directors.

The DIRECTOR-GENERAL said that Dr Samba had served WHO for a long time and with great dedication. His openness to new ideas had been much appreciated, and he would remind him of his promise to continue WHO's work after his retirement. He wished Dr Samba success in all his future endeavours.

¹ Resolution EB115.R2.

Dr NDONG (Gabon), speaking on behalf of the African group, expressed appreciation of Dr Samba's outstanding services to humanity in general and to Africa in particular, and congratulated the new Regional Director on his election.

Appointment of the Regional Director for Europe: Item 7.2 of the Agenda (Document EB115/19)

Dr NDONG (Gabon), Rapporteur, read out the following resolution adopted by the Board during the open meeting:¹

The Executive Board,
Considering the provisions of Article 52 of the Constitution of WHO;
Considering the nomination and recommendation made by the Regional Committee for Europe at its fifty-fourth session,²

1. REAPPOINTS Dr Marc Danzon as Regional Director for Europe as from 1 February 2005;
2. AUTHORIZES the Director-General to issue a contract to Dr Marc Danzon for a period of five years from 1 February 2005, subject to the provisions of the Staff Regulations and Staff Rules.

Dr DANZON (Regional Director for Europe) said that he was honoured that the Board had renewed its trust in him for five more years as head of the Regional Office for Europe, and would do his utmost not to disappoint expectations. His reappointment was taking place in a world climate which, although dramatic, perhaps gave grounds for hope owing to the new spirit of solidarity shown in the response to events in south Asia. For WHO, which was both a technical agency and an upholder of universal values, such solidarity represented a duty; for the European Region, it was an encouragement to improve the services it provided to Member States for strengthening their health systems and promoting their public health programmes, particularly those targeting fragile populations.

During the next five years the Regional Office would continue its task of adapting major global programmes to regional needs, particularly HIV/AIDS, the "3 by 5" programme, attainment of health-related Millennium Development Goals, and implementation of the WHO Framework Convention on Tobacco Control. It would also continue to improve its knowledge of the needs of the Region's 52 Members, so as to adapt its activities to their requirements. In so doing it would work in partnership with the Director-General and colleagues from other regions, and in cooperation with other bodies with which WHO had close ties.

The DIRECTOR-GENERAL congratulated Dr Marc Danzon on his reappointment.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union, congratulated the Regional Director on the work already accomplished, and assured him of the Union's full support for the next five years.

The CHAIRMAN added his own congratulations to those voiced by previous speakers.

¹ Resolution EB115.R3.

² Resolution EUR/RC54/R2.

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

Revision of the International Health Regulations: update: Item 4.1 of the Agenda (Document EB115/4) (continued from the second meeting, section 4)

The CHAIRMAN said that revision of the International Health Regulations was probably one of the most important and most difficult issues currently before WHO. The slow progress was a matter for concern, not only because of the nature of the subject but because prolonged deliberations were absorbing funds that could well be used elsewhere.

Dr BRUNET (alternate to Professor Dab, France) advised holding parallel discussions in subgroups, since progress was most likely to be achieved in that way on points that were difficult to resolve.

Mrs GILDERS (alternate to Mr Shugart, Canada) said that support for the revision process had been evident at the session of the Intergovernmental Working Group in November 2004, and progress had been made in building consensus on many topics, but much still remained to be done. At the forthcoming session, delegations would therefore have to display a spirit of collaboration and cooperation. Canada remained committed to the timetable for adoption of the revised Regulations at the Health Assembly in May 2005; the Chair's proposed text would undoubtedly help to focus negotiations on critical areas.

Dr AHMED (Ghana) welcomed the strategy for reviewing the International Health Regulations and expressed support for Guinea's position regarding national sovereignty. The question of geographical spread should be taken into account in the list of diseases to be included in Annex 2. It would be advisable to separate the political and technical aspects of the Regulations.

Mr JUNOR (Jamaica) noted that Jamaica had been the only English-speaking Caribbean country represented at the Group's first session in November 2004. The amendments that had been suggested at the regional meeting held in March 2004 in Grenada had been fed into the international negotiating process. Key issues had included the definition of disease, the selection of focal points in each Member State, the determination of an appropriate reaction to an international health emergency, the financial and technical assistance required by Member States for implementation of the Regulations within the given time frame, and the balance that would have to be achieved between respect for human rights and the invasiveness of the medical interventions used to treat and control some diseases. Member States would have to strengthen their surveillance systems, and review existing laws on procedures and national capacity to implement the Regulations. The difficult question of whether to charge for medical and other interventions in the public sector, and the question of whether to give Member States the option of rejecting, or making reservations to, the Regulations, would have to be tackled.

The review was relevant and timely, because Member States had to be vigilant with regard to security in the light of terrorist threats to use biological agents and communicable diseases as weapons. For that reason, the definition of diseases in the twenty-first century could not be confined to infectious conditions, but must include illnesses caused by chemical and radionuclear substances.

Ms HALTON (Australia) expressed support for both the revision process, which the second session should facilitate, and the preparation of background papers on particular issues. She favoured simplicity as a guiding principle, and hoped that the panel of experts that would convene before the next session would be able to agree on a practical mechanism to trigger the operation of the Regulations. The Director-General's recently appointed special envoy would without doubt help to promote consensus. The recent outbreaks of severe acute respiratory syndrome (SARS) and avian influenza had highlighted the need for a strong new global framework to provide maximum security against the international spread of disease while causing minimum interference with traffic and trade.

Dr ACHARYA (Nepal) said that one issue debated during consultations organized in the South-East Asia Region had been Member States' insufficient core capacity to implement the Regulations within the proposed time frame. It had therefore been suggested that consideration be given to a phased approach, allowing Member States ample time to develop such capacity. It was essential to assess gaps in implementation capacity at points of entry and exit, since implementation represented a huge challenge for countries like Nepal which had open borders with neighbouring countries. Disquiet had also been expressed about the lack of clarity regarding national focal points and their role in the notification process, and about the use of unofficial sources of information. A further concern had been the scope of notification of chemical and radionuclear events, and of hazards caused by the deliberate release of chemical agents. It had been felt that that aspect of the Regulations might need further elaboration and that the concerns voiced by the member for the United States of America were understandable. Substantial financial, technical and logistic support would be needed by some countries in order to build core capacity for implementation of the Regulations as outlined in the proposal.

Ms DENG Hongmei (China) commended efforts to revise the Regulations; the revision process should continue to be carried out under the auspices of WHO. Political considerations should not impinge, or the process would be delayed.

As far as implementation was concerned, due allowance should be made for the different laws, regulations and conditions obtaining in various countries by providing for longer periods before the entry into force of some articles. Further negotiations would be required in order to sort out differences of opinion on some key issues. China was ready to work with other parties to complete the revision process as soon as possible.

Dr LAMATA COTANDA (Spain) endorsed the statement made at the previous meeting by the member for Luxembourg, and emphasized the importance of adopting the revised Regulations. It was regrettable that, despite the progress made, it had not been possible to submit a consensus text to the Board. Further efforts should therefore be made at the current session of the Board to resolve some of the technical difficulties impeding agreement, so that the Regulations could be adopted at the forthcoming Health Assembly.

Dr PHOOKO (Lesotho), speaking on behalf of the African group, said that its members still had some concerns about the text. In particular, an appropriate balance should be maintained between the mandate of WHO and the sovereignty of individual Member States. Human rights should be accorded due prominence. In respect of health measures at points of entry into a country, due consideration should be given to entry by road or rail, to take account of the situation of African countries.

The group was also concerned about possible imposition of charges for health measures under the Regulations, and urged the Intergovernmental Working Group to bear in mind the interests of developing countries in that regard. The additional measures proposed in Article 39 might provide some countries with the flexibility to take additional action; however, it was important to safeguard against unilateral measures, which might hamper efforts to promote multilateralism. Flexibility must be accompanied by transparency and nondiscrimination, and the technical aspects of the institutional framework of the Regulations must be carefully separated from the political aspects. Member States must ensure that WHO acted only within its mandate and did not encroach upon the mandates of other international organizations.

With regard to the proposed revision of Annex 2, which was central to the Regulations, the African group intended to participate in the ad hoc group of experts due to meet before the second session of the Intergovernmental Working Group. It did not expect the ad hoc group to discuss the text of the Annex, but rather to provide expert advice to guide the Intergovernmental Working Group in its negotiations.

Possible contradictions between some articles of the Constitution of WHO and those of the International Health Regulations, particularly in respect of reservations, must be avoided.

Mrs LE THI THU HA (Viet Nam) said that, as a country that had been affected by the outbreaks of SARS in 2003 and avian influenza in 2004, Viet Nam fully supported the revision of the International Health Regulations, which were designed to provide maximum protection against the international spread of disease, while minimizing interference with international traffic and trade. She noted that consensus had been reached on a range of issues and hoped that the revised text would be submitted to the Health Assembly for consideration in May 2005.

Dr GAKURUH (Kenya) endorsed the statement made by the member for Lesotho. She stressed the need to define formal and informal sources of information and their use and, for developing countries, to make a proper assessment of their implementation capacity and the financial implications of implementation well in advance of implementation.

Dr BUSS (Brazil) noted that the MERCOSUR and Andean Pact countries were due to meet in Uruguay at the end of the month to agree on a common position for the next session of the Intergovernmental Working Group.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the Latin American and Caribbean Group, said that the Intergovernmental Working Group had made some progress at its first session, but much remained to be done. The Latin American and Caribbean Group supported the procedure proposed by the Chair of the Intergovernmental Working Group and the convening of an ad hoc group of experts to discuss the revision of Annex 2 of the Regulations. That ad hoc group should have the same number of members as the Executive Board in order to ensure adequate representation of the regional groups.

Dr AGARWAL (India)¹ said that effective national surveillance systems and international coordination were essential to prevent the spread of disease. Much work remained to be done if the revised Regulations were to be submitted to the Health Assembly in May 2005. In India, the Chair's proposed text would be submitted to national stakeholders for comment; regional consultations would also be held. India welcomed the establishment of an ad hoc group of experts to examine Annex 2 of the Regulations.

Mr ERGANI (Turkey)¹ associated himself with the statement made by the member for Luxembourg the previous day.

Ms THOMPSON (European Commission), speaking at the invitation of the CHAIRMAN, commended the close cooperation between WHO and the European Commission in activities to prevent the spread of communicable diseases. The European Union, as a regional economic integration organization, and its 25 Member States, would work towards a consensus on the revisions to the Regulations at the second session of the Intergovernmental Working Group. Some important issues remained unresolved, including ways of identifying a public-health emergency of international concern, the scope of the Regulations, the sovereignty of Member States and the roles and responsibilities of WHO. More effective working methods and greater flexibility and imagination would be needed at the second session if the revision was to be completed in time for the Fifty-eighth World Health Assembly.

Mr ANGOT (Office International des Epizooties (OIE)), speaking at the invitation of the CHAIRMAN, said that OIE wanted to increase collaboration with WHO, particularly in the area of emerging and re-emerging diseases, of which 75% were zoonoses. The Directors-General of the two organizations had signed an Agreement in December 2004 and had stressed the need to increase

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

surveillance and take action as close to the source of infection as possible. Diseases such as avian influenza could be controlled by tackling pathogens at their source. It was essential to re-establish surveillance systems to detect zoonoses in the countries affected by the tsunami.

At the first session of the Intergovernmental Working Group, OIE had drawn attention to the international standards adopted by its Members that dealt with health information, international trade in animals and animal products and the role of national veterinary services. The collaboration between WHO and OIE also covered the OIE Global Early-Warning System for Transboundary Animal Diseases, the United Nations Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on Their Destruction, and antibiotic resistance.

The CHAIRMAN, responding to the comments of the member for Spain, said that he had been informed by the Legal Counsel that the Board itself did not have a mandate to discuss the text of the draft revision of the International Health Regulations, which would be taken up by the Intergovernmental Working Group the following month.

Dr ASAMOA-BAAH (Assistant Director-General) acknowledged the genuine difficulties that remained and the different positions on a wide range of issues. He had noted, in particular, points made with regard to the centrality of the decision instrument, the importance of a list of selected diseases, the issue of scope, and the need to respect, rather than compromise, national sovereignty. It appeared that further attention should be given to national capacity building, the role of the focal points, and the provision of financial and technical support to a number of parties. Political factors should not be allowed to derail the process and political and technical aspects should be separated where possible. There was also a need for simplicity, a phased approach to implementation in the light of the different capacities of different countries, and more effective working methods. The issue of ground crossings should be given due attention and a consensus reached on charges and reservations. It was important that the need for flexibility offered by the additional measures was balanced by the need for transparency, while respecting the Charter of the United Nations, human rights and the Constitution of WHO. The role and responsibilities of WHO also needed to be defined, and the Organization's work linked to that of other agencies. The bureau of the Intergovernmental Working Group would be meeting shortly to finalize some of the arrangements for the second session and would undoubtedly take into consideration the sentiments expressed by the Board.

Ms WHELAN (Ireland),¹ speaking in her capacity as the Chair of the Intergovernmental Working Group, expressed optimism that the Group would be able to complete its work in accordance with its mandate, and urged participants to demonstrate the same degree of flexibility at the forthcoming session as they had in November 2004. She welcomed the importance accorded to her textual proposal, which would be available in all official languages before the end of the current session of the Board so that she could receive feedback.

The Board took note of the report.

Achievement of the health-related Millennium Development Goals: status report: Item 4.2 of the Agenda (Documents EB115/5 and EB115/5 Corr.1)

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries, Croatia, Romania and Turkey, said that the tsunami was a timely reminder of responsibilities with respect to preparation for outbreaks of disease and their prevention. Globalization provided a healthy breeding ground for the spread of disease, and it was

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

essential for every region of the world to have epidemic alert and surveillance systems to reduce threats to global health. Completion of the revision of the International Health Regulations was an absolute priority for the European Union, and every effort should be made to resolve the outstanding issues.

She welcomed the emphasis placed on the five new and emerging areas of concern in the Proposed programme budget 2006-2007. Without prejudice to the discussions at the Health Assembly, she supported the six priority areas of work identified, in particular Making pregnancy safer. Further information should be provided on prioritization, however, notably on the activities to be scaled down or stopped. The new European Centre for Disease Prevention and Control would shortly help to make community action more effective and facilitate synergies between WHO and the European Union.

Several countries were linking economic development and health. The SARS outbreak in 2003 had shown health systems and economies to be equally vulnerable. Health systems could be strengthened by incorporating health strategies with poverty-reduction policies and donor programmes. Indeed, if the health-related Millennium Development Goals were to be achieved, there needed to be further investment in the health area besides consideration of gender, equity and social cohesion. The European Union would be an active partner in that connection, notably to those countries that were particularly lagging behind in attaining the Goals.

Many health-related problems undermined the economic and social development of countries and their poverty-reduction efforts. The High-Level Forum on the Health Millennium Development Goals (Abuja, December 2004) had highlighted, for example, the need to face up to the massive shortage of health workers and to strengthen coordination among donors. Tuberculosis, malaria, chronic noncommunicable diseases and tobacco use seriously hampered the attainment of the Goals. The European Union welcomed the entry into force of the WHO Framework Convention on Tobacco Control, and would play an active role in the Conference of the Parties.

Unless more effort was made in the area of reproductive health, both maternal and infant mortality and HIV/AIDS would prove major stumbling blocks to the achievement of the Millennium Development Goals. New and innovative strategies for HIV/AIDS must be developed, and the European Union welcomed the steps taken by WHO in that regard. The essential balance between prevention and treatment must be maintained, and prevention and treatment services must be better integrated, made more accessible, and staffed with competent and motivated personnel. As the latest statistics confirmed the feminization of the AIDS epidemic, women should be given special attention in HIV/AIDS policies. The "3 by 5" initiative remained a key element in the global strategy against HIV/AIDS, and Member States should be provided with information on the implementation of the strategy and action to be undertaken in 2005 to attain the objectives. WHO should also work with all UNAIDS other cosponsors, particularly at the country level. At the European ministerial conferences on HIV/AIDS held in Dublin and Vilnius in February and September 2004 respectively, an alarming increase had been reported in new HIV infections in middle-income countries, including certain countries in eastern Europe and central Asia. A road map had been developed and specific action undertaken by governments.

With regard to the Proposed programme budget 2006-2007, the process of reform in the United Nations system should enable WHO to channel more effective support to the developing countries. The Director-General should inform the Health Assembly of the progress made in connection with that reform process and the options envisaged or implemented.

Dr ANTEZANA ARANÍBAR (Bolivia) observed that the opening sentence of document EB115/5 was a sharp reminder of the difficult challenges that remained. With the benefit of hindsight, the Millennium Development Goals might even appear to have been selected without sufficient consideration having been given to what could realistically be achieved.

However, although at least 10 of the 18 targets were health-related, success in attaining the Goals would in most cases depend on the degree of coordination between the health sector and the other sectors involved. For example, the dilemma facing the health sector of whether to improve people's health in order to achieve economic development or whether alleviating poverty first would more effectively improve health could only be resolved through cooperation with the economic, social

and political sectors. Furthermore, although the Goals appeared to be exclusively oriented towards poor and developing countries, in reality their attainment depended equally on the commitment of all countries, including rich nations.

Another aspect that needed to be considered was the inequality of living conditions which caused migration from poor to rich countries. It would be very difficult to overcome the numerous economic obstacles to attainment of the Millennium Development Goals – economic conditions that affected the health sector but over which it often had no control. *The world health report 2003*,¹ the Proposed programme budget 2006-2007 and strategic directions accorded the highest importance to that aspect of health development. Future relations between WHO, other organizations of the United Nations system, the Bretton Woods organizations and WTO, would therefore be of paramount importance.

The status report mentioned WHO's intention to support building capacity within ministries of health to enable them to participate more effectively in macroeconomic debates. Such skills could also prove useful in improving access by least developed countries to knowledge, technologies and services. WHO should therefore re-think its role and the nature of its cooperation, rather than encouraging countries to orient their efforts and national budgets in line with its own budget priorities. The importance of cooperation with all other sectors and organizations, the need to re-examine national and international instruments to that end and the need to strengthen the leadership role of health ministries in national decision-making, could not be over-emphasized.

Dr PHOOKO (Lesotho), speaking on behalf of the African group, expressed concern at the finding in the report that most poor countries would not meet the health-related Millennium Development Goals, that no region of the developing world was on track to meet the child mortality target, and that the maternal mortality ratio and newborn mortality rate in the African Region were the highest in the world. He recalled the commitment of the African health ministers, expressed at the fifty-fourth session of the Regional Committee for Africa in Brazzaville in 2004, to accelerate the attainment of the Goals relating to maternal and newborn health in Africa. In line with the resolution adopted, he requested WHO's support and technical assistance to increase investment in maternal and newborn health; develop, implement, monitor and evaluate appropriate road maps; develop tools and guidelines to strengthen health-care delivery systems, in particular, for emergency obstetric care; and train mid-level health workers in the provision of emergency obstetric and newborn care.

Both the Proposed programme budget 2006-2007 and the Eleventh General Programme of Work 2006-2015 gave priority to the achievement of the Millennium Development Goals, but adequate funding had to be made available for the 10-year Programme of Work.

Dr AHMED (Ghana), noting that some of the factors that accounted for the expectation that most poor countries would not achieve the health-related Millennium Development Goals had been addressed, said that close attention needed to be given to the reasons for the depletion of human resources as qualified personnel moved to developed countries.

In many countries, education and the dissemination of information on the Goals was limited, particularly at policy level. WHO was attempting to address the issue by increasing its advocacy role in individual countries. Although the strategy was to involve all sectors of the community, in practice, it tended to be slightly oriented towards the health sector. The decision to include locally relevant targets was helpful since it took account of the fact that levels of development varied between countries. The economic situation in many poor countries created a further barrier to their attaining the Goals and was another area in which the advocacy of WHO and other international bodies could make a difference to their achieving at least some Goals by 2015.

The meeting rose at 12:35.

¹ *The world health report 2003: Shaping the future*. Geneva, World Health Organization, 2003.

FOURTH MEETING

Tuesday, 18 January 2005, at 14:25

Chairman: Mr D.Á. GUNNARSSON (Iceland)

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

Achievement of the health-related Millennium Development Goals: status report: Item 4.2 of the Agenda (Documents EB115/5 and EB115/5 Corr.1) (continued)

Dr CAMARA (Guinea), welcoming the status report, outlined measures Guinea had taken for attaining the Goals, including: the preparation of a document providing a framework for coordination, planning and resource mobilization, with a view to poverty reduction; and strengthening the health system through improvements in the basic health services, including emergency services. Thanks to partnerships with France, Japan, WHO, UNICEF and the United States Agency for International Development, Guinea had drawn up national programmes to combat malaria, achieve safer pregnancy and secure integrated management of childhood illnesses. Immunization programmes had been reinforced. In general the health services had been decentralized to bring them closer to those in need and extend their reach to remote areas. Despite that, Guinea, like other African countries, was faced with the challenge of attaining the Millennium Development Goals in a context of poverty, high infant and maternal mortality, the problems of refugees from unstable neighbouring countries, and the effects of structural adjustments. There was a lack of skilled birth attendants and of insecticide-treated bednets for pregnant women and children under five years of age. Supplies of chloroquine, iron and folic acid used for prophylaxis against anaemia in pregnant women were inadequate and access to drinking-water and sanitation was still insufficient. The special needs of the developing nations, particularly of the poorest countries, must be taken into account if the Goals were to be met by 2015.

Dr GAKURUH (Kenya) welcomed the status report and supported the statement by the member for Lesotho. On account of the many diverse problems facing the African Region, special emphasis should be laid on achieving political and economic solutions. Listing some of the key prerequisites for attaining the Millennium Development Goals, she noted that most African countries lacked human resources for health. Kenya faced a further challenge – the inability to employ 6000-7000 trained nurses on account of an employment embargo, as a result of which many dispensaries had been closed or were drastically understaffed. The quality of health services was affected by a shortage or inconsistent flow of supplies, dilapidated infrastructures and inadequate or non-functioning equipment.

Regarding management support, referral systems had collapsed through lack of transport and communication capacities, and there was a lack of confidence among patients in the lower level of health facilities. Community-level health activities had decreased as a result of adverse trends since the Declaration of Alma-Ata on primary health care.

Political involvement at the highest level was essential in order: to meet the need for evidence-based advocacy to facilitate the development of human resources for health and the sharing of skills within regions; to provide additional funding to acquire those human resources and ensure supplies, equipment and rehabilitation or reconstruction of infrastructures; and to establish alternative health-care financing conducive to sustainability.

Mr COSTEA (alternate to Professor Cinteza, Romania) supported the views expressed by the member for Luxembourg. Romania recognized the urgent need for all Member States to speed up

efforts to reach the Millennium Development Goals, which otherwise would not be met in many parts of the world: no developing country had yet reached the projected target levels to reduce child mortality; maternal mortality had declined only in countries with already low mortality levels; and countries with high levels of mortality were experiencing stagnation or even reversals. Lessons could nevertheless be learnt from those developing countries that had made progress towards achieving the Millennium Development Goals.

Health sector reform in Romania was based on the principles of equity of access to the health services and better allocation of resources and aimed in particular at decreasing the morbidity rate and the number of premature deaths. Regarding Goal 6, notable progress had been made in combating HIV/AIDS through universal access to treatment, action plans and interventions for people with risk behaviours, and free access to counselling and testing. The treatment of HIV-positive pregnant women had almost eliminated mother-to-child transmission, and the risk of nosocomial transmission had been removed.

He stressed the importance of the plan to achieve the Millennium Development Goals published by the United Nations Millennium Project;¹ Romania would carefully examine the relevant recommendations and was ready to cooperate with WHO both nationally and regionally.

Ms CHA-AIM PACHANEE (adviser to Dr Suwit Wibulpolprasert, Thailand), expressed appreciation of WHO's support, particularly in capacity-building and technical advice to Member States in their efforts to reach the Millennium Development Goals, an objective extremely difficult to reach given current trends. She endorsed the report's emphasis on more health investment and better use of limited resources. Between 1980 and 1990 the maternal mortality rate in Thailand had fallen by more than three quarters with no significant increase in the health budget. It was important to ensure that funds were spent on improving access to essential primary health care services rather than on tertiary care for the urban rich. The much-needed sustainable increase in the national health budget could only come about with peace and economic growth. Whereas 20 years previously, half the national budget of Thailand had gone to security and public debt servicing, the subsequent peaceful situation and rapid economic growth had gradually made it possible to spend more on improving infrastructures, social services, education and health, and subsequently to implement a policy of universal access to health insurance and to antiretroviral agents. It was important therefore that the Secretariat should work multisectorally to contribute to peace, constructive trade relations and globalization.

She strongly supported the need for information to track progress towards achieving the Goals, especially in view of the unreliability of some statistics. Member States and international organizations should support the Health Metrics Network in order to ensure expansion of its coverage.

Because the regular budget allocation for strengthening health systems and human resources for health had been reduced when there was an urgent need to strengthen those systems, she requested that the budget allocation in that area be reconsidered. She also urged Member States to support the necessary increase in assessed contributions in order to cover those important areas.

The Secretariat should increase its efforts to support capacity-building within ministries of health in order to achieve the Goals. That process, however, required close cooperation between ministries of health and other sectors, civil society and the private sector if the Goals were to be met.

Mr DELVALLÉE (alternate to Professor Dab, France), supporting the views expressed by the member for Luxembourg, said that achievement of the health-related Millennium Development Goals would be at the core of international cooperation for the French Ministry of Foreign Affairs, the Ministry of Health, other health agencies and all relevant partner nongovernmental organizations. Moreover, the Goals would be given priority in bilateral cooperation, the strengthening of health

¹ United Nations Millennium Project. *Investing in development: a practical plan to achieve the Millennium Development Goals*. New York, 2005.

systems and relations with WHO and the other organizations of the United Nations system. Clearly, no country would achieve those Goals without careful consideration of their funding. National contributions, whether voluntary or compulsory, would not suffice. With the support of 110 other countries France had launched the idea of an international tax, whose revenue might, for example, go towards combating AIDS. There had been a similar suggestion from the United Kingdom of Great Britain and Northern Ireland to create an international financial facility to fund vaccination. Those suggestions were consonant with the conferences on resources for the Global Fund to Fight AIDS, Tuberculosis and Malaria, the first of which would be held in Sweden in March 2005, and with a high-level review of progress towards the Goals (New York, 14-16 September 2005). It was to be hoped that all countries involved would combine their efforts to increase development and that the forthcoming Health Assembly would discuss Member States' specific contributions towards those Goals.

Dr LAMATA COTANDA (Spain) pointed out that 20 000 children in the world died of hunger every single day, and that hunger was the main cause of premature death. Those facts needed to be brought to the attention of all peoples and governments to impress on them the need to transform economic relations so as to promote economic development. Goal 8 stressed that point as a precondition of better health conditions. Although that was not its main purpose, WHO could draw constant attention to the direct link between the economy and health. In the discussions on the Asian tsunami, emphasis had been laid on the need to encourage solidarity and mobilization of resources. Similarly, WHO could highlight the ongoing catastrophe of those premature deaths due to lack of food so as to urge governments, peoples, private initiatives and humanitarian organizations to cooperate in order to bring about change. For perhaps the first time in history there was sufficient expertise and technology available for such change, but it could not be achieved without political will and support.

Strengthening of health systems, training of health professionals and universal coverage were basic objectives that could be achieved with more funding and more efficient use of resources. From the donors' point of view, however, overlapping of activities, one-off activities with no follow-up, or repeated evaluation of programmes under way in different countries (or even within the same country or group of countries) were all too frequent. WHO could and should play a greater role in collaborating with the countries concerned to improve coordination and optimize use of available funds. The opportunity to overcome the scourge of hunger in the twenty-first century must not be allowed to slip away.

Dr HUERTA MONTALVO (Ecuador) said that, at the Board's recent seminar (Reykjavik, 9-10 December 2005), in discussing future scenarios in global public health, there had been much insistence that health and development were a single subject. The health-related Millennium Development Goals must therefore begin with the eradication of poverty. Although that was not WHO's specific field, poverty was directly related to, and should not be separated from, the Organization's work. Poverty spread easily and combating it was a health-related Goal. Political and technical concerns needed to be considered jointly. The same was true of the Goals; health should be regarded as the means of attaining them all. All countries with the necessary capacity should cooperate in achieving the Goals, including those related to health.

Dr QI Qingdong (alternate to Dr Yin Li, China), expressed support for WHO's actions towards achieving the Millennium Development Goals, a system-wide undertaking requiring firm political commitment and concerted efforts by all sectors. There were no grounds for optimism about progress since health-related work was beset by obstacles. The main difficulties must therefore be analysed and solutions found. Stage-by-stage targets should be set and practical measurements used, in order to make WHO a driving force for achieving the Goals.

He particularly supported WHO's position that emphasis should be placed on countries that faced greater problems in achieving the Goals. At the same time, there should be an exchange of successful experience so that, ultimately, all countries reached the Goals. The time was propitious, five

years after the adoption of the Millennium Declaration, for a systematic assessment of progress. It was particularly important to encourage development aid agencies to increase their commitment, which would encourage inter-State cooperation for shared development. China hoped to see further measures by WHO for the attainment of the Goals.

Ms VALDEZ (alternate to Dr Steiger, United States of America) observed that the Millennium Declaration had provided all Member States with a clear set of Goals; the challenge was to find ways of achieving them. WHO had an important mandate, working with Member States, to ensure quality and integrity of reporting on the health-related Goals, and could also help to support a more coordinated, evidence-based approach to track more closely how donor development assistance was flowing and being spent, and how its impact was being measured and evaluated. However, WHO should not seek to attain the Goals by engaging in macroeconomic debate or advising countries on international trade agreements. Such efforts would deplete scarce resources and in any event fell within the purview of other international organizations. She was somewhat concerned at WHO's use of the term "right to health" and suggested that the full formulation contained in the WHO Constitution, and reproduced in the footnote on page 5 of the report should be used.

It had been clear from the debate that, despite concerted efforts, the Goals were unlikely to be attained. Referring to the comments of previous speakers, she stressed WHO's potential key role in showing how investment in health assisted economic growth and development and in emphasizing the need for political commitment at the highest level. WHO also had an important part to play in helping Member States keep the Millennium Development Goals to the fore in national and international policy debate.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) acknowledged the importance of the status report which not only dealt with WHO's contribution to reaching the health-related Millennium Development Goals but also laid out the main lines for the Eleventh General Programme of Work for 2006-2015. The wide-ranging cooperation between WHO and various partners in the United Nations system was welcome. He appreciated the position of principle taken to strengthen work at country level but success depended largely on the qualifications of the staff implementing and supervising such activities; that point needed careful attention by Member States and regional offices. Countries with less developed social and economic systems and countries in transition that had limited budgets would find it difficult to distribute their resources more effectively. In recent years, however, most of those countries had enjoyed substantial external support. WHO could help ensure that such assistance was properly used.

He approved the support provided for work on patents, particularly with regard to new drugs, and to reducing tariffs and the cost of medicines, medical products and medical equipment. He also approved the greater role in supervising and monitoring the work being done at all levels to attain the Millennium Development Goals. In that context, some common criteria for the work of national statistics offices would be useful.

Ms PEXOVÁ (alternate to Professor Fišer, Czech Republic) commended WHO's efforts to achieve the Millennium Development Goals and asked whether a draft resolution on their attainment would be prepared for consideration by the Fifty-eighth World Health Assembly.

Mr JUNOR (Jamaica) said that the status report constituted a frank analysis of the situation regarding achievement of the health-related Goals, including some very disappointing trends. Five years after the adoption of the United Nations Millennium Declaration, there was a real risk of the gap between developed and developing countries widening. There was also a risk that the Goals might be met on a global scale with no improvement in the health status of the poorest and most vulnerable peoples of the world. The objective could thus be lost and serious action was therefore essential: consideration must be given to how the global overall score was reached. More weight should perhaps

be given to poorer countries to ensure that the coverage reflected the disparity between rich and poor nations, and that a false sense of achievement was not induced.

Some countries had already made significant achievements in certain areas included in the Millennium Development Goals and had therefore set themselves more ambitious targets. The Board needed to help Member States not progressing towards the Goals to focus on the reasons for such failure. In some countries it seemed to stem from an incapacity to implement strategies, owing mainly to inadequate human resources and infrastructures. Educational standards in particular needed to be improved as poor levels impaired capacity to sustain the results of the technical assistance offered.

The need for appropriate financing could not be over-emphasized. The performance assessment report of the Programme budget 2002-2003 showed very poor implementation rates for the areas of work covered by Goals 4 and 5, and stated clearly in respect of sustainable development that much remained to be done in order to forge consistent positions across the Organization, and that, despite much progress, the place of health on the development agenda was still not secure. It was a matter of great concern therefore that the Proposed programme budget 2006-2007 showed that, for the areas covered by Goals 4 and 5, a very low proportion of funds came from regular contributions. According to the document, part of the problem for WHO in achieving its objectives arose from uncertainty about normative programmes. The allocations between voluntary contributions and core budget issues needed serious examination. WHO should commit itself anew to the Millennium Development Goals, given their importance for humanity.

Dr YOOSUF (Maldives), referring to the partnership between WHO and the United Nations, expressed the hope that the new practical plan to combat poverty, said to be a cost-effective blueprint for achieving the Millennium Development Goals, would work. Attaining the Goals required national and international resource mobilization and effective resource management. To that end, people had to be trained in public health and health management. More advocacy was also needed, at policy-making and other levels, among those deciding how national budgets were utilized.

Many countries that found it difficult to achieve the Goals had poorly functioning health systems and were experiencing a natural or man-made crisis of some kind. Maldives, for example, had made great progress in reducing maternal and infant mortality rates and in raising immunization coverage and life expectancy. Six days before the tsunami, it had been taken off the list of least developed countries. It would be many years before the country could return to its former levels of development.

To achieve the Goals, governance, equity and resource management would have to be improved. In that respect, tracking, monitoring and reporting of resources, as mentioned in the status report, were of key importance.

Mrs GILDERS (alternate to Mr Shugart, Canada) welcomed WHO's renewed emphasis on achieving the health-related Millennium Development Goals and its call for greater investment in public health and collective action within a broad development framework sensitive to gender and equity issues. It was alarming to note that most poor countries were unlikely to meet the health-related Goals, and in particular that no region of the developing world was on track for the child mortality target. Greater collective action was clearly, and urgently, required. The member for Jamaica was right to highlight the importance of integrating the Goals into the budget-planning process, and it was encouraging to note that the Eleventh General Programme of Work would cover the period corresponding to the target period of the Goals. Other speakers had mentioned the crucial link to be made between health and economic development; WHO should support that process. The events due to take place in 2005 presented a unique opportunity for a new global consensus in support of stronger international cooperation and action to achieve the Goals which WHO should seize to forge new partnerships for the purpose.

The CHAIRMAN, speaking as the member for Iceland, said that the High-Level Forum on the Health Millennium Development Goals (Abuja, 2-3 December 2004) had emphasized that those Goals

could be met if there was a substantial increase in funding and more effective aid. A major concern was the urgent need to strengthen health systems, especially, as the member for Jamaica had pointed out, in terms of human resources. The lack of health personnel in many poor countries was one of the main obstacles to improving the health system. In particular, health personnel were needed in HIV/AIDS-affected communities. The problem had to be tackled at all levels, nationally and internationally. The Secretariat needed to work closely with the Member States, the World Bank and the International Monetary Fund on macroeconomic policies to address a complex issue.

Dr AGARWAL (India)¹ said that specific health-related Millennium Development Goals would be reached only if broader health strategies heeded the local context regarding equity, ethnicity, gender and the major determinants of health. The fifth anniversary of the Millennium Summit afforded a unique opportunity to review progress and to reaffirm the global commitment to achieve the Goals. India, for its part, was committed to cutting its child mortality by two thirds of the 1990 rate by 2015, to halving the current infant mortality rate to 30/1000 by 2010, and to a programme of exclusive breastfeeding for the first six months of life. It planned to implement integrated management of childhood illnesses in phases throughout the country. Maternal mortality would be reduced by ensuring that all pregnant women were registered and received minimum antenatal check-ups and tetanus toxoid immunization, by promoting safe delivery, improving access to anaesthetists and blood banks, and providing reproductive and child health services in remote areas. India further aimed to reduce malaria morbidity and mortality by 25% by 2007 and 50% by 2010, to eliminate leishmaniasis by 2010, and to halve tuberculosis mortality by 2010. Regarding HIV/AIDS, it would continue to emphasize the prevention of mother-to-child transmission, the reduction of blood-borne transmission, the care and treatment of HIV-infected people, and improved surveillance to obtain epidemiological data on time trends in HIV infection.

Ms KEITH (The Save the Children Fund), speaking at the invitation of the CHAIRMAN, said that WHO should establish standards and regulating principles for disease-selective programmes to ensure monitoring of their impact on national health systems. Well-trained, supported and motivated health workers were an essential part of a functioning health system, and time should be made available at the Fifty-eighth World Health Assembly to discuss the current shortage of human resources. Also, a report should be issued on progress in implementing resolution WHA57.19 on international migration of health personnel. She endorsed WHO's suggestion that *The world health report 2006* be devoted to human resources and that 2006 be dedicated to tackling the crisis in human resources for health. Paying for health care had led the poorest into further poverty. She urged national health and finance ministers, WHO and donors to follow Uganda's lead in ensuring that essential health services were free at the point of access. The question of user fees in particular needed to be addressed urgently. In order to achieve the health-related Goals, WHO and donors needed to increase their support to developing countries for operational research on health-funding mechanisms for the poor in the interests of greater equity. Her organization would help to develop the required knowledge base, and asked WHO, donors and academics to work with nongovernmental organizations to document best practices in such situations. It also supported endeavours to improve the quality and scope of health information systems and development goal reporting; it nevertheless urged that health systems indicators of the human resource process be added to Millennium Development Goal monitoring. Save the Children shared WHO's concern about the focus on outcome indicators.

Dr ROSES PERIAGO (Regional Director for the Americas) said that the countries of Latin America and the Caribbean had agreed on some necessary actions for attaining the health-related Millennium Development Goals: more rapid progress towards substantially reducing inequity in health and access to basic services and towards social health protection; increased health spending and

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

investment and more careful allocation of sector resources; a shift in focus to primary health care and health promotion; a sustained effort to strengthen the public health infrastructure; and the formulation and implementation of intersectoral policies and activities that would have an impact on the economic and social determinants of the health targets incorporated in the Millennium Development Goals. The result would be greater social cohesion and enhanced health rights for people. The health policies, plans and programmes of the region's countries would therefore aim to reverse the trends observed in respect of most health indicators; should they fail to do so, the targets set for 2015 would not be met. To that end, PAHO's 45th Directing Council had adopted resolution CD45.R3 in September 2004 on Millennium Development Goals and Health Targets, setting objectives for Member States in the Region of the Americas, few of which had fully incorporated the objectives into their policy, planning, programme and budget processes. Finally, the right to health meant strengthening democratic governance coupled with social cohesion, given that true democracy could only be established if none of the region's inhabitants were excluded from the benefits of development.

Dr ANTEZANA ARANÍBAR (Bolivia), seconded by Dr BUSS (Brazil), proposed that the Secretariat draft a resolution for consideration by the Health Assembly on the close links between development in general and health.

Mr AITKEN (Director, Office of the Director-General) pointed out that the Millennium Project report had just been issued.¹ It would be difficult to draft a resolution during the present session of the Board; the report would have to be analysed in greater depth first. He suggested that the Secretariat draft a resolution in the following week or two and circulate it via e-mail for consultation and comment. The draft resolution would then be submitted by the Director-General to the Fifty-eighth World Health Assembly. In response to a query from Dr STEIGER (United States of America), he said that there was nothing unusual in having the Director-General present the text of a possible resolution for consideration by the Health Assembly.

It was so agreed.

Dr LEITNER (Assistant Director-General) said that she had noted the continued commitment to the Millennium Declaration and attaining the Millennium Development Goals. Progress towards achieving the goals, however, was uneven and in some cases inadequate. What was needed were new instruments, new ways of working together, alternative sources of funding, and reallocation of existing funds. Some members had affirmed that it was for Member States to monitor the situation at country level, but WHO could help them to obtain reliable data, strengthen information systems, and ensure that data were disaggregated so as to inform policy decisions at all levels. Others had agreed that forthcoming events in 2005 should be used to forge new partnerships. In that respect, WHO was engaged with the Bretton Woods institutions and other financial institutions, and would continue to be so. She understood the cautions against the Organization spreading itself too thinly. On the other hand, the Secretariat was being approached for input into the human rights debate and trade negotiations to ensure that health issues were given due consideration. In order to do that properly and to facilitate the participation of health ministries in such forums regionally and internationally, a minimum of staff capacity was needed. The health sector had, in particular, to strengthen health systems, tackle issues of health personnel and health information, and come to grips with prevention and mitigation.

The present discussion, the status report and the High-Level Forum on the Health Millennium Development Goals (Abuja, 2-3 December 2004) had all highlighted the specific situation of countries in crisis, where the Goals were least likely to be achieved. A way had to be found of moving beyond

¹ United Nations Millennium Project. *Investing in development: a practical plan to achieve the Millennium Development Goals*. New York, 2005.

crises in order to secure in the long term the gains made and promote the sustainability of socioeconomic development.

The Board took note of the report.

Infant and young child nutrition: Item 4.4 of the Agenda (Document EB115/7)

The CHAIRMAN recalled that the Fifty-seventh World Health Assembly had decided that the draft resolution on infant and young child nutrition submitted to it should be discussed by the Board at its present session.¹ He drew attention to the report contained in document EB115/7 and the draft resolution therein.

Dr TANGI (Tonga) said that he was commenting mainly on behalf of the small Pacific island countries that had sponsored the original draft resolution considered by Committee A at the previous Health Assembly. The summary records showed that 16 speakers had spoken in support, six had spoken against or had requested more time to consider the resolution, and two had requested that it be considered immediately. The Board was being presented with a revised text and the original for comparison. The amended draft resolution had been prepared, no doubt with the best of intentions, by the Secretariat. A substantial proportion of the original text had been deleted, however, and the text before the Board constituted a different resolution altogether. It appeared to shift responsibilities and was not acceptable to the sponsors. Although there had since been some further discussion of the matter with one sponsor, Nepal, for some reason the five small Pacific island sponsors had not been consulted. One of the latter had learnt about the amended text and had requested him, as a Board member from the Region, to investigate the matter. The Board should discuss the original draft resolution since that was the request of the Health Assembly, a procedure prescribed by Rule 9 of the Rules of Procedure of the Executive Board. The Board should not set a dangerous precedent by failing to comply with that Rule.

Dr ACHARYA (Nepal) said that the report clearly indicated that the Health Assembly had requested the Board, at its 115th session, to consider the draft resolution proposed by the six Member States listed in paragraph 1 and to submit it for consideration at the Fifty-eighth World Health Assembly. In other words, the Board had been requested to consider the same draft resolution that had been submitted to the Fifty-seventh World Health Assembly. Although Nepal had responded in time in respect of the amended draft resolution and had sent its comments via its permanent mission in Geneva, it appeared that the other sponsors of the original draft resolution had not been consulted. He was pleased to note that the member for Tonga had been able to consult with the countries concerned in the meantime.

In the amended draft resolution, the text of paragraph 1(3) (numbered 1(1) in the original) had been unduly diluted, giving the impression that the potential for harm was restricted to infants in high-risk groups. Nepal therefore proposed that the text of the original paragraph 1(1) be reinstated, to read: “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;”. Paragraph 1(4) should be amended to read: “to work closely with all stakeholders to continue to reduce the concentration and prevalence of pathogens, including *Enterobacter sakazakii*, in powdered infant formula by doing necessary research and action”. In paragraph 1(5), “bodies” should be replaced by “organizations, including research on infant and young child feeding, which should be free from commercial influence”. The inclusion of the last phrase was of particular importance. Nepal also strongly objected to the deletion of the original paragraph 1(3) and proposed that it be reinstated. Paragraph 2(1) should be amended to read: “to

¹ Document WHA57/2004/REC/3, summary record of the eighth meeting of Committee A, page 151.

continue to give full consideration to those resolutions of the Health Assembly that are relevant within the framework of its operational mandate when elaborating standards, guidelines and recommendations, including revision of standards and guidelines on labelling, quality and safety of processed foods for infants and young children”.

Mrs GILDERS (alternate to Mr Shugart, Canada) commended the report and the efforts made to incorporate in the amended draft resolution the changes proposed by Member States during and since the last Health Assembly. Canada accorded the highest importance to infant, young child and maternal nutrition and welcomed the continued activities of WHO and FAO, notably the standard-setting by the Codex Alimentarius Commission in those areas. In recent years Canada had paid particular attention to the prevention of micronutrient deficiencies by strengthening the dietary availability of essential nutrients such as iron, vitamin A and iodine. As a follow-up to the WHO report on iodine deficiency,¹ several Board members, Member States and international organizations, in particular the International Council for the Control of Iodine Deficiency Disorders, had prepared a draft resolution for submission to the Fifty-eighth World Health Assembly. Efforts to eliminate iodine deficiency disorders must be maintained and accelerated where necessary to prevent further recurrences.

In November 2004, Health Canada had issued a recommendation that healthy full-term infants should be breastfed exclusively for the first six months of life; that was in line with WHO's recommendation.

Dr SOPHIDA CHAVANICHKUL (adviser to Dr Suwit Wibulpoprasert, Thailand) endorsed the comments made by the member for Tonga and expressed support for the original draft resolution. She also shared the concerns expressed by Canada in relation to iodine deficiency disorders. The establishment of best practices for infant and child nutrition was vital for the health and development of the future citizens of the world and the prospects of all nations. Implementation of the International Code of Marketing of Breast-Milk Substitutes remained uneven. The Code should be implemented seriously by all Member States, and be reinforced by a legal framework, with effective penalties for violations, and social sanctions for non-compliance should be supported. In line with the Code, maternity leave of six months, which was one of the main strategies in support of exclusive breastfeeding for six months, should become an international standard. In many developing countries, mothers were allowed only one month of maternity leave. Cooperation on the part of public- and private-sector employers was clearly needed. Supplementary feeding after six months was also crucial. WHO should advocate the use of locally sourced nutritious foods rather than the importation of expensive foreign products. Mothers were the most important factor in promoting exclusive breastfeeding and should be encouraged to recognize the benefits of breastfeeding and the importance of maintaining their own health. A report in *The Lancet* in 2003 had indicated that a substantial proportion of deaths among children under five years of age could be prevented through breastfeeding. The Board should establish a drafting group to consider the draft resolution.

Dr STEIGER (United States of America) agreed that national governments and the private sector should address the potential for pathogenic contamination of infant formula and other such products. National policies and standards should be developed on the basis of the best possible scientific evidence. A WHO resolution on the topic was premature, however, and might be counterproductive. The Codex Alimentarius Commission had the mandate for establishing international standards, guidelines and related texts in the areas of food, nutrition and food labelling and was currently reviewing standards for infant formulas, including those for the manufacture of powdered infant formula and relating to the potential for contamination with *E. sakazakii* and other pathogens during manufacture. The United States had brought the hazards associated with such

¹ de Benoist B et al., eds. *Iodine status worldwide : WHO global database on iodine deficiency*. Geneva, World Health Organization, 2004.

contamination to the attention of the Commission during its revision of the Recommended International Code of Hygienic Practice for Foods for Infants and Children. The Codex Committee on Food Hygiene had noted that there were still many gaps in the data related to such contamination. Further research was therefore needed in order to assess the risks posed. While progress had been made, processes would need to come to fruition before Member States could debate the situation adequately and develop appropriate national policies. Deliberations must be science-based and all options for preventing contamination by *E. sakazakii* should be considered, including safe preparation and handling procedures for powdered formula. United States Government scientific experts had been consulted and had indicated that, although there was a potential for some infants to develop illness from infection by that pathogen, the greatest risk was to infants born at a gestational age of less than 36 weeks up to a post-term age of four to six weeks, to immunocompromised infants at any age, and to full-term infants admitted to level-two and level-three neonatal intensive care units. The risk to healthy full-term infants was probably low. The situation called for complex and different solutions, tailored to national and cultural needs, including the development of effective alternatives to infant formula to control exposure in high-risk infants, and better education in various segments of public health and distribution networks, and among infant carers and product manufacturers. Since the Codex Alimentarius Commission was already considering all those aspects, the most helpful course for the Board was to recognize that significant progress had already been made and to avoid any action that might impede continuation of that progress.

Dr AHMED (Ghana) said that the question of infant and young child nutrition was pressing in African developing countries, where rates of breastfeeding remained high in rural areas, but were falling in urban areas as a result of changing lifestyles. When that happened, problems such as high rates of illiteracy or inadequate refrigeration and storage could result in a special risk to infants fed on infant formula. Moreover, infants with a low birth weight or born to HIV-positive mothers were more likely than others to receive infant formula and therefore to run the risk of infection from pathogens present in non-sterile formula products. Carers of such infants must be alerted, through labelling or other means, to the fact that such products might be contaminated. Notwithstanding the work of the Codex Alimentarius Commission, WHO should take action of its own on the matter. He was also strongly in favour of enforcing the recommendation on breastfeeding, as advocated by Thailand.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries Croatia, Romania and Turkey, stressed the importance of the subject for the European States. She hoped for rapid progress by the Codex Alimentarius Commission. WHO should also take a stance, however, especially in the light of recent events in one of the European Union's Member States. The European Union was in favour of a resolution on infant and young child nutrition, but proposed several amendments to the text contained in document EB115/7. In paragraph 1(3), the phrase "geared to the particular needs of developing countries" should be deleted, because information and training on the preparation, use and handling of powdered infant formula should not be confined to certain geographical areas. In paragraph 2(2), the phrase "so as to ensure that users are made aware that the product is not sterile and must be appropriately prepared and stored" should be inserted after the words "appropriately labelled products". The word "independent" should be inserted before "research" in paragraph 3(2).

Dr QI Qingdong (alternate to Dr Yin Li, China) welcomed the fact that the global strategy for infant and young child feeding¹ was leading to action. He expressed his appreciation of the Secretariat's work to support that strategy. There was no doubt that the promotion of exclusive breastfeeding for the first six months was producing good results, but there was still a long way to go. All countries should take effective steps to improve infant and young child nutrition. As for powdered

¹ Resolution WHA55.25.

infant formula, it was clear that the products were not free of risk. The manufacturers must ensure that consumers used the products properly. He noted that for the past 10 years WHO had been working in conjunction with UNICEF on infant and young child nutrition.

He supported the proposal for the submission of a resolution on combating iodine deficiency to the Fifty-eighth World Health Assembly.

Dr HUERTA MONTALVO (Ecuador) said that, although his country would also support a resolution on iodine deficiency, the issue of contaminated infant formula was even more pressing. The member for Tonga had already explained how the text of the draft resolution had evolved. It was confusing to be presented with different texts originating from different sources and reaching different conclusions. The Board did not have sufficient information to decide how infant formula should be labelled, and whether the labels should merely carry a warning that the product was not sterile. He enquired about the cases of contamination that had occurred in France. Members of the Board also looked for guidance to the Secretariat, which was in a position to summarize technical information received from all Member States. The Board was currently faced with a draft resolution that had been altered without the knowledge of the sponsoring countries and without adequate technical information. It was important to ascertain the temperature at which bacteria present in a powdered formula would be killed, and whether the sterilization process would result in the loss of vitamins, as some reports claimed. There could be no question of adopting the resolution, even in amended form, without the technical support needed to clarify those issues.

Professor DAB (France) explained that contamination of powdered infant formula by *E. sakazakii* had resulted in the deaths of two infants in France out of nine cases (four infected and five whose digestive tracts had been colonized by the bacterium) in the period between 25 October and 13 December 2004. The cases had occurred in five hospitals, and a thorough epidemiological survey had established that the nine strains of the bacterium were indistinguishable both from one another and from those found in samples of one product that accounted for 50% of the milk powders marketed in France. Two batches of that product had initially been withdrawn from the market, as a compromise solution between the need to protect the population and a desire not to disrupt supplies. It had been agreed with the manufacturers that the powder version of the product should be entirely withdrawn, both in France and elsewhere; the same preparation in sterile liquid form was still in use. Discussions were taking place with all the companies concerned, and especially with the manufacturers of the product, to decide in what circumstances it could be brought back on the market.

Although the Codex Alimentarius Commission had broad expertise, the fact that *E. sakazakii* had resulted in fatalities in a country with good hygiene standards made it legitimate and indeed urgent for WHO to tackle the matter. According to investigations, the risk of contamination resulted from a combination of factors. It was difficult to sterilize the products with the available technology, and also difficult to analyse them microbiologically, and the methods used to do so were not standardized. There were also shortcomings in the quality-control procedures. No sample of several batches of the product manufactured in early 2004 had been stored, so that it was impossible to identify retrospectively the production stage at which an error might have been made. The problems of preparation and storage pertained not only in France, and it appeared that the training of health professionals was inadequate.

Thus, a real public health problem had to be addressed. The public, health professionals and doctors all assumed that infant formulas were sterile, which in the present state of knowledge was not necessarily the case. Professional users and parents must be fully informed without further delay of the state of affairs, and that was indeed the recommendation from those parts of the industry with which the French health sector was engaged.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that his country shared the concern of other Member States about the quality of powdered infant formula. The Board must adopt a resolution on the subject. He supported the proposal for a drafting group to be set up.

Dr YOOSUF (Maldives) agreed that the draft resolution before the Board was not acceptable as it stood. There was sufficient evidence of the danger posed by *E. sakazakii* to insist that the public should be warned. It was not clear why the original draft resolution had been altered. It was hard to imagine that any member of the Board or Secretariat was in favour of sponsorship of health professionals by manufacturers of breast-milk substitutes, or of research on infant and young child feeding being exposed to commercial influence; yet the paragraphs in the original draft that had sought to prevent such situations had been deleted. He too supported the proposal for a drafting group to be established.

Ms HALTON (Australia) said that access to adequate nutrition of high quality was clearly vital in ensuring a successful start to life and healthy adulthood. Promoting exclusive breastfeeding for the first six months was a priority for Australia. In addition to the issue of infant formula, iodine deficiency had also been mentioned, and looked forward to consideration of that issue at the next Health Assembly.

The member for Tonga had raised legitimate procedural concerns about the draft resolution; lessons must be drawn for the future. On the substance, she noted that the technical regulation of labelling and standards was being dealt with by the Codex Alimentarius Commission. However, although progress was good, the work was not complete. The Board should not adopt a resolution that covered areas that it did not necessarily have the technical competence to address. The policy of support for breastfeeding, on the other hand, was clearly part of WHO's mandate. Technical labelling requirements, scientific evidence, ensuring good manufacturing practices, product recall and consumer education in appropriate use of products were issues on which WHO should have a view; but which, in view of their complexity, would be better dealt with in a drafting group.

Ms STERKEN (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of the International Baby Food Action Network, said that parents everywhere had a right to be informed about the problem of intrinsic contamination of powdered infant formula by *E. sakazakii*. The recent international recall of one such product and the deaths of two infants in France were reminders of a real risk. Labelling to indicate the non-sterile status of powdered infant formula was thus of special importance. French mothers had been distressed that such vital information had been provided by the media and industry hotlines rather than through accurate labelling and alerts from governmental authorities.

The procedures of the Codex Alimentarius Commission were long: the one in question might be completed only in 2008 or 2010. In the meantime, babies were dying. Parents had the right to full and accurate information on infant feeding, based on sound, independently funded science. Health and nutrition claims were marketing tools intended to mislead and deceive expectant and new parents. No breast-milk substitute should carry health claims when science-based evidence confirmed that artificially-fed infants were prone to increased mortality and morbidity rates, less than optimal growth, lower cognitive and visual development and increased risk of obesity.

Sponsorship of health professionals by the infant feeding industry created conflicts of interest. Some governments had already enacted legislation that prohibited various forms of sponsorship by the industry. A Health Assembly resolution urging all governments to prevent conflicts of interest by prohibiting commercial sponsorship was needed. A strong, clear resolution would provide clear guidance to the Codex Alimentarius Commission.

Mrs LEHNERS-ARENDT (International Lactation Consultant Association), speaking at the invitation of the CHAIRMAN, said that the Association had endorsed the global strategy for infant and young child feeding set out in resolution WHA55.25, and its members were able to provide practical, clinical and evidence-based support for the implementation of that strategy. Governments should start to define national goals and objectives for breastfeeding within a realistic time frame and achievements and outcomes should be measured. Putting the global strategy into practice could prevent 19% of all mortality in infants under five years of age.

Nutrition and health claims were used to promote sales of breast-milk substitutes and must be prohibited. A resolution was needed on *E. sakazakii* in order to take into account the concerns of parents that full information should be included on labels of breast-milk substitutes, including the fact that powdered infant formula was not sterile. While sponsorship by manufacturers of infant formula was a difficult issue, others should follow the example of members of her organization and refuse such sponsorship. Research into infant health and nutrition formed the basis for public policies on infant feeding and should be free from commercial influence. She urged the Board to present a strong draft resolution on all those matters to the Fifty-eighth World Health Assembly.

Dr BRONNER (International Special Dietary Foods Industries), speaking at the invitation of the CHAIRMAN, said that her organization had a long-standing commitment to sharing its expertise with WHO to help to combat malnutrition and develop better products for the specific nutritional needs of infants and young children. Infant food manufacturers made concerted efforts to minimize the presence of *Enterobacteriaceae*. Powdered infant formula was an inherently safe product when hygienically handled, prepared and stored according to manufacturers' instructions. A joint FAO/WHO Workshop on *Enterobacter sakazakii* and other Microorganisms in Powdered Milk Formula (Geneva, 2-5 February 2004) had established that combined control measures were the most effective means of reducing risk and that the health community should focus on providing guidelines on appropriate handling and storage of products.

Health and nutrition claims played an important role in enabling health-care professionals to determine the value of products in meeting the nutritional needs of infants and young children. They also enabled the consumer to exercise the right to make an informed choice and were a way of securing optimized nutrition for babies that were not breastfed. The appropriate response to ethical concerns about commercial influence should be not simply to eliminate sponsorship of much-needed research but to establish a forum or mechanism incorporating funding guidelines designed to protect the integrity of all parties concerned.

Dr HUERTA MONTALVO (Ecuador) suggested that a document should be drawn up to reflect all the points of view expressed and circulated in electronic form to all Member States with a view to its consideration at the next Health Assembly. Waiting five years for the Codex Alimentarius Commission to complete its work was not an option, as in the meantime children were dying.

The DIRECTOR-GENERAL said that one important issue raised during the discussion was whether the Secretariat had taken prompt and appropriate action to inform the public and Member States about the potential for *E. sakazakii* contamination of powdered infant formula. In April 2004, an expert committee had met and a report had been issued on the subject. After the outbreak in France in late 2004, the International Food Safety Authorities Network had provided information on the incidents to the food safety authorities of Member States.

The CHAIRMAN, pointing out that the courses of action proposed by the members from Thailand and Ecuador were not mutually incompatible, said that in the absence of any objection, he would take it that the Board wished as a first step to establish a drafting group.

It was so agreed.

Dr LEITNER (Assistant Director-General) said that the procedural omission just discussed had been unintentional and the Secretariat would learn the necessary lessons from it. On the substance, there were two interrelated issues, one of public health and one of standard setting. Immediate action on the public health front was a possibility. Once the Codex Alimentarius Commission had set its standard, public policies might be revised to reflect that work. The Board and the Health Assembly should take regular stock of what public health policy needed to reflect in terms of food safety standards and precautionary measures. On the one hand, public health policies should not pre-empt the

standard-setting process; on the other hand, that process was protracted, and a balance must be struck. The discussion also showed the need to frame the resolution so that it applied to all Member States, not just to developing countries. She acknowledged that the Secretariat's efforts, which had been well intentioned, had been found lacking: hence the need for further drafting work to arrive at a result that was satisfactory to all.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

The meeting rose at 17:55.

FIFTH MEETING

Wednesday, 19 January 2005, at 09:05

Chairman: Mr D.Á. Gunnarsson (Iceland)

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

Social health insurance: Item 4.5 of the Agenda (Document EB115/8)

Dr HUERTA MONTALVO (Ecuador), referring to paragraph 1(1) of the draft resolution, supported the idea of systems that would allow risk pooling, but was concerned that the reference to prepayment might be confused with private prepayment schemes, which differed from a system of income-based contributions to a general fund. It was also important to determine the scope of the so-called social health insurance schemes, which were a traditional system based on payment by the workforce. Broader health insurance schemes were needed that were part of an integrated health plan, a basic reference point for private and public insurers alike, providing universal coverage for individuals and families rather than services such as treatment and care, and prevention and control of environment-related risks. The concept of external funding, whether or not from state funds, also needed to be clarified to ensure that financing models were not established on the basis of external debt, as they would be non-sustainable. The draft resolution might also provide for the participation of citizens, and an oversight mechanism.

Professor FIŠER (Czech Republic) said that, to avoid having conflicting recommendations from two different international organizations, a situation that had occurred three years previously, he proposed the insertion, in paragraph 2(2) of the draft resolution, of the words “in coordination with the World Bank,” after “to provide Member States”.

Dr GAKURUH (Kenya) welcomed the timely attention being given to the topic, which was fundamental to the health sector in the African Region, where grossly inadequate financial resources made health-care reform a struggle. In Kenya, efforts to enact a bill to establish a social health insurance system were proving difficult, not least because of the resistance of the private insurance sector. She therefore fully supported the draft resolution, particularly in view of the need for support to countries from not only the World Bank but all stakeholders, in dealing with one of their biggest problems, that of developing a policy advocacy document.

Dr CAMARA (Guinea) fully supported the draft resolution. In Guinea, many people had difficulty in paying the reasonable rates set by the Government because of the level of poverty, which affected some 40% of the population, and of fluctuations in incomes. During the past five years the authorities had attempted to tackle the situation by means of community-managed mutual funds; but such schemes were not yet well advanced. Efforts were continuing, however, and those systems that had been established showed a potential for broadening access for fund members and ensuring that demand could be met by stabilizing some of the charges of health care establishments. As part of the poverty reduction strategy, the Ministry of Health was trying to expand access beyond the system of mutual funds, which were only available to members. The preferred system would provide universal coverage, involving a financing policy focused on mobilization of resources and the pooling of purchasing power; payment exemption for the poorest to ensure universal access; and an increase in funds for the highly indebted poor countries to provide care for the poorest through contractual agreements with health-care establishments.

Dr STEIGER (United States of America) said that he was disappointed with the deep-seated bias shown in WHO, including the Executive Board, against private enterprise. All proposals embodied a statist approach and reflected a presumption that the private sector's motives were questionable, on subjects such as infant formulas, pharmaceuticals and food. In the "3 by 5" initiative, for instance, there was little mention of the private sector or of the advantage that could be taken of the many non-state providers. The report regrettably reflected that bias. There was no comprehensive description of the full range of public and private options for comprehensive health insurance for all. The Secretariat, and the relevant documentation, ought to make clear the advantages of private providers, such as responsiveness to patients, flexibility, innovation and efficiency. Subsidies to purchase private insurance could achieve equity in a mixed system, and every government needed a reasonable overall regulatory regime. WHO should continue its work on the subject but propose a broader range of schemes and mixes that would expand coverage and minimize problems such as those mentioned by the previous speaker. The range should include the private and public systems, and blends of the two, depending on a country's political and economic realities, while striving for efficiency and sustainability.

He therefore proposed the following amendments to the draft resolution. The fourth preambular paragraph should be amended to read: "Acknowledging that a number of Member States are pursuing health-financing reforms which may involve a mix of public and private approaches (including the introduction of social health insurance);".

In paragraph 1(1), the words "introduce or develop prepayment of financial contributions for the health sector" should be replaced by "include a method for prepayment of financial contributions for health care, ...". In paragraph 1(3), the words "Millennium Development Goals" should be replaced by "internationally agreed development goals, including those contained in the United Nations Millennium Declaration". In paragraph 1(6), the words "health-financing reform" should be replaced by "different methods of health financing", and the words "and private, public and mixed schemes" should be inserted after "social health insurance schemes".

In paragraph 2(2), the proposal by the member for the Czech Republic should be extended by addition of the words "and other relevant partners". In paragraph 2(3), the words "to create an evidence base in order to identify best practices" should be replaced by "to provide technical support in identifying data and methodologies to better measure and analyse the benefits and costs of different practices ...". In paragraph 2(4), the words "to assist Member States, as appropriate," should be added at the beginning.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) appreciated the inclusion of the topic on the agenda and the draft resolution. During the past 100 years universal health insurance cover in Spain had advanced from a limited system in 1900, covering a small group of workers, to compulsory contributory sickness insurance in 1942 and, since 1986, to an almost totally tax-funded national health system based on universal coverage, financing proportional to personal income, equity and access according to need. The accent was on primary care, preventive care and sound training of health professionals, with decentralized regional management. The capacity to improve an entire system would largely depend on a country's available income; but there was no doubt that, at any given level, results could be improved by the way that health services were financed and organized. Universal coverage, solidarity-based viable financing and efficient management were key factors. Spain had collaborated with various countries and with WHO in developing management structures and the training of health professionals, and was ready to collaborate, through WHO, in providing technical assistance.

Mrs GILDERS (alternate to Dr Shugart, Canada) said that access to health services must be universal and based on need, not ability to pay. Canada continued to reform the health system in order to increase its efficiency and long-term sustainability. It supported the draft resolution, recognizing that the choice of financing mechanisms would reflect the situation in each country. Much could be learnt through the exchange of ideas in forums such as WHO; ultimately, however, a government's

decision on the way to modify its existing health financing system should reflect what was most likely to lead to universal coverage, in the light of the country's situation and objectives.

Mrs LE THI THU HA (Viet Nam) said that Viet Nam's social health insurance system currently covered 20% of the population. Optimal pooling had been achieved through the established framework, and the most vulnerable groups, namely the poor and the elderly, were covered. Many problems, such as the limited benefit package, financial stability, management capacity and interministerial cooperation persisted. The Government had recently reviewed the 1989 decree on health insurance, and was receiving support from WHO in drawing up a master plan for social health insurance. For low-income countries such as her own, a parallel approach was recommended, comprising compulsory health insurance and a social security framework for workers in the public and private sector and their dependants; development of legislation involving a suitable tripartite administrative structure; a voluntary, community-based health insurance system for the self-employed and the informal sector in rural areas, for a limited period of three years from implementation of the plan; and social assistance through Government funds to purchase health insurance for the economically non-active and the poor. The master plan envisaged a comprehensive range of benefits, including primary health care, in-hospital and outpatient care, and the entitlement of all categories to the same benefits. The Government's commitment to achieving universal coverage had been reflected in a resolution adopted by Congress in 2001; its full effect would, of course, take many years to achieve, and much remained to be done. WHO's continued technical support was therefore needed; for that reason Viet Nam supported the draft resolution.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that the report set out important principles of health-system funding and showed that, although no single financing mechanism could be recommended as the optimum method in all situations, pooling resources could improve the supply and use of services, since poverty-related factors were an obstacle to universal health insurance coverage. In most of the countries where 60% of the population was living on less than US\$ 2 a day, sustained external funding would be essential from the outset, as would strengthening the capacity of administrative and oversight staff. He supported the draft resolution as amended by the previous speakers.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) said that health insurance was of great relevance to the quality of the services offered. In Kuwait, primary and specialized health care was provided free of charge. People suffering from incurable diseases were sent abroad for treatment at the expense of the State, notwithstanding the high costs involved. A social health system had been introduced for foreign workers, who were asked to pay a small contribution, the remaining charges being borne by the State.

Dr ACHARYA (Nepal) said that the report highlighted the fact that universal coverage could be realized only through a mix of financing systems, that Government stewardship was needed and that funds had to be collected efficiently and then pooled. Hence tax-funded health financing and social health insurance were both viable mechanisms. The debates on health-care financing which had been held in many high-level forums in south-east Asia had identified regional issues that influenced the technical feasibility of social health insurance, including the structure of the labour and financial markets, the existence of other types of insurance schemes, the need for regular contributions, and health and management infrastructures. Lack of consensus and trust, inadequate health care, insufficient human and social capital, political instability and the absence of policy debates were preventing the expansion of social health insurance in most countries of the South-East Asia Region. It was to be hoped that the holistic approach of WHO and its support would make it possible to address those concerns in the future. It was vital for countries like Nepal, whose health insurance scheme was in its infancy, to make progress in that area. He therefore supported the draft resolution with the proposed amendments.

Dr WANCHAI SATTAYAWUTHIPONG (adviser to Dr Suwit Wibulpolprasert, Thailand) noted that the sizeable increase in budgetary appropriations for social health insurance activities was evidence of significant commitment to that subject. Thailand had launched health insurance for the poor in 1975, but, after 25 years, had found that less than half the target group was actually benefiting from the scheme and therefore that a substantial number of households were suffering from catastrophic illnesses. The subject had consequently become a priority issue in the 2001 general election and the new Government had decided to implement a scheme that provided universal coverage at a cost of 30 baht per patient per visit to a public or private health facility for treatment ranging from minor complaints to major surgery and cancer treatment; the poor, the elderly, children and other underprivileged sections of the population were exempt from payment. The introduction of the co-payment component had made it possible to abolish direct insurance contributions, and had led to the establishment of a financial mechanism based on a per capita fee, with the result that each facility tried to enrol large numbers of patients as a means of increasing its budget for salaries and operating expenses. All those mechanisms had greatly enhanced poor people's awareness of their rights.

The programme had proved to be extremely popular, had scored successes in fund-raising, pooling of resources and procurement, and had strengthened the health infrastructure and human health resources. Nevertheless it had to be borne in mind that the country had adequate resources for health, including human resources, in the area of care, drugs and technology, owing to its climate of peace and economic growth. It also had a proper management system. If those conditions had not obtained, the abolition of the financial qualifying condition would have led to low-quality services.

He supported the amendments to the draft resolution proposed by the members for the Czech Republic, Kenya and the United States of America and proposed the addition of two subparagraphs. The first, in paragraph 1, would read: "to ensure adequate and equitable distribution of good-quality health-care infrastructures and human resources for health to ensure that the insurees will receive equitable and good-quality health services according to the benefit package". The second, in paragraph 2, would read: "to create sustainable and continuous mechanisms, including regular international conferences, to facilitate countries in the continuous sharing of experiences and lessons learnt on social health insurance".

Dr MOLDOVAN (alternate to Professor Cinteza, Romania) said that in her country health care, health promotion and preventive medicine were chiefly funded by the national social health insurance fund which was financed from employees' and employers' compulsory contributions, State budget subsidies, donations and sponsorship. Although the Romanian health system faced difficulties in respect of access to health services, equity in financing and the quality of the services provided, she believed that by developing the social health insurance system it would be possible to ensure universal access for all citizens to basic health services, to enhance quality of life by improving the quality and safety of medical treatment and to introduce tax-deductible private health insurance as a means of reducing informal payments. WHO's recommendations would help countries with economies in transition to devise strategies for developing schemes of that kind.

Dr BUSS (Brazil) expressed support for the draft resolution. Brazil had a free, universal, public health system financed by general taxation, which was designed to meet the needs of the population. Services were offered by a mix of public and private providers, the latter being contracted by the public sector. Private practices and private financing systems were regulated by the State through an agency which had been established for that purpose. In order to put in place systems that met universal health needs, WHO should draw on and analyse individual countries' experiences and promote an exchange of information on innovations introduced into national health systems for the benefit of other countries. Its role in managing such information was vital for the improvement of health systems. Close attention should be paid, therefore, to paragraph 2(3) of the draft resolution, referring to the creation of an evidence base.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that, although his country was experiencing rapid socioeconomic development, urban and rural economies were growing at different paces and the income gap between various sectors of urban society was widening. When establishing social health insurance it was essential to protect people's rights and to promote the sustained development of society. In 1998, China had launched a basic medical insurance system that had gradually been introduced throughout the country and subsequently improved; for example it had been extended to the private sector, the self-employed and to rural areas, with a view to covering the entire rural population by 2010. Developing countries were bound to encounter many challenges and difficulties in promoting universal health insurance coverage. For example, they would have to reduce disparities in health facilities between urban and rural areas and provide health care for all residents, finance insurance in a way that struck a balance between revenue and expenditure, regulate the quality and pricing of social medical services, improve skills, increase the accessibility of medical services and strengthen the management of the social health insurance system. The Secretariat could provide Member States with suggestions and support, with particular emphasis on the exchange of technologies and experience. China endorsed the draft resolution.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the key to achieving the goal of health for all lay in finding a mechanism that would enable the whole population in every country to have equitable access to an acceptable standard of care at a cost which that country could finance. In a country like Bolivia, the fact that a substantial percentage of the population had no access to health services and that social security coverage was poor was indicative of certain problems. The Spanish model offered equity, quality and universal access. The systems that developing countries were adopting should therefore provide options designed to do likewise.

Unfortunately the focus was on curative treatment and little interest was being shown in the equally important prevention of disease. For that reason, the document should have referred to health promotion and the prevention of disease. Account should also have been taken of the changing epidemiological profile, particularly of developing countries, the additional burden placed on social security mechanisms by increased life expectancy and the loss of revenue caused by job losses. Rising unemployment meant that more imaginative financing solutions would have to be sought. Paragraph 12 of the report made it clear that no one system constituted a panacea, because conditions and possibilities varied from country to country. There was no such thing as a free health system; somebody had to pay. He favoured a mixed system of tax-funded financing combined with the participation of the private sector. He agreed with the Thai amendments, but requested clarification of paragraph 2(2), which was complex and somewhat controversial.

Dr AHMED (Ghana) outlined the many changes made to the financing of the health system in his country. Immediately after independence a free health service had been funded through direct taxation. Out-of-pocket payments, to cover about 20% of the cost of drugs, had been introduced in the 1980s. A law establishing social health insurance had been passed in 2003, to provide access to health care services and to underpin those services with a reliable source of financing. The scheme was based on district mutual health systems. For-profit and non-profit private schemes existed alongside the Government-sponsored district mutual schemes. The latter were run by district committees and were funded by contributions from all the people in the district: everyone had to belong to a private or public scheme. Indirect taxes in the form of a national health insurance levy on some goods and services were also paid into the central fund.

Social insurance covered the cost of about 90% of basic health services, with the Government supplying the remaining 10%. The Government therefore had sufficient funds to focus on health promotion and the prevention of disease. Some problems had been met in implementing the mutual schemes in more than 130 districts throughout the country, but an attempt was being made to solve them. All persons over the age of 70 and all pensioners and their families received free health care.

He supported the draft resolution as it stood.

Dr TANGI (Tonga) said that, in his country, health care had always been funded by the State. Infant and maternal mortality rates were low, and immunization coverage stood at 98%. However, the Government's current expenditure on health care, totalling up to 11.5% of the budget, was unsustainable in the long term. It was not yet clear which system of health-care financing would be adopted, but it was essential to ensure that people with chronic illnesses were not disadvantaged by the new arrangements. A research project on health-care coverage was under way, with the support of the World Bank. The results of a survey of more than 1000 households conducted in 2004 to determine their out-of-pocket expenditure on health care were being analysed. A health foundation was being set up, partly financed from taxes on tobacco, to conduct health promotion activities, particularly for noncommunicable diseases – an area in which he had also requested WHO support.

He supported the draft resolution, with the proposed amendments.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) welcomed in particular the emphasis on Member States' freedom to choose their own system of health-care financing and on the provision of technical information by WHO to Member States. He suggested two amendments to the draft resolution: the sixth preambular paragraph should be amended to read: "recognizing the leading role of State legislative and executive stewardship in ...", and paragraph 1(3) should be amended to read: "... to contribute to meeting the population's need for health care and improving its quality ...".

Dr PHOOKO (Lesotho) said that social health insurance would make health interventions possible even in poor countries such as his own. It should be developed and administered in consultation with stakeholders, including health professionals, the finance sector, and the private sector. WHO should support Member States in developing tools and methodologies for evaluating the impact of insurance on health services; more information on best practices in health insurance would be useful. He supported the draft resolution with the proposed amendments.

Dr ABDUL WAHAB (Bahrain) expressed support for the draft resolution with the proposed amendments. In his country, health services had always been provided free of charge for all residents and even temporary visitors. However, the burden of health expenditure on the State budget could no longer be sustained, and a more appropriate policy was needed that would safeguard the health of the population, particularly the large numbers of foreign workers. The Government had introduced fees for secondary and tertiary health care, but had taken care to maintain free emergency care for expatriate workers.

The Government was studying the various types of health insurance schemes introduced in the Middle East and elsewhere, but had not yet found a model that would provide appropriate and affordable coverage for everyone in Bahrain. In the light of those developments he asked WHO to prepare a working paper describing the various types of schemes used in different countries, so that countries such as his own could study the different options and decide which one would suit them best.

Dr YOOSUF (Maldives) said that his country was trying to develop a system of health financing that would alleviate poverty and reduce the need for out-of-pocket payments for health care, a task that was difficult in a country with a small, widely-dispersed population, where the costs of providing health care and transport were high. The burden of disease was shifting from communicable to chronic diseases, which were expensive to diagnose and treat and required expensive medical technology, and the population's expectations were increasing. He agreed with the member for the United States of America that the private sector had a valuable role to play in the provision of health care. However, capacity in the public sector should also be increased, so that the Government could regulate the system appropriately whether provision was publicly or privately funded.

He proposed that paragraph 2(1) of the draft resolution should be amended to read: "... universal coverage, including the special needs of small island countries and other countries with small populations ...".

Professor DAB (France) expressed support for the draft resolution with the proposed amendments. Access to care was one of the factors that determined the health status of a population. Care should not be separated from prevention. There was no universal solution which would bring health expenditure under control at a stroke: the issue must be approached with humility and pragmatism. The relative importance of the public and private sectors in health care should be determined by scientific and practical, rather than ideological, factors. Epidemiological and economic research had shown that State-run systems were inadequate in quality and performance, while for-profit systems were not necessarily more efficient or less costly and indeed restricted patients' access to care, as shown by the data on health status from various countries. It was important to remember that health care brought benefits as well as expense – a fact which was often not emphasized enough.

Dr AGARWAL (India)¹ welcomed the draft resolution. Social health insurance had received considerable attention in recent years as the most promising option for extending health-care coverage to the majority of a country's population. The health insurance system adopted had to be appropriate to the country concerned and involve various methods of risk pooling, such as community-based financing and subsidies for the poor. The health policy adopted in India in 2002 encouraged the creation of private health insurance packages to increase insurance coverage in the secondary and tertiary health sectors. About 75 million people were covered by some form of health insurance, including the central government health scheme, the employers' state insurance scheme and separate schemes run by different ministries. Social health insurance systems should pay particular attention to population coverage, methods of financing, level of fragmentation, composition of risk pools, benefits packages, provider payment mechanisms and administrative efficiency.

Mr KRECH (Germany)¹ welcomed the draft resolution. Social health insurance and tax-funded health systems should be seen in the wider context of universal coverage and health financing. Germany helped its partner countries to develop solidarity-based systems with prepayment of financial contributions in order to distribute the risks more evenly among the population. Currently, more than 100 million people each year were forced into poverty by having to make out-of-pocket payments for health care. The financing mechanism which should be adopted depended on the cultural, historical and political context of the country concerned. To reflect that wider context, therefore, the Board might wish to consider changing the title of the report and the draft resolution to "Health financing, universal coverage and social health insurance".

If a country decided to develop a social health insurance system, it should receive the best possible technical assistance. Germany's development assistance agency had reorganized the way it worked with WHO and ILO. The three agencies had improved coordination of their efforts at country level in the African, South-East Asia and Western Pacific Regions. He expressed the hope that WHO would meet the increasing demand from Member States for technical assistance in the field of social health insurance and invited Member States to attend a joint conference being organized by the three agencies to review experiences in social health insurance, which would take place in Berlin in November 2005.

Following an explanation of procedure by the CHAIRMAN, Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the European Union and its Member States, formally seconded Germany's proposal to amend the title of the report and the draft resolution.

Ms LAMBO (The Save the Children Fund), speaking at the invitation of the CHAIRMAN and also on behalf of the International Alliance of Women, said that, if developing countries were to achieve sustainable universal coverage, they would need to explore new mechanisms of health financing with pro-poor redistributive taxation, as had been done in Sri Lanka. Her organization

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

supported the abolition of user fees and the increase in the resources allocated to health, as called for in the report published by the United Nations Millennium Project.¹ Essential health care must be free at the point of access. Her organization urged donors and national governments to ensure that adequate long-term resources were allocated to ensuring provision of essential health services free of charge for everyone, and called on WHO to include a statement on user fees and cost-sharing mechanisms in its report.

Her organization was finalizing a report on user fees that highlighted their failure as an effective health-financing mechanism in low-income settings: user fees discriminated against poor, marginalized and sick people, were complex to manage, incurred high transaction costs, reduced health-service coverage and raised only between 5% and 10% of recurrent costs, while failing to spread the financial risk over time or among households. WHO should provide developing countries with the tools and technical support they needed to decide on the most effective mechanism for their own situation. The proposed monitoring tool, the so-called “primary health care lens”, could help countries to explore the potential impact of policies on the poorest people before adopting them.

Countries making changes in their health-financing systems would require long-term, predictable resources and transitional support. Save the Children’s recent research on the cost of coping with illness in eastern and central Africa showed that paying for health care had led the poorest people into further poverty, but a recent report² showed how one poor country had succeeded in concentrating public funds on ensuring equitable access to inpatient care for the poor, while expanding the private sector to serve people able to pay. WHO and donors should support operational research in developing countries on pro-poor health-financing mechanisms, in order to increase equity and contribute to the health-related Millennium Development Goals.

There was no blueprint for success in health financing, but WHO should publicize the good practice of countries such as Madagascar, Sri Lanka and Uganda, where free access to health services had increased use by the poorest people.

It should be made clear in the draft resolution that user fees had a negative impact on health outcomes, especially for the poorest women and children. The Board might also wish to include a reference in paragraph 1(6) to the sharing of experiences gained from ineffective as well as effective health-financing mechanisms and, in paragraph 2(3), to WHO’s support for countries in exploring the most effective health-financing mechanisms to ensure universal access to health care.

Dr EVANS (Assistant Director-General) welcomed the comments and expressions of support. In many of WHO’s 192 Member States, the current financing situation was not merely unsatisfactory, but positively injurious to the citizen. Evidence from more than 70 countries suggested that about 100 million households globally were impoverished every year because of their expenditure on health care. The situation should be monitored, and more should be done to develop financing systems that did not require patients to pay out of their own pockets at the point of service. The idea of moving towards financing systems that promoted universal coverage had been strongly supported, but it was clear that there was not “one size to fit all”. The report and the draft resolution recognized multiple options for the financing of health systems that included both the public and private sectors.

The way in which global financing mechanisms related to the financing objectives of national health systems was still not well understood. External funds for specific health programmes should be managed and organized to support the development of national financing systems. In some areas of the world, most notably Africa, the inflow of funds from external sources was calling into question the relationship between the size of the health sector and the size of the public sector relative to the size of the overall economy, and threatening to upset a delicate balance. The issue required careful

¹ United Nations Millennium Project. *Investing in development: a practical plan to achieve the Millennium Development Goals*, Sachs J ed. New York, 2005.

² *Bucking the trend: how Sri Lanka has achieved good health at low cost – challenges and policy lessons for the 21st century*. McNay K, Keith R and Penrose A (Eds). London, Save the Children, 2004.

consideration, particularly at a time when, although potential opportunities existed for the expansion of health systems in some countries, difficulties were being encountered by others because of fears of macroeconomic instability. WHO would be working with the World Bank and IMF in that regard.

Every effort would be made to respond to the numerous requests for technical assistance and for the development of a paper on options and best practices in collaboration with the regional offices.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments and assured members that a revised text containing all the amendments made during the discussion would be circulated in due course. He recalled that the representative of Germany, supported by the member for Luxembourg, had suggested that the title of the draft resolution should read: "Health financing, universal coverage and social health insurance".

Dr BUSS (Brazil), supported by Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) and Dr HANSEN-KOENIG (Luxembourg) affirmed that it would be preferable if all the amendments proposed were circulated in writing before a decision was taken on the draft resolution.

Dr HUERTA MONTALVO (Ecuador) pointed out that, if the draft resolution were to attempt to reflect all the points of view expressed, there was a danger that it would be inconsistent. Universal coverage was not merely the responsibility of the state, but of all sectors, and unless that was made clear, the role of organizations like WHO would be diminished. Health for all, a long-standing objective in the Americas, could not be attained using methods that left certain sectors out of account.

He himself would welcome the involvement of the World Bank in the matter. While economic considerations should be taken into account, they should not take precedence over health considerations. He questioned whether, in his country, budgetary allocations should be earmarked for servicing external debt rather than for health. The whole discussion had a substantial ideological component which could not be dealt with simply by trying to include all shades of opinion.

The CHAIRMAN suggested that further consideration of the item should be deferred until a new text had been made available.

It was so agreed.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

Blood safety: proposal to establish World Blood Donor Day: Item 4.6 of the Agenda (Document EB115/9)

Mr JUNOR (Jamaica) endorsed the proposal to establish a World Blood Donor Day, but expressed concern over certain aspects of the draft resolution contained in document EB115/9. The HIV/AIDS epidemic and the related stigmatization and discrimination compounded the difficulty in persuading people to donate blood voluntarily, in the Caribbean countries and elsewhere. Jamaica had introduced a system that encouraged families whose members were undergoing surgical procedures or giving birth to donate blood in case it might be needed; donors were credited with the amount of blood they had given, and could decide how their contribution would be used. Jamaica fully supported the prohibition of paid blood donation but wanted the phrase "and family or family replacement" deleted from paragraph 2(3) of the draft resolution which sought to eliminate both types of blood donation. He was aware that the United States of America intended to propose amendments that included the wording "family or family replacement blood donation" in that subparagraph, which he would be unable to accept.

Dr STEIGER (United States of America) said that HIV/AIDS and other factors had made blood safety even more urgent than it had been in 1975, necessitating action in addition to that undertaken in

connection with resolution WHA28.72. He supported the idea of an international World Blood Donor Day, but the draft resolution should not be confined to the Day itself and should refer to policies endorsed as good practice by WHO expert meetings and committees.

In the light of further broad consultations with Member States and the Secretariat, therefore, he proposed the following amendments. The preambular paragraph should be amended to read "Having considered the report on blood safety and the meeting report of the WHO Forum on Good Policy Process for Blood Safety and Availability," with a footnote giving the full title and date of that meeting. In the fourth preambular paragraph, the words "and blood product" should be added after "unsafe blood", because the transfer of plasma had also caused a problem with HIV transmission in some Member States. In paragraph 2(3), he supported the amendment proposed by the member for Jamaica, and proposed that the words "none exists" should be replaced by "needed". The paragraph should be further amended by adding at the end: "except in limited circumstances of medical necessity and, in such cases, to require informed consent of the transfusion recipient;". In the light of the recommendations of the meeting report of the WHO Forum on Good Policy Process for Blood Safety and Availability, he proposed the addition of four new paragraphs after paragraph 2(4), that would read:

- (5) "to support the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems, in particular through the following:
 - (a) government commitment and support for a national blood programme with quality systems, through a legal framework, national blood policy and plan, and adequate resources,
 - (b) organization, management and infrastructure to permit a sustainable blood transfusion service,
 - (c) equitable access to blood and blood products,
 - (d) voluntary, nonremunerated blood donors from low-risk populations,
 - (e) appropriate testing and processing of all donated blood and blood products,
 - (f) appropriate clinical use of blood and blood products;
- (6) to establish a quality process for policy- and decision-making for blood safety and availability, based on ethical considerations, transparency, assessment of national needs, scientific evidence and risk/benefit;
- (7) to share information nationally and internationally to make clear the scientific, economic and social basis of national policy decisions related to blood safety and availability; and
- (8) to strengthen partnerships at all levels to accomplish these recommended actions."

In the United States, blood safety was a major pillar of the President's Emergency Plan for AIDS Relief, and extensive resources had been devoted to help countries in Africa, Asia and the Caribbean to ensure safe blood supplies with a view to reducing the transmission of HIV. The United States was also working on blood safety issues with WHO, for example, contracting to perform direct blood safety advisory and implementation services in Ethiopia, Haïti and Namibia as part of the Emergency Plan.

Mrs GILDERS (alternate to Mr Shugart, Canada) endorsed the draft resolution and the amendments proposed by the previous speaker which would strengthen it and reflect the work of the Expert Committees. Canada would continue to promote and support the annual designated World Blood Donor Day and was committed to enhancing current systems for the recruitment and retention of voluntary, nonremunerated blood donors and strengthening implementation of stringent criteria for donor selection. Since 1999, Canada's health department had spent a total of Can \$9.5 million on establishing a national blood safety surveillance programme, and its health products and food branch had invested Can \$25 million annually since 1998 to maintain a strong regulatory framework. The Canadian Government would continue to support multisectoral collaboration to promote voluntary, nonremunerated blood donation.

Dr HANSEN-KOENIG (Luxembourg) expressed support for the draft resolution and the amendments proposed by the member for the United States of America, and endorsed the proposal to establish an annual World Blood Donor Day, which would provide encouragement to both new and existing donors. More than 30 years had elapsed since the Twenty-eighth World Health Assembly had called for voluntary, nonremunerated blood transfusion services to be set up. As her country believed that blood safety depended on the voluntary nature of donations, it had been disquieting to learn that in 2000-2001 only 39 Member States had operated a completely voluntary and nonremunerated system. For that reason Luxembourg was providing development assistance to several countries that were attempting to introduce high-quality voluntary, nonremunerated blood transfusion services.

Dr HUERTA MONTALVO (Ecuador) recalled an unfortunate situation in Ecuador when blood contaminated with HIV had been used in renal dialysis. It therefore accorded the highest importance to the issue and welcomed the report and draft resolution, as well as the proposed amendments.

Professor DAB (France) also expressed support for the draft resolution and the amendments proposed by the member for the United States of America. In order to ensure blood safety, his Government had set up an agency to define and enforce standards, and another to organize the collection and distribution of blood products. It would ensure that both agencies cooperated fully in the organization of World Blood Donor Day.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) pointed out that the importance of blood safety was increasing in line with demand for donated blood. The situation became acute in the wake of an emergency, whether in the form of a natural disaster, terrorist attack or armed conflict. He supported the principle and practice of voluntary donation, but the safety aspect was a cause for concern since adequate testing facilities did not exist in his country. More effort needed to be put into increasing the number of voluntary donors.

The introduction of legislation that would encourage voluntary blood donation, as reflected in paragraph 2(3) of the draft resolution, was a positive development. On 1 January 2005 an amendment to his country's federal law on blood donation, clearly distinguishing between paid and voluntary donation, had come into effect, and the voluntary blood donation service had expanded as a result.

He expressed support for the draft resolution, with the proposed amendments, and for the proposal to establish a World Blood Donor Day.

Mr KHAN (Pakistan) said that safe blood transfusion was an essential part of health-care services worldwide. Blood safety was an integral part of the prevention of transmission of HIV and other blood-borne pathogens and in controlling epidemics of hepatitis B and C in most developing countries. The collection of blood exclusively from voluntary, nonremunerated blood donors from low-risk populations was crucial in ensuring the safety, quality, availability and accessibility of blood transfusion. The brunt of the ill effects of blood shortages was borne by women with pregnancy complications, children with severe life-threatening anaemia and trauma victims.

In 2004, his Government and the Pakistan Red Crescent Society had organized a World Blood Donor Day in Islamabad as part of worldwide events to thank millions of voluntary blood donors. He supported holding the event annually on 14 June.

He endorsed the draft resolution as amended by the member for the United States of America, but warned that developing countries might face technical and economic difficulties in implementing it. Many regions of the world, including the Eastern Mediterranean Region, were undergoing major upheavals that had devastated local infrastructures, including health infrastructures.

Dr PHOOKO (Lesotho) commended the report and the proposal to establish World Blood Donor Day, and agreed that blood should be collected only from voluntary, nonremunerated donors to ensure the safety, quality, availability and accessibility of transfusion. Lesotho was among those countries with the highest prevalence of HIV infection and had been trying to interest the families of

people with HIV/AIDS in undergoing a test for a small remuneration. He had been heartened to hear the views of the member for the United States of America in that regard and supported his proposed amendments to the draft resolution.

Dr QI Qingdong (alternate to Dr Yin Li, China) welcomed the proposal to establish World Blood Donor Day. As a result of a sustained effort over several years, nonremunerated blood donation in China had increased from 22% in 1998 to 85% in 2003. Referring to paragraph 8 of the report, he asked for more detailed information on the channels used for collecting the discarded blood, the standards donors had to meet, and the countries involved. He supported the proposed amendments regarding family and family replacement donation.

To mitigate China's concern in regard to appropriate clinical use of blood and blood products, he suggested the insertion of an additional subparagraph in paragraph 2 of the draft resolution that would read: "to introduce stringent requirements for ensuring that clinical blood transfusions are carried out in an appropriate manner, thus avoiding unnecessary waste that might lead to a blood shortage and encourage paid donations".

Dr SAM (Gambia) said that it would be difficult for countries to attain the Millennium Development Goals if they did not have accessible, safe and adequate blood supplies. Some resolutions had been adopted by past Health Assemblies mentioning the need for national policies on blood transfusion, but some developing countries in Africa either did not yet have such policies or were not yet in a position to implement them. At the very least, the draft resolution should ensure that that situation was remedied.

He welcomed the proposal to establish World Blood Donor Day. However, a more pressing concern was to encourage developing countries to ensure long-term availability by introducing regular, nonremunerated donation programmes within national blood transfusion services.

In the interests of clarity, it would be helpful if the amendments proposed by the member for the United States of America could be circulated in writing.

Dr YOOSUF (Maldives) expressed support for the draft resolution and the amendments proposed. A large percentage of the population of Maldives suffered from thalassaemia and required frequent blood transfusions. He would like to see an increase in voluntary donations and the expansion and strengthening of blood bank services by means of awareness-raising and education programmes.

Dr MOLDOVAN (alternate to Professor Cinteza, Romania) recalled that Romania had repeatedly expressed concern over blood and blood components, and supported the views expressed by the member for Luxembourg. In 2004, Romania had conducted a national campaign to promote voluntary blood donation. She welcomed the establishment of an annual World Blood Donor Day on 14 June.

Dr WANCHAI SATTAYAWUTHIPONG (adviser to Dr Suwit Wibulpolprasert, Thailand) said that the report clearly showed that there was a shortage of blood supplies in the developing world. Blood safety was also a matter of concern: unsafe blood transfusion had been responsible for 10% of HIV infections in the 1980s and 1990s.

He welcomed the proposal to establish World Blood Donor Day, which would serve to create awareness of the importance of ensuring the safety and adequacy of blood donation and supply. He endorsed the draft resolution, but believed it would be strengthened by the addition of a new subparagraph in paragraph 2 reading: "to provide adequate financing for quality blood donation services and extension of services to meet patients' needs", and of a new subparagraph in paragraph 5 reading: "to work with concerned organizations to assist Member States in strengthening their capacity to screen all donated blood against major infectious diseases".

He shared the concerns regarding blood donation by family members and therefore supported the amendments proposed by the member for the United States of America.

Mrs LE THI THU HA (Viet Nam) said that her country attached great importance to blood safety and to the promotion of voluntary and nonremunerated blood donation. Its experience gained from promoting blood donation on humanitarian grounds had shown that special attention should be given to public advocacy and information, education and communication about voluntary and nonremunerated blood donation, and to the recognition of voluntary blood donors and their right to blood in case of need.

A national voluntary blood donation day had been celebrated in her country on 1 June each year from 1994 to 2000. Viet Nam had responded actively to World Blood Donor Day on 14 June 2004 with various mass-media information, education and communication activities. She supported the draft resolution and endorsed the amendments proposed by the members for Jamaica, Thailand and the United States of America, which she requested be submitted in writing.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) said that nonremunerated, safe and well organized blood donation was an essential part of health systems, and should therefore be promoted by all governments, in a way that was appropriate to specific social and cultural conditions and took into account the needs of different areas and population groups. Spain had a national blood donation system and a safe blood transfusion system. Its blood donation system had made considerable progress, since the annual number of donations had reached almost 40 per 1000 population. Blood transfusion services needed to be improved to guarantee the quality and safety of transfusions and to secure a stable number of donors to meet ongoing blood transfusion needs, not merely those in crises. Once blood had been collected and stored in safe banks, the appropriate and effective clinical use of blood and blood products needed to be ensured. Training programmes for health workers should be developed as a means of preventing unnecessary or unsuitable transfusions.

He supported the draft resolution, with the amendments proposed by the members for Jamaica and the United States of America.

Dr ACHARYA (Nepal) welcomed the draft resolution. The issue of blood safety was important in the context of blood-borne diseases, including HIV/AIDS. Since family and family replacement blood donation was normal practice in Nepal, he supported the deletion of the phrase “and family or family replacement” in paragraph 2(3), as proposed by the member for Jamaica. Although the celebration of more than one blood donor day in a year might lead to confusion, the importance of the issue led him to support the proposal to establish a World Blood Donor Day on 14 June.

Dr CAMARA (Guinea) commended the initiative of drafting the resolution on blood safety, which was an essential aspect of the fight against HIV/AIDS. Equitable access to blood transfusion was vital, since thousands of people, particularly pregnant women and children, died as a result of anaemia and lack of access to blood transfusions. In view of the risks inherent in blood transfusion and the danger that the benefits of blood donation would be negated if safe procedures were not established in developing countries, he requested that assistance be given to such countries to ensure that the blood collected on blood donor days was devoid of any pathogen, particularly HIV. In the hope that such assistance would be provided, he supported the draft resolution, together with the amendments proposed by the members for Jamaica and the United States of America.

Dr AHMED (Ghana) said that the report was especially timely for countries such as his own that were developing blood transfusion policies. Blood transfusion had considerably increased in Ghana, especially for trauma victims and in obstetrics.

Referring to paragraph 2(3), he pointed out that introducing legislation to ban the use of paid donors would disadvantage countries that had insufficient numbers of voluntary donors. He therefore endorsed the draft resolution as amended by the member for the United States of America, especially its proposal to amend the wording of paragraph 2(3) to the effect that legislation should be introduced “where needed”.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) commended the report. Safe blood transfusion was an important issue to which governments should pay constant attention. Kuwait had been monitoring the issue carefully and encouraged voluntary blood donation.

Dr TANGI (Tonga) supported the draft resolution and the proposed amendments. As the member for Pakistan had pointed out, blood was one of the few health products that society was requested to donate voluntarily, yet it underpinned the entire health system. He therefore fully supported the establishment of a World Blood Donor Day.

Dr SAM (Gambia), referring to family and family replacement blood donations, said that, in the absence of routine national blood donor recruitment and of a system of voluntary, nonremunerated blood donation, families were compelled to donate blood because of the unavailability of blood banks. Emphasis should therefore be placed in the draft resolution on the need to develop and implement donor-recruitment programmes. He endorsed the amendments proposed by the member for the United States of America to paragraph 2(3), but suggested that the word “discourage” rather than “eliminate” be used.

He supported the establishment of an annual World Blood Donor Day which should serve as an educational and donor recruitment tool, and proposed the addition of a new paragraph 2, reading: “The annual World Blood Donor Day should be an integral part of the national blood recruitment programme”.

Dr ABDUL WAHAB (Bahrain) also endorsed the draft resolution. The elimination of family blood donation might not be in the best interests of countries in his area of the world, where a large proportion of the population was affected by some form of haemoglobinopathy, particularly sickle-cell disease and thalassaemia, which demanded regular and repeated transfusions. There was also an escalating demand for transfusions in trauma cases and for pregnant women. In the absence of a system of regular voluntary donation, those countries relied on family blood donation in emergency situations, in order to increase blood reserves and blood bank availability. He therefore suggested that paragraph 2(3) should be amended to read: “to ensure the safety of family or family replacement blood donation through the implementation of stringent criteria for donor selection and to require the informed consent of the transfusion recipient”. The closing words incorporated the amendment proposed by the member for the United States of America. Thus, family donation would not be prohibited but would have to be performed under stringent regulations.

Dr STEIGER (United States of America), said that he was prepared to accept the amendment proposed by the member for Bahrain to paragraph 2(3), but wished any amended wording to reflect that paid blood donation should be discouraged with a view to being eliminated.

Dr ABDULLA (Sudan) supported the draft resolution, but pointed out that in Africa and in most developing countries, the belief in taboos discouraged or prevented people from donating blood. In developing voluntary donor recruitment systems, cultural issues needed to be taken into account and an attempt made to change cultural attitudes. In paragraph 2(2) he therefore proposed the insertion of the words “culture-sensitive” between “strengthen” and “systems”.

Dr AGARWAL (India)¹ endorsed the spirit of the draft resolution. India’s annual voluntary blood donation day had long and successfully been celebrated on 1 October. While he supported the proposal to establish a World Blood Donor Day, he suggested that the observance date of 14 June be reconsidered because in India, college and university students, which formed its largest target group, were on holiday during the month of June.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Voluntary, nonremunerated blood donation had increased in India, where activities had been undertaken to promote public awareness of the need for safe and voluntary blood donation. While blood was collected mainly from voluntary and family replacement donors, his Government was taking steps to phase out family replacement donation. Promotion of public awareness should precede the enactment of legislation to eliminate family replacement donation.

The CHAIRMAN, speaking as the member for Iceland, welcomed the report. In view of the current knowledge of the possible and preventable transmission of different pathogens during blood transfusion, any unsafe handling and donation of blood should be regarded as unacceptable. The various risks and ways of eliminating them were well described in the report. The establishment of a World Blood Donor Day would highlight the important contribution made by blood donors worldwide. Iceland therefore fully supported the draft resolution and the amendments proposed.

Speaking as CHAIRMAN, he said that the amendments tabled would be submitted in written form at a later stage.

Dr LEPAKHIN (Assistant Director-General) said that the establishment of a World Blood Donor Day had been proposed because of the successful celebration of the Day in 2004, in which 73 countries had participated and during which millions of units of blood had been donated voluntarily.

He expressed his appreciation of the amendments to the draft resolution proposed by the member for the United States of America. While the text under consideration was similar to the texts of previous Executive Board resolutions on blood safety, it was right that the attention of governments should again be drawn to that important issue.

Turning to family member donation, he said that the word “eliminate” had been used as there was a risk of transmission of disease from one family member to another. However, its replacement by “discourage” could be discussed further. With regard to the question raised by the member for China, most of the 2.5 million units of discarded blood had been collected in countries where paid donations took place, which proved that paid donation was unsafe. In reply to the concern raised by the representative of India, he said that countries that already celebrated their own national blood donor days should make every effort to keep them. However, a world day would promote global solidarity. The date of 14 June had been suggested because it would mark the birthday of Karl Landsteiner, the discoverer of human blood groups.

Mr JUNOR (Jamaica), referring to paragraph 2(3), noted that the prevailing view of Board members appeared to be that family donations should be specifically allowed, not discouraged. All countries had a duty to ensure that all blood collected was safe, and family donation was therefore not an issue.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

The meeting rose at 12:50.

SIXTH MEETING

Wednesday, 19 January 2005, at 14:30

Chairman: Mr D.Á. GUNNARSSON (Iceland)

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

Procedures and guidelines: Item 4.7 of the Agenda

- **International Nonproprietary Names: revised procedure** (Document EB115/11)

The CHAIRMAN drew attention to Annexes 1 and 2 of the document which contained, respectively, the revised Procedure for the selection of International Nonproprietary Names (INN) for pharmaceutical substances and the revised General principles for guidance in devising them.

Dr STEIGER (United States of America) expressed his appreciation for the work done by the Secretariat and said that he found the revised procedure very satisfactory.

Professor KARAULOV (adviser to Mr Skotnikov, Russian Federation) emphasized the importance of a revised procedure in order to avoid confusion arising from similar names. Most of the proposals made during consultations on the revised procedure had been taken into account; the Board should therefore adopt the revised text. Further work was needed, however, to make the document more widely known.

Mrs GILDERS (alternate to Mr Shugart, Canada) said that from the outset her country had strongly endorsed the aims of the INN programme, which had played an increasingly important role in safe prescription, dispensing and use of medicines. The goals had gained greater prominence in recent years, with concerted efforts by regulatory authorities and health professionals to complement WHO's work in reducing the avoidable consequences of medication and prescription errors caused by similarities between names. She applauded recent efforts to provide a more streamlined and transparent process for the selection of INN and in regard to the exceptional substitution of such names. The revised procedures more clearly defined the compelling circumstances and processes under which proposals for revised names could be considered while also providing for the engagement of key parties in the selection process. Canada therefore endorsed the adoption of the revised procedure.

Dr ANTEZANA ARANÍBAR (Bolivia) unconditionally supported the revised procedure, which provided clear, universally understood language for communication between and within countries and for use by drug regulatory authorities. The work on INN had been very effective. It was particularly important to avoid confusion by ensuring that any new trade names created did not closely resemble INN.

Ms HALTON (Australia), strongly endorsing the views expressed by previous speakers, stressed the importance of the work under way in ensuring that no confusion arose when prescribing and dispensing medicines. Australia and New Zealand had already agreed that they would adopt the approach set forth in the revised procedure: where no INN existed for a particular product, they would use the appropriate naming conventions and policies.

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) applauded the efforts of the Expert Group in framing the procedures and guidelines for INN. Given the benefits of the system to the health profession, he welcomed any way of speeding up or revising the process. Action must be taken to ensure that INN were used extensively among professionals and understood by the public. Accordingly, INN should be simplified and made more attractive than the trade name; their use should be actively promoted; and Member States should be supported in their efforts to popularize INN through legislation and social measures. He approved the revised procedure.

Dr LEPAKHIN (Assistant Director-General) stressed the importance of having the same names for the same products worldwide to prevent errors and confusion and save lives. The guidelines were intended to make the process more efficient and speed up the procedure and he thanked all those countries that had helped in their preparation and expressed support for INN. Responding to the suggestions made by the member for Thailand, he affirmed that WHO would do its best to make names attractive. There was a need to enhance knowledge of INN in the medical profession and the Secretariat looked forward to collaborating with Member States on that matter.

The CHAIRMAN said that he took it that the Board wished to adopt the revised Procedure for the selection of recommended International Nonproprietary Names for pharmaceutical substances contained in Annex 1 of document EB115/11 and proposed a resolution to that effect, which read as follows:

The Executive Board,
Having considered the report on the International Nonproprietary Names,

ADOPTS the revised Procedure for the selection of recommended International Nonproprietary Names for pharmaceutical substances.

The resolution was adopted.¹

The CHAIRMAN said that he also took it that the Board wished to note the revised General principles for guidance in devising International Nonproprietary Names for pharmaceutical substances, set out in Annex 2 of document EB115/11, together with the report on the feasibility studies contained in the document.

It was so agreed.

- **Dependence-producing psychoactive substances: supplementary guidelines**
(Document EB115/12)

Ms HALTON (Australia) said that one of her Government's key priorities and areas of spending over the past eight years had been prevention of the use of illicit drugs and the provision of effective treatment for users. In that context, Australia thanked the Secretariat for preparing the supplementary guidelines in consultation with other United Nations bodies; it appreciated that they had been developed in an effort to provide technical clarification of the existing Guidelines but was concerned that they might have the unintended effect of restricting access to important drugs used to treat drug addiction.

The existing Guidelines had served expert committees well for many decades; however, the supplementary guidelines might result in policy changes, the effect of which was unclear, rather than

¹ Resolution EB115.R4.

the intended technical clarification. Her country therefore preferred that the existing Guidelines should remain unchanged.

Professor KARAULOV (adviser to Mr Skotnikov, Russian Federation) recalled earlier attempts to resolve the long-standing problem of lack of regulation. The issue had been debated by the Board at its 105th session in January 2000.¹ The current draft supplementary guidelines were a further step in the process of producing a single, unified convention covering the content of three relevant United Nations Conventions. Paragraph 5, providing for changes to the existing status of substances subject to control, was unacceptable, because that function, according to the Single Convention on Narcotic Drugs, 1961, lay within the competence of the International Narcotics Control Board and not WHO. If that paragraph were deleted, he could accept the remaining text.

Dr STEIGER (United States of America) endorsed the view of the member for Australia that it was not at present necessary to supplement the existing Guidelines.

Mrs GILDERS (alternate to Mr Shugart, Canada) said that, although the supplementary guidelines addressed concerns about the different classification of drugs in the 1961 and 1971 Conventions, she supported the Australian proposal to maintain the existing Guidelines.

Mr KHAN (Pakistan) agreed that it was imperative to maintain the existing system.

Professor DAB (France) said that the illicit use of psychoactive substances was a matter of serious concern for France, which was also concerned that sick people worldwide should receive proper treatment for pain. The fact that the several existing conventions were not perfectly aligned made the Secretariat's task difficult. It might be better to consolidate the conventions, because the proposal before the Board might pose more problems than it solved. For example, the words "unduly" and "legitimate medical and scientific purposes", in paragraph 5 of the proposal, were obviously open to a variety of interpretations. He therefore shared the view of previous speakers that the existing Guidelines should be maintained.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that the supplementary guidelines, which dovetailed with the international conventions in force, met a need and the Secretariat should therefore continue consultations with Member States in order to reach a consensus on them. The 1961 and 1971 Conventions differed on the classification of some of the substances they regulated. Cannabis, for example, was not regulated by the 1961 Convention, yet tetrahydrocannabinol was regulated in the 1971 Convention; he would welcome clarification of such apparent differences.

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) said that current Thai legislation was in line with all three United Nations Conventions and the guidelines proposed in 2004. Although Thailand had no quarrel with the supplementary guidelines, it agreed that some further clarification was necessary.

Dr AGARWAL (India)¹ fully supported the supplementary guidelines on dependence-producing psychoactive substances. There was a need to develop adequate training programmes and modules for primary care workers and a comprehensive education programme in that regard. India's national drug de-addiction programme and its national programme on substance abuse addressed the issues of treatment, detoxification and rehabilitation.

¹ See document EB105/2000/REC/1, Decision EB105(3) and Annex 9.

Professor GHODSE (International Narcotics Control Board), speaking at the invitation of the CHAIRMAN, said that after the tsunami in December 2004, the Control Board, in line with its mandate and in order to prevent shortages of medical supplies, would grant requests for additional supplies of essential narcotic drugs and psychotropic substances expeditiously. It had transmitted to all the countries affected by the disaster the Model Guidelines for the International Provision of Controlled Medicines for Emergency Medical Care developed jointly with WHO several years previously; some governments were already making use of them.

The insufficient availability of opioid analgesics for the treatment of pain in developing countries remained a matter of great concern to the Control Board. Although global consumption of morphine had increased significantly between 1984 and 2003, the availability of opioids globally was still characterized by a marked imbalance: developing countries accounted for about 80% of the world's population, but for only about 5% of global consumption of morphine. In addition, some regions of the world did not receive an adequate supply of essential anxiolytics and other psychotropic agents through regular distribution channels. He called on governments to ensure a sufficient supply of those substances for medical purposes through adequately controlled distribution channels. In order to address the problem, in 2004 WHO and the Control Board had started to formulate a global strategy against pain which aimed to help developing countries to build capacity in and raise awareness of the use of opioids in pain treatment.

It was essential that any process to review the supplementary guidelines on dependence-producing psychoactive substances should not conflict with the United Nations Conventions, nor trespass on the responsibility of other United Nations bodies. The original supplementary guidelines were fully in line with the Conventions and respected the mandates of WHO, the Commission on Narcotic Drugs and the Control Board. He therefore asked the Executive Board either to approve the original supplementary guidelines prepared by the WHO working group in cooperation with the United Nations Office on Drugs and Crime and the Control Board, or else to delete paragraph 5 of the revised version, which was not in line with the United Nations Conventions. There would be no objection, however, if the Executive Board decided to maintain the status quo.

Dr LEPAKHIN (Assistant Director-General) recalled that the supplementary guidelines had been prepared for the purposes of greater clarity. Some countries were concerned that technical clarification could unintentionally undermine the existing Guidelines. Others thought that work should continue in order to improve the supplementary guidelines. The situation was paradoxical in that work on the supplementary guidelines had started at the request of the WHO Expert Committee on Drug Dependence, which had asked for specific guidance on the choice between the three United Nations Conventions. While WHO and the Expert Committee could no doubt manage without the supplementary guidelines, they would be left in a difficult position, as the need for clarification remained. It would therefore be worthwhile to continue working on the matter with a view to providing the Expert Committee with the guidance it had requested.

The CHAIRMAN, noting that most speakers had preferred to maintain the status quo, suggested that the Board should agree to maintain the revised Guidelines for the WHO review of dependence-producing psychoactive substances for international control approved by the Executive Board in decision EB105(3), and to ask the Secretariat and the Expert Committee on Drug Dependence to continue their work on the issue.

It was so agreed.

Global smallpox vaccine reserve: Item 4.8 of the Agenda (Document EB115/36)

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) supported the proposal to establish a reserve. The concern at the gravity of the current situation was entirely justified: nobody under the age of 25 years was protected from a natural outbreak or terrorist release of smallpox.

Moreover, the smallpox vaccine formerly in widespread use was no longer appropriate for mass immunization because of the potential for complications in immunocompromised people, including those infected with HIV. WHO had therefore taken the only appropriate decision, namely, to set up a two-component strategic stock of smallpox vaccine supplies. The reserve would provide a total of 205 million doses, a figure established on the basis of epidemiological studies. It would be necessary to develop, as soon as possible, clear legal, procedural, technological, financial and organizational mechanisms for the two components. Vaccine quality should be high, and delivery to countries with divergent legislation for registration and use should be regulated. The experience gained in the centralization of clinical trials and evaluation of the quality and efficacy of antiretroviral agents for prequalification should ensure that the reserves of smallpox vaccines were of standard quality. The establishment of a reserve should in no way preclude research into a new generation of safer and more effective smallpox vaccines.

Professor DAB (France) endorsed the comments made by the previous speaker. The world was fortunate to have an effective instrument for dealing with the continuing threat of smallpox. The establishment of a global reserve was therefore a logical step in enhancing the capacity for international response, given that most countries were unable to build and maintain a national stock of high-quality vaccines. As in many other areas, any prevention strategy that focused on a single country was likely to fail. France therefore supported the proposal to establish a global reserve, with WHO playing a leadership role. On the occasion of the fifth meeting of the Global Health Security Initiative (Paris, 10 December 2004), his country's Minister of Health had announced that France would make available to WHO five million doses of smallpox vaccine out of the national strategic reserve but the vaccine would be stored and maintained on French territory. The quality of the vaccines would be monitored regularly and only vaccines found to be of high quality would be provided in the case of an emergency. France would continue to support WHO's efforts in the area.

Dr QI Qingdong (alternate to Dr Yin Li, China) endorsed the proposal in principle. All possible measures should be taken to prevent accidental release of smallpox virus from laboratories holding stocks. WHO should develop rules and regulations to govern the maintenance of virus stocks, exercise stringent management of vaccine stocks, and establish sound supervision and surveillance mechanisms to deal with any possible spread of smallpox in the case of an outbreak. The status of laboratory administration should be reported to the Board and the Health Assembly on a regular basis. WHO should also arrange a meeting of experts to consider standards and protocols for smallpox vaccine manufacture, and formulate and disseminate appropriate regulations. Member States should be kept informed in a timely manner of progress in the establishment of a global reserve. Some countries had already started developing strategic national reserves.

Dr STEIGER (United States of America) commended the progress made on the proposal to establish a global reserve, and endorsed the operational framework set out in the report. The United States had joined other countries at the Paris meeting of the Global Health Security Initiative in making a contribution to the reserve, with a pledge of 20 million doses from the national stockpile. As in the case of France, the vaccine would be maintained in the United States under national quality-control procedures until required for use. While procedures and protocols had been established for maintaining a small reserve at WHO and for accepting donations from Member States, there were still no clear plans or protocols for action in the event of an unintentional or intentional release of smallpox virus that would require distribution of vaccine. In that context he drew attention to a recent high-level international exercise held in Washington, which had posited a multinational release of smallpox virus. It had quickly become apparent that most countries had no capacity for producing smallpox vaccine, that there was none available for purchase and that there was no mechanism for sharing vaccines with others in an emergency. There was also no agreement on whether vaccines could be diluted to extend coverage. Clearly there was still work to be done to ensure that the world was ready to respond to a smallpox emergency.

Mrs GILDERS (alternate to Mr Shugart, Canada) commented that the WHO operational framework addressed preparedness for the response to a smallpox outbreak but, as the previous speaker had indicated, there were still some matters outstanding. Moreover, the report did not reflect the full scope of the discussions during the recent meeting of the WHO Ad Hoc Committee on Orthopoxvirus Infections or its recommendations. Quality control of vaccines held in the reserve and preparedness plans for their distribution when needed were important components of the initiative. Canada had donated funds to WHO for the establishment of the vaccine reserve and supported the establishment of a strategic group dealing exclusively with smallpox within the Global Outbreak Alert and Response Network and the continuing development of the operational framework and emergency plan. Canada served as the secretariat for the Global Health Security Initiative, and was consulting with the Secretariat on the possibility of arranging a briefing on the Initiative's activities.

Mr DE CASTRO SALDANHA (alternate to Dr Buss, Brazil) supported the establishment of a smallpox vaccine reserve. Brazil expected to complete the establishment of a minimum national stock of 183 000 doses of smallpox vaccine, the level considered necessary to contain a national smallpox outbreak, during 2005. In line with the recommendation set out in paragraph 9 of the report, and thanks to the donation of viral strains by the National Institutes of Health in the United States of America, Brazil was in a position to start producing smallpox vaccine quickly if necessary. International support to finance local manufacture would be needed, however.

Dr PREECHA PREMPREE (adviser to Dr Suwit Wibulpolprasert, Thailand) supported all efforts to ensure prompt control measures to minimize the health impact of any smallpox outbreak. He supported the establishment of the vaccine reserve but requested WHO to undertake research to determine a realistic estimate of potential vaccine demand, since the figure of 200 million doses mentioned in paragraph 1 of the report was based on 1979 population figures.

Dr TANGI (Tonga) thanked the Secretariat and the developed countries for their work, which would benefit small countries such as his own. He requested clarification of the scope of the term "bioterrorism" as used in the report, and expressed the hope that existing stocks of the smallpox virus were held in extremely secure laboratories.

Mr KHAN (Pakistan) remarked that it would be important to establish global smallpox vaccine reserves on several continents in order to ensure timely distribution of vaccines to any part of the world in the event of an emergency. Pakistan was collaborating with the National Institutes of Health in the United States of America and, together with India and other countries around the world, such as Brazil, had the capacity to participate in the initiative. Bioterrorism should not be accorded undue prominence because it was not the only possible cause of a smallpox outbreak: a natural disaster might also trigger an emergency.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) supported the establishment of the reserve. WHO should be in a position to control smallpox vaccine manufacture and storage. He therefore supported decisive action to investigate and coordinate control of existing stocks, thereby avoiding an uncoordinated rush by countries to augment strategic national reserves. The approach should be the same for all global public health threats, regardless of the cause, whether unintentional, as in the case of avian influenza, or intentional, as in the case of terrorism.

Dr AGARWAL (India)¹ supported the establishment of a global reserve of smallpox vaccine together with the necessary supplies of diluent for vaccine reconstitution and bifurcated needles for vaccination. Procedures for maintaining the reserve must be transparent. India had the capacity to

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

manufacture smallpox vaccine but would require supplies of appropriate seed strains and the transfer of the advanced technology required to prepare safe and potent vaccines. Those needs should be given further consideration.

Dr ASAMOA-BAAH (Assistant Director-General) thanked the Board for accepting the proposal for an expanded global smallpox vaccine reserve. He paid tribute to all who had encouraged the endeavour and made generous pledges in its support. The work to establish a vaccine reserve was only beginning, but it was necessary to prepare for the kinds of eventualities mentioned by the members for China, Pakistan and Tonga. He had also taken note of the observation that the vaccines at present available were not ideal, and that the ongoing work to establish the reserve should not be allowed to derail efforts to develop newer and safer vaccines. As stated, those efforts should be subject to the best international scrutiny, and vaccines donated to the reserve should be of the highest quality. He noted that some countries, specifically Brazil and India, were capable of producing vaccines if international funds were made available for the purpose. He looked forward to working with Member States on developing the vaccine reserve. The aim was not merely to possess the vaccine, but to ensure that all Member States were prepared in the event of a smallpox outbreak.

The DIRECTOR-GENERAL observed that in addition to the two known stocks of smallpox virus, in the Russian Federation and the United States of America, there might be other unknown stocks elsewhere, which in itself was a problem. Moreover, it was possible that the virus was being kept in some form as a weapon. Vaccine production had stopped when smallpox was eradicated in 1979-1980, with the result that people were no longer protected against a highly virulent and sometimes lethal virus. It should also be borne in mind that the seed virus from which the vaccine was made was a different strain from the smallpox virus itself. Finally, members should be aware that a second edition had been published of WHO's manual on public health response to biological and chemical weapons.¹

The CHAIRMAN invited the Board to note with appreciation the report and the progress made in establishing a global smallpox vaccine reserve, and to request that the work be continued.

It was so agreed.

Antiretrovirals and developing countries: Item 4.9 of the Agenda (Document EB115/32)

The CHAIRMAN, introducing the item, explained that the topic had been placed on the agenda at the request of a Member State, following the discussion held at the 114th session of the Board.²

Mr DE CASTRO SALDANHA (alternate to Dr Buss, Brazil), referring to the flexibilities allowed in respect of intellectual property rights by the Doha Declaration on the TRIPS Agreement and Public Health, said that the Doha Declaration must be implemented by developing countries in such a way as to ensure the effective participation of local producers of generic drugs. He had several recommendations for WHO in that respect.

In helping Member States to make the best use of those flexibilities and the WTO General Council's Decision of 30 August 2003 on the implementation of paragraph 6 of the Doha Declaration, WHO should allow at least 10 years for local producers of generic drugs to adjust to the technical demands of producing antiretroviral agents.

¹ *Public health response to biological and chemical weapons: WHO guidance*, 2nd edn. Geneva, World Health Organization, 2004.

² See document EB114/2004/REC/1, p. 83.

The labelling and packaging requirements in the Doha Declaration must be translated into suggested specifications, to be adapted to the technical conditions in which local producers of generic drugs operated, while conforming to health standards laid down by WHO. That would keep the production of patented drugs economically viable should compulsory licensing, as permitted by the Declaration, be introduced.

When legal instruments were devised to incorporate the flexibilities allowed by the Doha Declaration into the legal systems of developing countries, some thought should be given to establishing machinery for government procurement that would facilitate the definition of local producers of generic drugs.

In its efforts to improve the quality of locally produced generic drugs, WHO should consider preparing legal regulations and standards for sound manufacturing practices, and for stability and bioequivalence in the prequalification of generic drugs. The regulations and standards could then be adopted by a technical committee of representatives of WHO and local regulatory agencies, which would also devise technical solutions to ensure the quality of locally produced antiretroviral agents. The WHO Certification Scheme on the Quality of Pharmaceutical Products Moving in International Commerce should include prequalification inspection not only of raw-material producers but also of intermediaries, so as to guarantee quality in all phases of the production of antiretroviral agents.

Dr GAKURUH (Kenya), speaking on behalf of the African group, said that the members of that group were encouraged by the emphasis the report placed on technical cooperation in the two key areas of implementation of the TRIPS agreement and promoting the quality, safety and efficacy of medicines.

She urged WHO to continue supporting action by Member States to implement the Doha Declaration and the WTO General Council's Decision on the implementation of paragraph 6 of the Declaration in such a way as to encourage efforts to make medicines affordable. Effective use of the flexibilities available under the TRIPS agreement required an integrated and coordinated approach by the agencies responsible for public health, trade and patents. She noted the efforts by WHO, in its technical cooperation and country support work, to promote a multi-agency approach. Its work in those areas had helped to incorporate public health objectives into the implementation of the TRIPS agreement, and should continue to be a priority. The cheaper the medicines, the more patients could be treated and the more sustainable the treatment would be. A key factor in bringing down the prices of antiretroviral agents was effective procurement strategies, which included overcoming patent barriers when necessary, and encouraging competition in generic drugs. Since that would require accurate and up-to-date information on the prices, quality and patent status of the medicines, she urged WHO to increase its efforts in that regard.

The African group noted the listing of the use made by Member States of the TRIPS flexibilities. In many cases, they had been used to promote the manufacture of fixed-dose combinations of antiretroviral therapy. The use of such combinations was in line with WHO's recommended treatment guidelines, but because of patent barriers the recommended first-line fixed-dose combinations were available only from generic manufacturers. WHO should continue to support the use of such combinations. In African countries, it was crucial to make compliance with treatment as easy as possible. Taking fewer pills each day helped, tending to improve clinical results and reduce the risk of drug resistance. Fixed-dose combinations were also relatively easy to procure and to store.

In improving the quality, safety and efficacy of medicines, building and strengthening capacity for national drug regulation were crucial. The group therefore requested continuance of technical assistance and capacity-building for drug regulatory authorities. The WHO Prequalification Project, originally intended as a service for United Nations procurement agencies, had proved a useful tool for developing countries, giving them a choice of quality medicines assessed against standards agreed by the world's leading regulatory agencies. It had also helped such countries to secure access to affordable medicines, especially antiretroviral agents. However, in view of the continuing HIV/AIDS crisis, the Prequalification Project needed further strengthening, in accordance with resolution WHA57.14. It should remain a permanent feature of WHO's work.

Finally, noting the formation of a new Department of Technical Cooperation for Essential Drugs and Traditional Medicine, she urged the Director-General to ensure that adequate resources were allocated to its work.

Dr ANTEZANA ARANÍBAR (Bolivia) noted that the report took into account the concerns and frustrations experienced by the developing countries with respect to production of antiretroviral agents. The assistance given by WHO, the Regional Office for the Americas and PAHO in the negotiations carried out by the Andean Group on the purchase of antiretroviral agents had contributed to the satisfactory results.

The HIV/AIDS pandemic most severely affected countries with the scarcest financial, human and technological resources. That presented a challenge to international solidarity, which was the very essence of an organization like WHO. The Latin American countries had so far received good assistance, for which thanks were due. Treatment for people living with HIV/AIDS was provided by the State in Latin America: in other words, it was free of charge. States were taking on an increasing number of commitments and in many instances would be unable to cope without the negotiations to reduce the price of antiretroviral therapy and without the assistance of other countries. He thanked Brazil in that respect for giving his country cheaper access to such medicines.

The discussion was not about intellectual property rights alone but about access to medicines that were a matter of life or death. It was not about who could pay and who could not, but rather about who would and who would not live. Amid all the talk about negotiations, one might ask whether health was negotiable, or whether the heart of the matter was solidarity with HIV-infected people and finding a way to help them. If the solution lay in parallel imports, local production or compulsory licensing, that would be all to the good. The point was to provide medicines that worked, to give infected people the necessary therapy and to establish a mechanism within WHO to facilitate access to the drugs they needed.

He asked for confirmation that the Secretariat would pursue further negotiations to establish such a mechanism.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica), speaking on behalf of the Caribbean countries, said that building local manufacturing capacity, particularly for antiretroviral agents, was beyond their reach since the requisite investment capital, technology, raw materials, research and development capacity were as yet unavailable. What was therefore needed was access to high-quality, affordable drugs from elsewhere.

A few countries in the Caribbean and Latin America had taken initiatives that might result in cheaper and sustainable access to medicines, and those initiatives were being followed with interest. The implications of the imminent opening of the CARICOM Single Market and Economy and the Free Trade Area of the Americas would have to be analysed; bilateral agreements would need to be reviewed and mechanisms set up to facilitate the flow of benefits between countries within the same economic space. WHO, through the Regional Office for the Americas, should provide guidance in that respect.

Jamaica had gained access to funding for the provision of antiretroviral agents through the Global Fund to Fight AIDS, Tuberculosis and Malaria, World Bank and other sources and was duly grateful, but it was concerned about sustainability and the lack of human resources and adequate infrastructure. Donor funds came with restrictions that did not cover some aspects of the process that needed to be made operational. That problem should be addressed through WHO.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that control measures and generic medicine production by developing countries could guarantee patients access to high-quality antiretroviral agents, thereby facilitating the prevention and control of HIV/AIDS. China was participating in the "3 by 5" initiative and had been able to produce five medicines that did not involve intellectual property rights; and through international cooperation projects it had been able to supply medicines to children.

China supported research and development of new antiretroviral agents and was working hard to provide medicines free of charge for poor rural dwellers, with the ultimate goal of drug provision free of charge to all patients needing treatment. Training for health professionals had been conducted and equipment purchased to make it easier to identify patients in need of treatment.

Statistics showed that more than 20% of patients who had received first-generation antiretroviral medication had had to stop treatment because of strong side effects. WHO should work harder on that problem and on helping developing countries to resolve the issue of patents in promoting the use of new antiretroviral medicines.

Dr HUERTA MONTALVO (Ecuador) said that a common theme running through the discussion on technical and health matters was therapeutic safety and how to achieve it. Access to high-quality medicines was central to the progressive realization of the highest attainable standard of health. The fact that one of the greatest threats to health was HIV/AIDS explained the continuing effort to elaborate relevant standards and to provide technical support to national pharmaceutical regulatory bodies. The Prequalification Project and activities to promote the quality of active pharmaceutical ingredients and finished-dosage-form antiretroviral agents represented a step forward.

Together with the provision of medicines, another means of fighting HIV/AIDS was condom use. It was therefore encouraging to see the recent report in the Spanish newspaper *El País* that the Roman Catholic Church had condoned the use of condoms to prevent transmission of HIV. Why had the Church, which had long resisted such use and even called it sinful, changed its mind? Because it had seen that there was no alternative. That was an important sign of the times.

Ms VALDEZ (alternate to Dr Steiger, United States of America) said that the report appeared to criticize aspects of the health solution represented by the decision adopted on 30 August 2003 by the General Council of WTO. That solution was designed to meet the objectives noted in the report, namely, to provide a simple and speedy legal procedure and a wide choice of quality generic medicines. It was not a complex solution, and she objected to the reports so describing it. In fact, most of the procedural steps required were not only straightforward but essential to ensuring that medicines were not diverted from their intended markets. Nothing in the solution detracted from the economic incentive for generic manufacturers to produce drugs under compulsory licences, as shown by the fact that royalty payments were tied to the economic value in the importing market rather than the market where the drugs were produced. The implication that the solution somehow substantially reduced the economic incentives to produce generic drugs was incorrect. Its purpose was fundamentally humanitarian, not commercial, as the Chairman's statement accompanying the 2003 decision had made clear.

The report also took issue with aspects of bilateral and regional trade agreements. It mischaracterized the language adopted by the Fifty-seventh World Health Assembly as expressing the concerns of Member States over specific provisions. In fact, Member States had agreed to encourage bilateral trade agreements to take into account the flexibilities of the TRIPS agreement and the Doha Declaration.

Her country supported the Secretariat's activities that promoted local production of high-quality medicines. That was a good use of scarce resources and more appropriate than an advocacy role with WTO in implementing the TRIPS agreement. The United States also appreciated the efforts to make the prequalification process more transparent: the disclaimer at the end of each prequalification listing, for example, was helpful to manufacturers and governments. Her country's Food and Drug Administration was working with the research-based and generic pharmaceutical industries, regulatory authorities in countries badly affected by HIV/AIDS and the international community to make a reality of safe and effective fixed-dose combination antiretroviral therapy of high quality and at low cost. Her country looked forward to working more closely with WHO in sharing practices and results for the best possible quality assurance of antiretroviral agents.

Mrs LE THI THU HA (Viet Nam) said that increasing access to life-saving treatment was the single most pressing challenge in the fight against HIV/AIDS, particularly in developing countries with limited resources. According to a recent estimate in Viet Nam, 15% of the 215 000 people living with HIV/AIDS were believed to be in need of antiretroviral therapy. The cost of antiretroviral medicines purchased by the Government and imported from international pharmaceutical companies approached US\$ 5000 per person per year. Under its new national HIV/AIDS strategy, her Government aimed to provide antiretroviral medicines to 70% of people living with HIV/AIDS. To reach that target, however, it would have to reduce the price of antiretroviral therapy and make it easily and cheaply available to those in need. The Global Fund to Fight AIDS, Tuberculosis and Malaria had approved a US\$ 12 million project to strengthen care and treatment in the 20 most affected provinces of the country, under which antiretroviral medicines would be provided to 2000-3000 people in need over the coming two years. The Minister of Health had requested WHO to procure the drugs some months before. On account of the declassification of some of the prequalified antiretroviral agents from WHO's list, both generic and branded products were in short supply and WHO had so far been unable to procure antiretroviral medicines.

Viet Nam welcomed the Secretariat's recent activities to promote local production with assured quality and to support Member States in making optimal use of the flexibilities allowed by the TRIPS agreement. The Government had received support from WHO and the Ford Foundation to review the legal and trade issues surrounding the provision of affordable antiretroviral medicines in Viet Nam. The report on that review had provided considerable insight into the question of patents on antiretroviral agents and had concluded that changes in Vietnamese patent law and in the interpretation and practice of domestic and international law would make such medicines more accessible and affordable.

Her Government was willing to strengthen its own capacity in antiretroviral production to enable its industry to reach prequalification status – a slow and costly process for small companies. Another issue was access to second-line treatment. International harmonization should be sought to avoid leaving the onus of such problems on individual countries.

While it was uncertain how production of generic antiretroviral agents would be affected by WTO's new rules, it was worrying that efforts to bring antiretroviral treatment to AIDS patients in developing countries might be threatened by the implementation of that new regulation. She therefore supported the statement by the member for Brazil.

Ms CHA-AIM PACHANEE (adviser to Dr Suwit Wibulpolprasert, Thailand) thanked the Secretariat for providing technical assistance to Member States in using the TRIPS flexibilities and improving the quality of locally produced generic medicines, which would give countries access to affordable and high-quality antiretroviral agents and hence attain the "3 by 5" target. Partnership among countries was also necessary for accessibility to antiretroviral medicines, as reflected during the XV International AIDS Conference (Bangkok, 11-16 July 2004) when Brazil, China, Nigeria, the Russian Federation, Thailand and Ukraine had signed a commitment concerning the acquisition of significant technical, scientific and technological experience in the fight against HIV/AIDS.

Thailand appreciated the efforts made by Canada and Norway to amend their national legal framework concerning implementation of compulsory licensing and exporting of drugs to developing countries.

At a time when many countries were negotiating to establish free trade areas, it was important that such negotiations take into account the use of TRIPS flexibilities. Any requests for provision beyond TRIPS, the "TRIPS-plus" provisions, should be considered with great concern and safeguard measures should be established to protect accessibility to essential medicines, including antiretroviral agents. She urged WHO to be active in that respect both nationally and internationally.

Effective access to antiretroviral medicines depended on good health infrastructures and comprehensive training of medical doctors and health personnel. WHO should work closely with all donors to advocate systematic and sustainable development of health-care infrastructures, including human resources for health, in order to support efficient delivery of HIV/AIDS care.

Thailand strongly supported the WHO prequalification scheme. It was regrettable that a significant delay had occurred in implementing it and that the Essential medicines area of work in the Proposed programme budget 2006-2007 did not include the expected results of that scheme. She expressed the hope that the programme budget 2006-2007 would be revised accordingly before the forthcoming Health Assembly. She requested the Director-General and supportive donors to consider the issue seriously and provide strong leadership and budgetary support for the scheme. She also requested that the Secretariat work proactively in providing support to developing countries in improving the production process of generic medicines in order to achieve prompt prequalification.

Dr BRUNET (alternate to Professor Dab, France) said that France strongly supported WHO's activities to promote broad access to high-quality drugs, particularly antiretroviral medicines. The implementation of the TRIPS agreement from 1 January 2005 and the flexibilities it provided for would modify the capacities of the developing countries to produce generic drugs; the flexibilities should offer a solution to the supply of antiretroviral medicines to developing countries. It was, however, still too early to know whether those flexibilities would enable the countries' needs to be met. Success or failure would depend on the mobilization of Member States and the Secretariat in particular to ensure that the resources obtained through the flexibilities could be used to meet local needs.

Data were lacking on the nature, type and origin of antiretroviral agents, and on the volume of medicines used for the treatment of HIV/AIDS in the world. The report said nothing about the quantities and distribution of exports from laboratories for which prequalification had already been given, simply because such data did not exist. In order to assist in the establishment of up-to-date global data in that area, France would provide WHO with support including a financial contribution of €600 000 in the coming financial period. Within the European Union, France also supported alignment of the TRIPS agreement with Articles 95 and 133 of the Treaty on European Union to ensure uniform implementation of the Agreement in all Member States.

Regarding the WHO prequalification programme, the fact that some antiretroviral medicines had been removed from the WHO list after inspections under the WHO programme had shown up difficulties or even fraud by subcontractors conducting bioequivalence studies reflected the efficiency of the programme that France had supported from the start, and which was valid not only for anti-HIV/AIDS medicines but those also for treating malaria and tuberculosis. France had earmarked €1 335 000 for financing that programme.

Too few generic drugs had been prequalified to date, a situation that would tend to push prices up. WHO had a deadline of March 2005 for prequalification of antiretroviral agents in generic form, and particularly in paediatric formulation. It was therefore essential that enough compounds were prequalified. He requested a report on the question indicating the number of prequalified paediatric forms existing at present and the short-term trends. France was ready to support the Secretariat in developing a system of information on antiretroviral supplies clearly indicating what medicines were produced and how many were used and developed.

Mr PALU (alternate to Ms Halton, Australia), commending the valuable work done by WHO, said that Australia supported increasing accessibility to affordable high-quality antiretroviral and other essential medicines. It also supported the right of WTO members to use the full TRIPS flexibilities for the purpose of protecting public health and in particular promoting access to medicines for all. Australia welcomed the WTO General Council's Decision on implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health in its entirety, and the strong emphasis in the report on ensuring that the products in question met international standards. It urged the international community to continue to be uncompromising on quality and to resist demands for urgent action that jeopardized the quality of generic antiretroviral medicines. The cost of allowing poor-quality antiretroviral medicines to be produced threatened entire treatment programmes.

The meeting rose at 17:35.

SEVENTH MEETING

Thursday, 20 January 2005, at 14:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

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

Antiretrovirals and developing countries: Item 4.9 of the Agenda (Document EB115/32) (continued)

Dr CAMARA (Guinea) endorsed the statement made by the member for Kenya on behalf of the African group the previous day. Although AIDS was a worldwide public health problem, its worst effects in terms of mortality, morbidity and impoverishment were being felt in the developing countries of sub-Saharan Africa. Despite the fact that all the countries concerned had adopted national policies or programmes to combat the scourge, the question of treatment had been neglected and the price of triple combination therapy remained too high for millions of people. For that reason, WHO and UNAIDS were to be congratulated on the “3 by 5” initiative, which aimed to broaden access to treatment.

He thanked Canada, Germany, the United States Agency for International Development, and the Global Fund to Fight AIDS, Tuberculosis and Malaria for their ongoing assistance to people living with AIDS in his country, and welcomed the AIDS initiative launched by the President of the United States of America. Guinea, whose medicines policy was based on generics, supported the policy of local production of antiretroviral medicines. However, because developing countries did not have the facilities to conduct efficient quality control, help from WHO or countries with experience in that area was vital. Fixed prices should not prevent those in need from gaining access to high-quality drugs, and the number of prequalified products should be increased. Sustainable financing mechanisms were needed, and small, poor countries would rely on international solidarity for that to be achieved.

Mr KHAN (Pakistan) commended the commitment of WHO to achieving the target of the “3 by 5” initiative, since the failure to deliver antiretroviral medicines to the millions of people infected with HIV amounted to a global health emergency. The Decision by the WTO General Council on the implementation of paragraph 6 of the Doha Declaration on the TRIPS Agreement and Public Health was a step in the right direction, because it would help Member States to ensure access to treatment and care.

The activities of WHO in support of local production of high-quality antiretroviral agents were much appreciated. The flexibilities in the TRIPS agreement should be fully used in the light of national situations with regard to patents and prices, and in that respect he supported the comments of the member for the United States of America. Eleven major antiretroviral medicines had recently been included in Pakistan’s essential medicines list and its AIDS control programme included treatment with such medicines.

Considerations of patent rights and profits paled into insignificance when women and children were dying of AIDS; WHO’s endeavours to assist the poor in developing countries needed to be complemented by the efforts of all its Member States. He shared the views expressed by the members for Bolivia, Brazil and Kenya on the matter of generic drugs. More research should be done on HIV/AIDS: at the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004) it had been noted that 90% of the US\$ 100 000 million set aside for research was being used by only 10% of countries, and that that imbalance should be rectified. Countries like Brazil, China and India had tremendous human resources for research and development of medicines to combat AIDS, but

lacked financial resources. Heavily indebted developing countries also required assistance, because they were often forced to spend more on debt servicing than on health.

Dr ACHARYA (Nepal) said that his country was neither a producer nor a large-scale importer of antiretroviral medicines, and only some 100 people infected with HIV were currently receiving such treatment. Nevertheless, it considered that issues related to the quality, production and cost of such medicines should be properly addressed.

The delisting and relisting of medicines on the WHO prequalification list had caused delay and confusion in the procurement and administration of generic drugs under the antiretroviral medicines programmes of developing countries. No country in the South-East Asia Region had used the full range of TRIPS safeguards. Since many antiretroviral agents were relatively new, they were still protected by patents, and as a result cheaper generic versions were not available. In many developing countries the difficulty of obtaining information about the patent status of antiretroviral medicines complicated both local procurement and importation of generic drugs. He therefore urged WHO to look for solutions to those problems, so that the goal of the “3 by 5” initiative could be achieved.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that, like many developing countries, Guinea-Bissau was faced with major public health problems that hampered socioeconomic development. Some 4% of all adults and 30% to 40% of people with tuberculosis were infected with HIV, and, unless a more effective response was found to AIDS-related problems, some 20 000 people might be infected by 2008. His country had supported the “3 by 5” initiative from the start, and would welcome technical assistance from WHO in strengthening its health system, improving access to antiretroviral medicines, enhancing quality control, monitoring treatments and promoting healthier lifestyles. It was already making efforts in those areas under several bilateral and multilateral cooperation programmes and with help from development partners. He endorsed the statement made by the member for Kenya, and supported the recommendations put forward by the members for Bolivia and Brazil.

Professor FURGAL (alternate to Mr Skotnikov, Russian Federation) said that WHO support for local production of antiretroviral agents would go far towards promoting safe, effective AIDS treatment within the framework of the “3 by 5” initiative. The severity of the HIV/AIDS epidemic called for decisive action. Securing high standards of quality for antiretroviral preparations was the sole means of avoiding drug resistance, and WHO should therefore provide more funding in order to strengthen the prequalification project in line with resolution WHA57.14.

Another way of ensuring that antiretroviral therapy was given to those who needed it was to make affordable preparations available. His country was currently engaged in consultations with experts from the Regional Office for Europe in order to strengthen the action of national regulatory bodies as part of a strategy for reducing the prices of antiretroviral preparations, and would therefore welcome information from Member States on their experiences in negotiating lower prices with pharmaceutical companies.

Dr ANTEZANA ARANÍBAR (Bolivia) expressed his gratitude for the cooperation his own and other developing countries had received from the United Kingdom of Great Britain and Northern Ireland and the United States of America, and welcomed the former's announcement of an initiative to make HIV/AIDS medicines more accessible.

The Director-General's decision to create a special department offering technical cooperation and support to developing countries was of the greatest importance, and he hoped that that cooperation would include the financial and human resources necessary.

Regional efforts and international cooperation, including on the part of the pharmaceutical industry, would be very important. Any action by the Organization to make it easier for developing countries to obtain essential medicines would be greatly appreciated.

Ms DLADLA (South Africa)¹ endorsed the statement made by the member for Kenya. The legislative changes made by Canada and Norway to permit the supplying of export markets under compulsory licensing arrangements were commendable; other countries should follow their example. Countries that had little or no domestic capacity to manufacture pharmaceutical products should adopt enabling legislation in order to implement the flexibilities in the TRIPS agreement. The issue of the supply of antiretroviral medicines should be considered in the wider context of access to affordable essential medicines in general and as part of a comprehensive strategy for the management, care and treatment of people with HIV/AIDS.

Dr AGARWAL (India)¹ said that legislation adopted by his Government in 2004 incorporated all the flexibility available under the TRIPS agreement and under the WTO General Council's Decision on the implementation of paragraph 6 of the Doha Declaration.

With regard to prequalification, information on benchmarks used in WHO's assessment of pharmaceutical manufacturers, and on good clinical practice and good laboratory practice parameters might usefully be transmitted to the pharmaceutical industry and drug regulatory authorities in all countries.

Ms THOMPSON (European Commission), speaking at the invitation of the CHAIRMAN, noted that, although more people had access to antiretroviral agents, that access was still limited. Although the pharmaceutical industry had made efforts to bring down prices, and significant reductions had occurred, the financing gap for antiretroviral agents, their continued high cost to poor people and the absence of effective delivery systems were still significant barriers. It was essential to increase local production capacity, promote good manufacturing practices and speed up the prequalification process.

The European Union had supported the adoption of the Doha Declaration and the Decision of the WTO General Council, which represented major steps forward in the supply of antiretroviral agents and other pharmaceutical products, particularly to the least developed countries. In October 2004, the European Commission had submitted a proposed regulation on compulsory licensing of patents relating to the manufacture of pharmaceutical products for export to countries where there was a public health need.

The report expressed concern that the system laid down in the Decision of the WTO General Council might be too complex and might not provide sufficient incentives for manufacturers of generic drugs or for the use of compulsory licences. There was no evidence for that view, however, since the system had not yet come into operation. If all parties concerned recognized the importance of preserving public health and the rights and interests of all economic actors, the new system would achieve its objectives.

Ms GOMBE (Consumers International), speaking at the invitation of the CHAIRMAN, said that the HIV/AIDS pandemic needed a coordinated and comprehensive response, including access to essential medicines, especially high-quality, safe, affordable antiretroviral agents and medicines to treat opportunistic infections. Her organization shared the concerns of countries about the affordability of first-line medicines for the treatment and management of HIV, and about the availability and affordability of second-line medicines since WTO's new rules had come into force in January 2005. It welcomed the establishment of the prequalification project which was an excellent example of rational drug policy at the international level. It had contributed to both the availability of medicines and the simplification of drug regimens, and was particularly useful to countries with a limited regulatory capacity of their own, which were often also the countries hardest hit by HIV/AIDS. The Global Fund to Fight AIDS, Tuberculosis and Malaria had decided to authorize funding only for medicines on the WHO prequalification list. The project, however, was not yet permanently established at WHO, and there were few staff. In its present form, it would not be able to meet the growing needs of countries

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

and provide access to affordable medicines. She therefore called for adequate support for the project, and the necessary resources to expand its work.

Dr BALE (International Federation of Pharmaceutical Manufacturers Associations) said that the pharmaceutical industry was helping to provide AIDS medicines in developing countries by means of funding, access and infrastructural development programmes. An independent audit had found that, as at September 2004, the seven companies that worked with WHO and its partners in the Accelerating Access Initiative had reached more than 330 000 people worldwide, including around 150 000 people in Africa.

Some pharmaceutical companies conducted programmes for children affected by HIV/AIDS. For prevention of mother-to-child transmission of HIV, one company had donated 20 million rapid antibody tests for use in Africa and 49 least developed countries, and another had provided nevirapine free of charge in 48 developing countries. Two paediatric formulations of nelfinavir and saquinavir had been offered to least developed countries in sub-Saharan Africa at no-profit prices. Companies were offering some antiretroviral medicines at cost price, low-cost, free of charge or at prices below those offered by producers of generic drugs. Thus, abacavir and the combination abacavir, zidovudine and lamivudine were being offered at no-profit prices to 63 of the world's poorest countries, and the new formulation of efavirenz was available at a cost of less than US\$ 1 per day in the least developed countries and those hardest hit by the HIV/AIDS pandemic. The antifungal medicine fluconazole had been donated to all developing countries for the treatment of opportunistic infections: to date, six million doses had been donated to treat 110 000 patients in 27 countries in Africa, Asia, the Caribbean and Latin America. Companies were also helping to improve health infrastructures: one had provided US\$ 6 million in grants to 28 nongovernmental organizations since 2002 to support training and capacity-building for the health-care providers hardest hit by HIV/AIDS. Another had provided US\$ 5 million to support practical improvements in HIV care in Brazil, Senegal, South Africa and Thailand. Many more examples were available on the Association's web site.

The pharmaceutical industry reaffirmed its commitment to working with the Secretariat, Member States and relevant nongovernmental organizations in the common fight against the HIV/AIDS pandemic.

Dr LEPAKHIN (Assistant Director-General) thanked members for their constructive comments. WHO would continue to provide appropriate technical assistance for the implementation of the TRIPS agreement, the Doha Declaration and the WTO General Council's Decision on the implementation of paragraph 6 of the Doha Declaration. Its collaboration with ministries of health and trade and with national patent offices, using a multi-agency approach, had proved an effective method of work. It had also cooperated with WTO in technical assistance programmes for the implementation of the TRIPS agreement.

In reply to the member for France, he said that efforts would be increased, in collaboration with regions and countries, to monitor implementation of the TRIPS agreement. WHO's national professional officers would provide technical assistance appropriate to the needs of the country concerned.

The members for Bolivia and Thailand had asked for guidance on the provisions of bilateral agreements on public health. It was intended to carry out a more detailed analysis of that issue.

Replying to comments made by the member for the United States of America, he said that the effectiveness of the WTO General Council's Decision on the implementation of paragraph 6 of the Doha Declaration would depend on the interpretation placed on it by Members of WTO: the report was intended to encourage Member States to adopt the simplest and speediest procedures possible. A public-health-oriented interpretation and implementation of the Decision would help to ensure universal access to essential medicines.

The report referred to several bilateral agreements with intellectual-property-related provisions that might affect the implementation of the TRIPS flexibilities: it was intended to help Member States

to take those flexibilities into account in bilateral trade agreements, as requested in resolution WHA57.14.

The resources needed to maintain and strengthen the prequalification project would continue to be provided, and he thanked the many governments that had given their support. The members for France and Nepal had remarked on the relatively low number of medicines for children on the prequalification list. At present, there were 12 prequalified antiretroviral formulations that could potentially be used for children, nine of them from originator manufacturers and three from manufacturers of generic medicines. The problem was not that the prequalification process had been delayed, but rather that only a small number of paediatric formulations had been submitted for assessment. At present, 48 antiretroviral medicines had been prequalified, and another 150 products were currently in line for assessment. No national drug regulatory authority, not even in the richest countries, had such a large number of products submitted for assessment.

The member for Brazil had asked about the involvement of drug regulatory authorities from developing countries in the definition of prequalification standards. The standards used for prequalification had been drawn up by the WHO Expert Committee on Specifications for Pharmaceutical Preparations, which included members from developing countries. Extensive consultations with national drug regulatory authorities had taken place before the standards were adopted. With regard to starting materials and excipients, a WHO certification scheme for pharmaceutical starting materials had recently been adopted, with guidelines for implementation.

Only one in five of the products submitted for prequalification was approved, thus helping to avoid the submission of poor-quality products. The prequalification project was one of the first in which WHO had concentrated on product quality. All the information obtained had been published on the Internet, and many developing countries had begun to make use of it. The Secretariat would continue to devote considerable attention to the prequalification project.

Two departments had recently been set up, one for technical cooperation in essential medicines and traditional medicines, and the other for policy and standards in medicines.

The Board took note of the report.

Draft global immunization strategy: Item 4.10 of the Agenda (Document EB115/13)

Mr KHAN (Pakistan) observed that immunization was a most effective and cost-efficient public health intervention; at current levels of coverage, it prevented the deaths of two to three million children each year. A further one to two million deaths annually could be prevented by 2015 if countries like his own substantially increased coverage with both current vaccines and those in the late stages of development. He welcomed the initiative to draw up a global strategy on immunization and the five strategic areas proposed; however, special strategies should be developed in order to be able to cover hard-to-reach populations on a regular basis.

Professor FURGAL (alternate to Mr Skotnikov, Russian Federation) welcomed the joint initiative of WHO and UNICEF to draw up a 10-year global immunization strategy, which would complement efforts to achieve the Millennium Development Goals. The subject was a long-standing and important one for WHO and the lessons learnt from the smallpox eradication campaign and the Expanded Programme on Immunization would be built upon. The global strategy should take into account developments for the prevention of vaccine-preventable diseases. Emphasis should be placed on epidemiologically and economically sound approaches, and on programmes for immunizing children against rubella, hepatitis B and *Haemophilus influenzae* type b and pneumococcal infections. Given the time frame envisaged, it might be possible to incorporate newly developed vaccines against HIV infection, malaria, tuberculosis and re-emerging communicable diseases, and it was highly likely that immunization services in public health systems would be strengthened.

He supported the five areas of the draft strategy, but suggested that additional sections might be added under strategic area 2 to deal with strengthening the cold chain, improving technology for safe

immunization, providing more information on the operational framework for immunization in emergency situations, and approaches to vaccinating immunosuppressed people, including those infected with HIV. The recently published practical guide for health staff on immunization set out the methodological basis for some of those issues.¹ The WHO Regional Office for Europe had done valuable work in his country in building new partnerships for strengthening immunization services with nongovernmental organizations and the private sector, one example being a project to immunize children against viral hepatitis.

He asked for further information about the consultative process, in particular the time frame for submission of the draft strategy to the governing bodies of WHO and UNICEF.

Dr HANSEN-KOENIG (Luxembourg) said that vaccines were the safest and most effective tool in the fight against infectious diseases and should be made available where they were most needed at a price the poorest people could afford. She agreed with the five strategic areas proposed, stressing the importance of reaching underserved populations, linking vaccination to other interventions, and promoting synergy between immunization and other health sector services in the interests of efficiency. She looked forward to discussing the draft strategy further at the Health Assembly, and asked for additional information on the time frame.

Ms GIBB (alternate to Dr Steiger, United States of America), noting that in many countries the poor and marginalized children remained unvaccinated and thus carried the greatest burden of mortality from vaccine-preventable diseases, fully supported the development of a global immunization strategy. The setting of specific goals for immunization coverage and disease-specific mortality reduction was essential; failure to do so would limit the credibility of any global strategy and would not encourage the international donor support needed for implementation at national level. Implementation of strategies must, however, contribute to building sustainable health-delivery systems.

In developing new strategies, WHO and UNICEF should expand the existing infrastructure used by the Global Polio Eradication Initiative and the strategic plan for measles mortality reduction so as to reinforce the routine immunization system, and to build surveillance and laboratory diagnostic capacity for all vaccine-preventable diseases and the communications and advocacy capacity needed for strengthening that system. WHO and UNICEF must also seek to strengthen the monitoring of vaccination coverage, disease surveillance and laboratory networks, and make that a visible component of any global strategy. The necessary level of support for capacity-building in that area should also be provided.

Many new vaccines and delivery technologies were at different stages of development. A strong infrastructure for immunization and health systems must be in place if countries were to benefit from those new products. Immunization contacts should be used to deliver other necessary public health interventions, as appropriate, provided that they were effective and cost-efficient. Dialogue was needed with the global and country-level partners specifically involved in order to ensure appropriate cooperation.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that the draft global immunization strategy, which China supported, would help to promote the Expanded Programme on Immunization and achieve the Millennium Development Goals. Immunization was the best way of preventing disease and was extremely cost-effective; the strategy should facilitate high coverage, continued finance and the necessary political commitment.

¹ *Immunization in practice: a practical resource guide for health workers – 2004 update*. Geneva, World Health Organization, 2004.

He welcomed the consultative process envisaged and requested further information on the regional and intercountry meetings to be sponsored by WHO and/or UNICEF, implementation and management details of the strategy, and plans for its regular review and assessment.

Dr PHOOKO (Lesotho) expressed support for the outlined strategy. A data quality audit carried out in Lesotho in 2004 by independent international auditors had highlighted deficiencies in the areas of field and laboratory surveillance, data collection and analysis, and management information. The findings served to emphasize the need for continued technical and other forms of support from WHO to enable countries, including those previously declared non-endemic for poliomyelitis, to maintain effective strategic immunization activities.

Dr SAM (Gambia) supported the draft global immunization strategy, and emphasized the cost-effectiveness of immunization. A comprehensive approach would discourage the vertical structure of other programmes and prevent many deaths.

Although developing countries did not have the necessary technology, they did have human resources that could be used in the introduction of new vaccines, and should not be excluded from activities under strategic area 2. Linking vaccinations to other interventions (strategic area 3) was highly successful, as demonstrated by the integrated management of childhood illnesses that had been piloted in some countries. In strategic area 4, better outcomes were more likely to result from strengthening health systems than from programmes run by individual organizations.

Dr PREECHA PREMPREE (adviser to Dr Suwit Wibulprasert, Thailand) said that the draft global strategy, which Thailand supported, should include capacity-building for developing countries in the areas of production, quality assurance and management of the vaccine delivery systems. Countries should also be able to decide which vaccines were to be included in the national programme, taking into account the epidemiological situation and cost-effectiveness, and have the capacity, through technology transfer, technical support and training programmes by WHO, donor countries and UNICEF, to provide accurate epidemiological and economic analyses for policy decision-making. He urged WHO to ensure that all the necessary vaccines were available and affordable in the developing countries.

Mrs LE THI THU HA (Viet Nam) endorsed the draft strategy. Increasing immunization coverage and introducing new vaccines into the Expanded Programme on Immunization, however, would depend on the epidemiological situation and availability of financial resources in countries, bearing in mind that new vaccines were often expensive. Countries with limited resources would need support from external partners, at least during the initial period.

Strategic area 1 was broadly acceptable, but should reflect the need to maintain high immunization coverage in countries where that had already been achieved.

Professor FIŠER (Czech Republic) supported the draft global immunization strategy. In his country, compulsory vaccination, carried out free of charge against 10 communicable diseases, prevented some 150 000 cases of disease and more than 500 deaths.

Mr SHUGART (Canada) stressed the need for close coordination between the global immunization strategy and the planned international finance facility for immunization within the Global Alliance for Vaccines and Immunization to ensure that individual countries increased their immunization and maintained it at a sustainable level. Better coordination should also help to reduce the administrative burden on developing countries. He also stressed the importance of providing more information on the expected cost of achieving the goals outlined in the strategy and the projected financing gap.

Mr PALU (alternate to Ms Halton, Australia) supported the development of a global immunization strategy and underscored the need for extensive consultation with Member States, partners and implementing organizations. A new approach should increase synergies in service delivery, but it would be essential to ensure that the roles and responsibilities of different agencies were clearly defined. He urged appropriate consideration of the constraints facing countries in delivering, planning, managing and, in particular, expanding immunization services.

Mrs SICARD (alternate to Professor Dab, France) welcomed the current initiative to expand and strengthen immunization programmes and the preceding wide consultation process. Although the Global Alliance for Vaccines and Immunization had assumed a leading role in that area, WHO also had an important part to play, particularly in extending the immunization coverage of both children and adults.

It was important to increase the availability of basic vaccines to large, impoverished populations in developing countries, particularly the numerous countries with inadequate infant vaccination cover. The global immunization strategy should give priority to resolving the chronic difficulties that beset health services in those countries.

Regarding strategic area 2, the most promising technological advances lay in developing vaccines that did not require a cold chain; reduced vaccination schedules might also be endorsed. France fully supported the WHO initiative, provided that the linkages with the Global Alliance for Vaccines and Immunization and the international finance facility were properly defined. In that connection she had noted the reduced appropriations for immunization and vaccine development in the Proposed programme budget 2006-2007, and would return to that issue during the relevant discussions.

Dr YOOSUF (Maldives) said that, although the present generation of vaccines were safe, they were unaffordable by many countries, as was the cost of the cold chain. It also seemed unlikely that new vaccines produced under strategic area 2 would be any cheaper. Vaccines that were safer, cheaper and easier to administer would be welcome. He supported the proposal by the member for Thailand that the strategy should include capacity-building at country level. Other areas requiring attention were the strengthening of drug and vaccine regulation authorities and bulk procurement of vaccines for the regions in order to reduce the cost, bearing in mind that small countries like Maldives had to pay as much as five times more for some vaccines than the bigger, wealthier nations.

Dr ARGAWAL (India)¹ said that the report highlighted not only the technical issues relating to immunization but also the need to develop and strengthen a harmonious relationship between immunization programmes and health systems in the context of global interdependence. In India the national programme for universal immunization against preventable diseases needed to be assured of an uninterrupted supply of vaccines at affordable prices. To minimize the danger arising from a volatile global market and thereby ensure longer-term national health security, India's national health policy for 2002 had envisaged that not less than 50% of the required vaccines and sera would be sourced from public sector institutions.

Mrs PHUMAPHI (Assistant Director-General) said that, to improve global immunization capacity and coverage at country level, the principal need was adequate coordination between the numerous programmes of partners involved and to take full advantage of other services. The new strategy therefore aimed at bringing together all the epidemiological skills, tools and guidelines that had been developed to deal with immunization programmes; to strengthen the Expanded Immunization Programme; to promote immunization campaigns; and to fund the increased marginal costs of reaching the last 20% of populations in hard-to-reach areas.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

She would take into consideration members' suggestions. The consultation process had started in 2004 and involved national Expanded Immunization Programme managers and the Global Alliance for Vaccines and Immunization. The World Bank, a partner in the Alliance, was working on costing the strategy, in order to tighten its focus. WHO was working also with global partners on the financing of immunization. As a partner, it was engaged in the background work for the international finance facility for immunization. Partners were working on the global interdependence aspects of immunization such as pricing, research on vaccines with new or improved antigens that did not require a cold chain and other vaccines against prioritized diseases.

Comments had been made regarding the cost of immunization and the fact that some of the system-wide barriers that inhibited access to other health services also inhibited access to immunization. WHO was trying to integrate processes for dealing with such issues into the WHO-UNICEF Global Immunization Vision and Strategy. An attempt was also being made to find new ways of working in countries with other partners to deliver immunization together with other health services. Developing strategies for collaboration for interrelated programmes, strengthening systems and using an integrated approach to child and maternal health programmes would improve the sustainability of Expanded Immunization Programmes.

Some Board members had noted that vaccines with new antigens being offered to the global community were expensive. As WHO could not guarantee low vaccine prices, even where there was overwhelming epidemiological evidence of heavy disease burdens, such as with rotavirus or human papillomavirus infection, it was important to establish partnerships through bodies such as the international finance facility in order to improve access to vaccines.

The Board noted the report.

Malaria: Item 4.11 of the Agenda (Document EB115/10)

The CHAIRMAN, introducing the item, drew attention to the draft resolution contained in document EB115/10 and an alternative draft resolution proposed by the United States of America, which read:

The Executive Board,
Having considered the report on malaria;¹

Noting that few countries endemic for malaria are likely to reach the targets set in the Abuja Declaration on Roll Back Malaria in Africa (25 April 2000) of ensuring that at least 60% of those at risk of or suffering from malaria benefited from suitable and affordable preventive and curative interventions by 2005, but that there is rapidly increasing momentum for expanding malaria-control interventions in African countries,

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

The Fifty-eighth World Health Assembly,
Having considered the report on malaria;
Concerned that malaria continues to cause more than one million preventable deaths a year, especially in Africa among young children and other vulnerable groups;
Recalling that the period 2001-2010 has been proclaimed the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, by the United Nations General Assembly,² and that combating HIV/AIDS, malaria and other diseases is included in the

¹ Document EB115/10.

² Resolution 55/284.

internationally agreed development goals, including those contained in the United Nations Millennium Declaration;

Recalling further United Nations General Assembly resolution 59/256 entitled “2001-2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa”;

Mindful that the global burden of malaria needs to be decreased in order to reduce child mortality by two thirds by 2015 and to help achieve the other internationally agreed development goals, including those contained in the United Nations Millennium Declaration, of improving maternal health and eradicating extreme poverty,

1. URGES Member States:

- (1) to establish national policies and operational plans to ensure that at least 80% of those at risk of or suffering from malaria benefit from major preventive and curative interventions by 2010 in accordance with WHO technical recommendations so as to ensure a reduction in the burden of malaria of at least 50% by 2010 and 75% by 2015;
- (2) to assess and respond to the need for human resources at all levels of the health system in order to achieve the targets on the Abuja Declaration on Roll Back Malaria in Africa and the internationally agreed development goals of the United Nations Millennium Declaration, and to take the necessary steps to ensure the recruitment, training and retention of health personnel;
- (3) to further enhance financial support and development assistance to malaria activities in order to achieve the above targets and goals;
- (4) to increase, in countries endemic for malaria, domestic resource allocation to malaria control and to create favourable conditions for working with the private sector in order to improve access to good-quality malaria services;
- (5) to pursue a rapid scale-up of prevention with the aim of at least 60% of pregnant women receiving intermittent preventive treatment and at least 60% of those at risk using insecticide-treated nets wherever that is the vector-control method of choice, by applying expeditious approaches, including targeted free, or highly subsidized, distribution of materials and medicines to vulnerable groups;
- (6) to support expanded access to artemisinin-based combination therapy, including the commitment of new funds, innovative mechanisms for the financing and national procurement of artemisinin-based combination therapy, and the scaling up of artemisinin production to meet the increased need;
- (7) to support the development of new medicines to prevent and treat malaria, especially for children and pregnant women; of sensitive and specific diagnostic tests; of effective vaccine(s); and of new insecticides and delivery modes in order to enhance effectiveness and delay the onset of resistance, including through existing global partnerships;
- (8) to support coordinated efforts to improve surveillance, monitoring and evaluation systems so as to better track and report changes in the coverage of recommended “Roll Back Malaria” interventions and subsequent reductions in the burden of malaria;

2. REQUESTS the Director-General:

- (1) to reinforce and expand the Secretariat’s work to improve existing national capabilities, and to cooperate with Member States, in collaboration with Roll Back Malaria partners, in order to ensure the full and cost-effective use of increased financial resources for achieving international goals and targets, including the

internationally agreed development goals related to malaria contained in the United Nations Millennium Declaration;

(2) to collaborate with malaria-affected countries and Roll Back Malaria partners to ensure that countries receive full support for necessary monitoring and evaluation, including the development and implementation of appropriate pharmacovigilance systems;

(3) to collaborate with Roll Back Malaria partners, industry, and development agencies in order to ensure that sufficient quantities of insecticide-treated mosquito nets and effective antimalarial medicines are made available, especially those required for combination therapies;

(4) to strengthen collaboration with partners in industry and academia for development of affordable high-quality products for malaria control, including rapid, easy-to-use, sensitive and specific diagnostic tests; an effective malaria vaccine; novel, effective and safe antimalarial medicines; and new insecticides and delivery modes to enhance effectiveness and delay the onset of resistance.

Dr STEIGER (United States of America) explained that his country's draft resolution proposed additional subparagraphs to paragraph 1 of the original draft resolution, and new language in paragraph 2. The reason for the additional text, which had resulted mainly from consultations held by the Secretariat, was the wish to emphasize access to the new combination therapies and the importance of renewed efforts to increase the provision of insecticide-treated bednets, and in research and surveillance.

In the course of further consultations, three other elements had been identified: first, the recognition that malaria was a growing problem in other regions of the world besides Africa. He therefore proposed an insertion at the end of the second preambular paragraph, that would read: "and that the disease continues to threaten the lives of millions of people in Latin America, the Caribbean, South Asia and other regions of the world".

Secondly, the draft made no reference to the current largest financier of antimalarial programmes in the world, hence, in recognition of its role, he proposed the addition of a final preambular paragraph that would read: "Recognizing that the Global Fund to Fight AIDS, Tuberculosis and Malaria has committed 31% of its grants, or US\$ 921 million over two years, to projects to control malaria in 80 countries".

The third element was the issue of indoor household insecticide spraying in appropriate circumstances, a vector-control measure that several Member States had decided to take. To reflect that situation he suggested the addition of a new subparagraph in paragraph 1, after paragraph 1(5), that would read: "to support indoor household residual insecticide spraying, where indicated by local conditions". For the sake of consistency, a similar subparagraph should be added in paragraph 2, after paragraph 2(3), that would read: "to provide evidence-based advice to Member States on the appropriate use of indoor household residual insecticide spraying, taking into account recent experiences around the world".

Dr HUERTA MONTALVO (Ecuador) expressed his appreciation of the draft resolution on malaria in document EB115/10 and of the proposal by the member for the United States of America, which he endorsed. He welcomed the emphasis on the free distribution of materials and medicines to vulnerable groups and expanded access to artemisinin-based combination therapy. His country needed to acquire more artemisinin to meet its needs. While the problems that malaria posed to Africa should not be minimized, it was important to recognize that malaria was out of control in 21 countries of the Region of the Americas. Concern about the high incidence of malaria in that Region would be reflected in a statement to be issued shortly by the countries of the Latin American and Caribbean Group. A state of alert might perhaps be considered regarding biological vector controls.

Dr SAM (Gambia) said that extensive epidemiological data showed the continuing public health burden of malaria. Other recent data showed that it was also a developmental problem; seen in that light, malaria was involved in all eight Millennium Development Goals. One macroeconomic study had found that the incidence of malaria was indirectly responsible for slowing development by 1.3%. Although 90% of the malaria burden was borne by sub-Saharan Africa, he appreciated that the disease also occurred in other parts of the world.

He welcomed the draft resolution and endorsed some of the amendments proposed by the member for the United States of America. With regard to the supply shortages of artemisinin-based combination therapies referred to in paragraph 12 of the report, efforts to ensure their availability should be focused on areas in which the malaria burden was greatest. Local cultivation of the plant from which artemisinin was extracted and, with the help of technology transfer, local production of the drug, would ensure sustainable supplies for those most affected. The rapid diagnostic tests for malaria that were currently available could not be considered inexpensive, given their considerable cost implications for countries in which the incidence of malaria was highest. The gold standard in the diagnosis of malaria, microscopy, was not expensive, however, and the technique cut down expenditure on artemisinin-based combination therapies since it screened out fevers not caused by malaria. The introduction of rapid diagnostic tests should not replace that gold standard; rather, resources should be invested in increasing the capacity for microscopy by training personnel in the technique and providing microscopes, to ensure that antimalarial medicines were not wasted on non-malarial fevers.

Dr NSIAH-ASARE (alternate to Dr Ahmed, Ghana) agreed that malaria was a developmental as well as a health problem. Efforts to reduce the burden of malaria in endemic countries should take into account the efficacy, accessibility, affordability and acceptability of both preventive and treatment strategies. Households should be enabled to take protective measures and to receive prompt and effective malaria care in order to reduce the cost of the illness. He therefore endorsed the amendment proposed by the member for the United States concerning household residual insecticide spraying as a preventive measure supplementing the use of insecticide-treated nets. Efforts should also be made to facilitate the early detection and rapid and effective treatment of malaria, not only to reduce the cost of treatment, but also to reduce the number of working days lost because of the disease. Increased attention should be given to malaria in the planning of poverty-reduction strategies.

Dr CAMARA (Guinea) said that malaria had a devastating effect in developing countries, including Guinea, which therefore supported all attempts to mobilize resources and commit partners to effectively combating the disease. He endorsed the draft resolution proposed by the United States of America.

Mr KHAN (Pakistan), affirming that for many countries, including Pakistan, malaria was a major public health problem, said that his country appreciated the fact that WHO had constantly given it top priority, and was optimistic that the Roll Back Malaria targets would be achieved. Pakistan's national programme was rapidly moving towards the target of a 50% reduction in the incidence of malaria by 2010 – a goal that would have been unattainable without assistance from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Action must be focused on five areas: early diagnosis and rapid treatment; multiple preventive measures; improved detection and response to epidemics; viable partnerships at national and international levels; and operational research. Funding and implementation were critical to success. The time had come to broaden the focus from a country-by-country to a continent-by-continent approach. For example, it was estimated that to eradicate malaria in the entire African continent would cost some US\$ 500 million, an amount similar to what the developed world spent daily on subsidizing its agricultural sector. There should also be greater emphasis on immunization programmes.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) endorsed the report. Some countries of eastern Europe and central Asia faced the renewed risk of importing the disease from malaria-endemic countries such as Afghanistan and Turkey. Hopes for controlling malaria were based on the large-scale application of antimalarial medicines and insecticides. It was particularly important to strengthen monitoring of the sensitivity of vectors and plasmodia when chemoprophylaxis was taken over many years. The scope of laboratory work should also be widened to include differentiation of plasmodial species and cytogenetic analysis of mosquito vectors.

In general, he supported the amendments proposed by the member for the United States of America. He proposed the addition of a new subparagraph 1(5), worded: "to improve coordination between health services in controlling the cross-border spread of malaria from foci in neighbouring countries".

Russian experts were ready to work actively in all areas of that important work, including the training of medical staff in the problems of epidemiological surveillance and malaria control.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that his country attached great importance to malaria control and remained ready to cooperate with WHO and other countries in research, including on the development of easy-to-use artemisinin-based combination therapies, which should be made available as quickly as possible. In that regard, it was hoped that China's programmes to develop such products for use worldwide would receive WHO technical support.

Dr ABDULLA (Sudan) said that malaria was the major cause of death in many developing countries and undermined their already weak economies. Efforts to combat the disease had hitherto not been commensurate with the scale of the problem. WHO must intensify its work, in particular by revising the Roll Back Malaria initiative, for which further funding was needed. The impact of the disease could also be reduced by the provision of artemisinin-based combination therapies and insecticide-treated bednets at affordable prices. WHO could help greatly in that regard by using its advantageous position to make bulk purchases on behalf of other countries and organizations. Accordingly, he proposed adding, at the end of paragraph 2(3) of the draft resolution, the words: "and to study the possibility of WHO undertaking bulk purchases on behalf of Member States".

There should also be greater coordination and collaboration with other organizations, with WHO remaining the technical consultant. To that end, he proposed the addition of a further subparagraph, at the end of paragraph 2, worded: "to further cooperation and create partnerships with countries supporting malaria control programmes to ensure that the funds available to combat the disease will achieve the efficiency and effectiveness sought".

Dr NDONG (Gabon) said that malaria presented a multi-faceted challenge. Although the arrival of combination therapies for treating malaria denoted considerable progress, there remained the problem of making them accessible to large sectors of the population. Cost would always be a major consideration, although the Global Fund to Fight AIDS, Tuberculosis and Malaria had already made a big difference. Referring to paragraph 8 of the report, he pointed out that, for countries such as his own, artemisinin-based combination therapy was expensive, and therefore other combinations had been used, particularly of products such as sulphaguanidine with pyrimethamine, which were effective in children and pregnant women. He asked whether the global subsidy for such therapies (paragraph 12) was a further contribution in addition to funding from the Global Fund. If so, that was excellent, but if not, his concern about cost was still valid.

It was also important that programmes instituted by countries should not function in isolation, but rather have support from the private sector, universities and research centres. When Gabon had discussed replacing chloroquine by combination therapies, such establishments had played a valuable part in the debate. He therefore proposed that, in the draft resolution, Member States should be urged to encourage universities and private and semipublic research centres to support national malaria control programmes.

Dr SUWIT WIBULPOLPRASERT (Thailand) supported the draft resolution contained in the report, but proposed three amendments. First, an additional subparagraph should be added to paragraph 1, reading: “to work closely with neighbouring countries in controlling malaria in border areas”. As a consequential amendment, a fifth subparagraph should be added to paragraph 2, to read: “to provide support for intercountry collaboration for malaria control, particularly along border areas”. Secondly, in subparagraph 1(3), the word “integrated” should be inserted before “human resources”, because the malaria control programme should be part of the strengthened integrated health and human resources system, not a vertical programme. Thirdly, in paragraph 2(3), the word “agencies” should be added after “development”, and the words “under a strictly controlled distribution system” should be added at the end. The purpose was to avoid irrational use of such therapies, which could accelerate the onset of resistance. In Thailand such products could be distributed only under the national malaria control programme.

He welcomed the comments by the member for the United States of America about the Global Fund to Fight AIDS, Tuberculosis and Malaria. In addition to a reference to Latin America and south Asia, south-east Asia, too, might be mentioned. He could support the United States proposals provided that paragraph 1(2) of the draft resolution in document EB115/10 was retained.

Dr PHOOKO (Lesotho) welcomed the report and its draft resolution, and noted the alternative draft resolution. Lesotho supported, in particular, the inclusion of indoor residual spraying as part of integrated vector control. In view of the comments by previous speakers, especially those of the members for Gambia, Guinea and Thailand, he requested more time to consider all the proposals.

Mr PALU (alternate to Ms Halton, Australia) said that malaria remained a debilitating problem not only in Africa but also in Asia and the Pacific. In recent years control programmes in the Pacific countries endemic for malaria, namely, Papua New Guinea, the Solomon Islands and Vanuatu, had faced reduced operational capabilities, while morbidity and mortality increased. He would therefore, like to see a reference to the Western Pacific Region included in the second preambular paragraph of the alternative text. As a strong supporter of the Roll Back Malaria initiative, Australia urged WHO to continue its efforts to assist countries in accelerating the change towards artemisinin-based combination therapies where feasible and appropriate.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the countries of the Region of the Americas, said that those countries noted with concern that the report did not contain any information on the situation concerning malaria in the Americas. According to statistics for the year 2000, 36% of the population in that Region lived in risk areas. A report by PAHO on malaria control programmes in the Americas, which also contained data for the year 2000, stated that 57% of the population of that Region lived in 21 countries in which malaria was transmitted. Eleven of those countries were in South America; seven were situated in Central America; and the other three countries were the Dominican Republic, Haiti and Mexico. It had been calculated that in those 21 countries some 293 million people were at risk of malaria because they lived in areas in which the social, economic and environmental conditions were conducive to transmission of the disease. In the year 2000, 1.14 million cases had been registered, 86% of which had occurred in the Amazonian countries of South America. Although most of the deaths caused by the disease occurred in Africa, it should not be forgotten that malaria could have explosive effects in the Region of the Americas if the problem were not given proper consideration, nor that the countries most affected by malaria in that Region were those that showed marked discrepancies in income, access to health services, education, environmental health and adequate living conditions. The countries of the Region therefore requested that they be kept informed of the planned activities of the Roll Back Malaria initiative, so as to combat malaria, with special emphasis on control in areas of epidemiological concern and on reduction of vector

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

density through the use of means other than insecticides. They supported the amendments proposed by the member for the United States of America concerning reference to other Regions in the draft resolution and the role of the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Dr BELLO DE KEMPER (Dominican Republic)¹ endorsed the Thai proposal concerning support for intercountry collaboration for malaria control along border areas, specifically in respect of the border between the Dominican Republic and Haiti. While welcoming the United States proposals, she suggested adding the words “evaluation based on proof that the use of insecticides is effective and harmless to human health and the environment” to the subparagraph on indoor residual insecticide spraying. Indeed, DDT, although effective, had proved to be harmful to human health, and an international convention had been negotiated to limit and eventually discontinue its use.

Dr CHOW (Assistant Director-General), responding to the many members who had mentioned the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral donors, said that WHO was working hard to secure concerted action between financial institutes, those providing expertise and private-sector, government and nongovernmental implementing partners. The points on the global incidence of malaria were well taken. Malaria was one of the prime diseases of poverty, and it had an impact in the workplace, exacerbated gender differences, and affected displaced and migrant populations, along border areas in particular.

Valid comments had been made on the cost of medicines, especially artemisinin-based combination therapies and diagnostic tests. Within the Roll Back Malaria partnership, WHO had built a malaria medicines and supplies service, an information network that sought to aggregate supply and demand in order to reduce transaction costs and make bulk purchases. A proposal by the United States Institute of Medicine for a global subsidy was for a mechanism additional to the Global Fund. WHO sought to make rapid diagnostic tests and microscopy broadly available. The situation was most challenging in peripheral areas with little infrastructure and few human resources. The aim was to work with the private sector and implementing agencies to reduce transaction and transportation costs, and to make rapid diagnostic tests and artemisinin-based combination therapies available at little or no cost where feasible.

Artemisinin-based combination therapies were transforming malaria treatment. During a visit to China he had observed the Government’s commitment to improving supplies of the raw ingredient and working with the private sector and implementing agencies to find ways of producing such therapies at a lower cost. He also noted the concern expressed that they should be distributed through a strictly controlled distribution system and used judiciously in the context of a properly functioning health system.

Dr STEIGER (United States of America), responding to a question by the CHAIRMAN, suggested that more time was needed to agree on wording acceptable to all, on the basis of a clean copy of the text, to be prepared by the Secretariat.

The CHAIRMAN took it that the Board agreed to that approach.

It was so agreed.

(For adoption of the resolution, see summary record of the twelfth meeting, section 1.)

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Public health problems caused by alcohol: Item 4.12 of the Agenda (Documents EB115/37 and EB115/37 Corr.1)

The CHAIRMAN, speaking as the member for Iceland, introduced a draft resolution on public health problems caused by harmful use of alcohol proposed by Austria, Bahrain, Belarus, Belgium, Bolivia, Canada, China, Cyprus, Czech Republic, Denmark, Ecuador, Estonia, Finland, France, Gabon, Germany, Ghana, Greece, Guinea, Guinea-Bissau, Hungary, Iceland, Ireland, Israel, Italy, Jamaica, Kenya, Latvia, Lithuania, Luxembourg, Maldives, Malta, Nepal, Netherlands, Norway, Pakistan, Poland, Portugal, Romania, Russian Federation, Slovakia, Slovenia, South Africa, Spain, Sweden, Switzerland, Tonga, Turkey and the United Kingdom of Great Britain and Northern Ireland, which read:

The Executive Board,

Having considered the report on public health problems caused by alcohol,¹

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

The Fifty-eighth World Health Assembly,

Recalling resolutions WHA32.40 on development of the WHO programme on alcohol-related problems, WHA36.12 on alcohol consumption and alcohol-related problems: development of national policies and programmes, WHA42.20 on prevention and control of drug and alcohol abuse, WHA55.10 on mental health: responding to the call for action, WHA57.10 on road safety and health, WHA57.16 on health promotion and healthy lifestyles and WHA57.17 on Global strategy on diet, physical activity and health;

Recalling *The world health report 2002*,² which indicates that 4% of disease burden and 3.2% of all deaths globally are attributed to alcohol, and that alcohol is the foremost risk to health in low-mortality developing countries and the third in developed countries;

Recognizing that the patterns, context and overall level of alcohol consumption influence the health of the population as a whole, and that harmful drinking is among the foremost underlying causes of disease, injury, violence, disability, social problems and premature deaths, is associated with mental ill-health, has a serious impact on human welfare affecting individuals, families, communities and society as a whole, and contributes to social and health inequalities;

Emphasizing the risk of harm due to alcohol consumption in the context of driving a vehicle, at the workplace and during pregnancy;

Alarmed by the extent of public health problems associated with harmful consumption of alcohol and the trends in hazardous drinking, particularly among young people, in many Member States;

Recognizing that intoxication with alcohol is associated with high-risk behaviours, including the use of other psychoactive substances and unsafe sex;

Concerned about the economic loss to society resulting from harmful alcohol consumption, including costs to the health services, social welfare and criminal justice systems, lost productivity and reduced economic development;

Recognizing the threats posed to public health by the factors which have given rise to increasing availability and accessibility of alcoholic beverages in some Member States;

¹ Documents EB115/37 and EB115/37 Corr.1.

² *The world health report 2002. Reducing risks, promoting healthy life*. Geneva, World Health Organization, 2002.

Noting the growing body of evidence of the effectiveness of strategies and measures aimed at reducing alcohol-related harm;

Mindful that individuals should be empowered to make positive, life-changing decisions for themselves on matters such as consumption of alcohol,

1. REQUESTS Member States:

- (1) to develop, implement and evaluate effective strategies and programmes for reducing the negative health and social consequences of harmful use of alcohol;
- (2) to encourage mobilization and active and appropriate engagement of all concerned social and economic groups, including scientific, professional, nongovernmental and voluntary bodies, the private sector, civil society and industry associations, in reducing harmful use of alcohol;
- (3) to support the work requested of the Director-General below including, if necessary, through voluntary contributions by interested Member States;

2. REQUESTS the Director-General:

- (1) to strengthen the Secretariat's capacity to provide support to Member States in monitoring alcohol-related harm and to reinforce the scientific and empirical evidence of effectiveness of policies;
- (2) to intensify international cooperation in reducing public health problems caused by the harmful use of alcohol and to mobilize the necessary support at the global and regional levels;
- (3) to produce a report on evidence-based strategies and interventions to reduce alcohol-related harm, including a comprehensive assessment of public health problems caused by harmful use of alcohol, to be presented to the Sixtieth World Health Assembly;
- (4) to draw up recommendations for effective policies and interventions to reduce alcohol-related harm and to develop technical tools that will support Member States in implementing and evaluating the recommended strategies and programmes;
- (5) to strengthen global and regional information systems through further collection and analysis of data on alcohol consumption and its health and social consequences, providing technical support to Member States, and promoting research where such data are not available;
- (6) to promote and support global and regional activities aimed at identifying and managing alcohol-use disorders in health-care settings and enhancing the capacity of health-care professionals to address problems in their patients associated with harmful patterns of alcohol consumption;
- (7) to ensure transparency, impartiality and balanced regional and gender representation in the selection of experts for technical consultations on alcohol and in activities of advisory panels, including the Alcohol Policy Strategy Advisory Committee, in accordance with the established rules and procedures;
- (8) to collaborate with Member States, intergovernmental organizations, health professionals, nongovernmental organizations and other relevant stakeholders to promote the implementation of effective policies and programmes to reduce harmful alcohol consumption;
- (9) to organize open consultations with representatives of industry and agriculture and distributors of alcoholic beverages in order to limit the health impact of harmful alcohol consumption;
- (10) to report through the Executive Board to the Sixtieth World Health Assembly on progress made in the implementation of this resolution.

The draft resolution had originally been prepared by the Nordic countries, which had engaged in broad consultations in the course of the session. Many different points of view had been expressed in what had not been an easy discussion; alcohol meant different things in different cultures. Even the title of the resolution had proved controversial: some had favoured the formulation “caused by use of alcohol”, while others would have preferred “caused by abuse of alcohol”. The latter wording presented a problem because pregnant women and drivers, for example, did not need to abuse alcohol to suffer its harmful effects. The text before the Board was a compromise between the many views expressed.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries Bulgaria, Croatia, Romania and Turkey, said that the European Union was deeply concerned about alcohol abuse and its serious medical, social and economic consequences, and in particular about the fact that young people were abusing alcohol at an increasingly early age. However, the 49 sponsors of the draft resolution included only Romania and Turkey of the candidates countries; Bulgaria and Croatia should be added. The European Union looked forward with interest to receiving the report on evidence-based strategies and interventions, which would provide effective guidance.

Dr HUERTA MONTALVO (Ecuador) said that Ecuador was an enthusiastic sponsor of the draft resolution, but had also carefully listened to other points of view. It was important to distinguish between use, abuse and dependence, for alcohol abuse could produce harmful effects without dependence. There was a suggestion to modify the title of the draft resolution in order to establish a strategy on public health problems caused by hazardous and harmful use which would cover the cases of pregnant women and drivers. Furthermore, it should not be forgotten that alcohol consumption could also be beneficial. Statistics were available on the reduced incidence of brain haemorrhages brought about by non-hazardous alcohol consumption. The point was to strike the proper balance.

He was gratified that the item had been included on the Board’s agenda, because one of the criticisms made by tobacco producers had been that the Organization had taken a hard line against smoking but had had little to say on alcoholism. It was important not to take an exaggerated stand on alcohol: a clear statement on what constituted hazardous or harmful consumption and how to avoid it would have a far greater impact on public health.

Mr KHAN (Pakistan) said that alcohol consumption was a leading cause of death and disability around the world. Pakistan shared the concern of all members about the rise in alcohol consumption, especially among young people. With globalization, it had become a global problem. He proposed that the phrase “especially domestic violence primarily targeted against female partners and children” should be inserted after the word “violence” in the third preambular paragraph of the draft resolution.

Strong action, including taxation measures, must be taken against alcohol manufacturers, and advertising agencies and the media should be targeted. In short, a strategy similar to that used for tobacco control could be applied in the case of alcohol.

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) proposed that the words “harmful use of” should be deleted from the title. He supported the amendment proposed by the previous speaker in respect of the third preambular paragraph of the draft resolution.

WHO’s current alcohol policies had two main defects. First, they came under “Mental health and substance abuse”, implying that the problems caused by alcohol were related only to mental health, whereas in fact alcohol use also caused many physical diseases and impeded well-being on account of its economic and social effects. Secondly, the focus on harm reduction suggested that, provided no harm was caused by drinkers, alcohol consumption was acceptable, which overlooked the adverse effects of alcohol on health. The increasing availability of alcohol, coupled with aggressive marketing, was chiefly responsible for the rise in alcohol consumption, especially in developing countries. Marketing, under free trade agreements in particular, significantly affected the type,

volume, frequency and conditions of consumption, which in turn affected the magnitude and severity of alcohol-related problems and the effectiveness of policies and action for reducing or preventing those problems.

WHO should learn from the experience gained in tobacco control, the time having perhaps come to consider a framework convention for alcohol control. As in the case of tobacco and gambling, most countries already had a legal framework for regulating alcohol, for example by applying excise duty and licensing sales and advertising to curb consumption. He therefore proposed that in paragraph 1(1) of the draft resolution the words “including an appropriate legal framework for marketing control” should be inserted between commas after “programmes”; and, in paragraph 2(1), “formulating, implementing and evaluating alcohol policy and” should be inserted after “Member States in”.

Professor FURGAL (alternate to Mr Skotnikov, Russian Federation) commended WHO's activities in relation to alcohol-related public health problems. Many countries continued to be affected, including his own, where there were more than two million registered alcoholics, alcohol-related diseases were widespread and consumption levels unprecedented. As that was a matter of particular concern to the country's leadership and all social institutions, the Russian Federation was a sponsor of the draft resolution. Future activities should take into account the work done so far. For example, in 1995 the Member States of the European Region had adopted the European Charter on Alcohol and were currently implementing the European Alcohol Action Plan 2000-2005. Further, the European Ministerial Conference on Young People and Alcohol held in Stockholm in 2001 had adopted a Declaration setting specific targets for 2006. The European Region had also issued several useful publications on alcohol and public health. WHO had already shown, in the area of tobacco control, that collaboration among Member States could be most fruitful. It should encourage similar efforts regarding alcohol control, perhaps with a view to a framework convention on alcohol control.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that the widespread harmful use of alcohol was increasing the disease burden and damaging society in many countries. China approved the various strategies set out in the report. The global dissemination of scientific information on the effects of alcohol use was of particular importance. It was also necessary to amplify action to prevent unintentional injury and promote mental health. WHO should play an active role in providing guidance to Member States, collecting evidence and developing early intervention. China supported the draft resolution together with the comments made by the member for Thailand.

Dr ACHARYA (Nepal), indicating that Nepal was a sponsor of the draft resolution, said that as use of alcohol could lead to dependence and hence abuse, both terms, “use” and “abuse”, should be used in the draft resolution. Alcohol consumption caused many public health problems in his part of the world, as elsewhere, with widespread illicit production and consumption, rural alcoholism, “pay-day drinking”, drinking and driving, and poverty resulting from alcohol dependence. Climate also played a role, with people drinking to combat the cold at high altitude. Strategies should focus on demand and harm reduction, with intervention and information aimed at increasing awareness of the effects of alcohol and empowering the individual, the family and the community against external pressures to consume alcohol. Drinking should, in short, be de-glamorized.

Dr CAMARA (Guinea), indicating his support for the amendments already made, proposed several further modifications. Since a policy was adopted, and then programmes and action plans were formulated, he suggested that paragraph 2(4) should become paragraph 1(1) and be amended to read: “to adopt effective policies and interventions to reduce alcohol-related harm and to develop appropriate technical tools to facilitate the implementation and follow-up of strategies and programmes;”. The present paragraph 1(1) would be renumbered 1(2) and read: “to develop effective programmes for reducing the consequences of and the health and social problems related to harmful use of alcohol;”. Finally, it was superfluous to request the Director-General, in paragraph 2(3), to

include a comprehensive assessment of public health problems caused by harmful use of alcohol in a report to be presented to the Sixtieth World Health Assembly, when he was requested in paragraph 2(10) to report through the Executive Board to that Health Assembly on progress made in implementing of the resolution.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait) welcomed the report and supported the draft resolution.

Dr TANGI (Tonga), observing that his country was a sponsor of the draft resolution, said that he had queried the statement in the second preambular paragraph of the draft resolution that alcohol was “the foremost risk to health in low-mortality developing countries and the third in developed countries”, but had been told that it was cited as such in *The world health report 2002*.¹ The Director-General already selected experts for technical consultations and advisory panels in accordance with the established rules and procedures, so that paragraph 2(7) was redundant and should be deleted. The paragraph read as though it had been included in response to a complaint about selection, perhaps from the alcohol industry. As in the case of tobacco, the alcohol industry should be given no place at the discussion table in view of its clear vested interest. Since decisions should be free of commercial influence, paragraph 2(9) should also be deleted. As to the funding implications of the draft resolution, it was important to ensure that the budget allocations for the areas of work concerning noncommunicable diseases and substance abuse sufficed for implementation.

Dr STEIGER (United States of America) expressed support for WHO’s efforts in the area under consideration. The United States supported the draft resolution in principle and could accept the text as submitted. It would, however, be strongly opposed to a framework convention on alcohol control. Food and alcohol differed from tobacco. Moreover, as stated by the member for Nepal, there was a high level of illicit alcohol production and consumption, which was not addressed by the draft resolution. Such products, sold without regulation, were much more harmful than properly regulated commercial ones. Many countries had stringent regulations and some chose to ban alcohol altogether. It was for Member States to make such choices, but it should be remembered that the prohibition of alcohol enforced by Canada, Norway and the United States of America between 1919 and 1933 had failed and had led to an increase in organized crime and high levels of illicit drinking and bootlegging. The United States supported a strategy with a public health orientation, focusing on the alcohol-induced problems that WHO and ministries of health could do something about. It could not support the deletion of paragraphs 2(7) and 2(9) as proposed by the member for Tonga, since it was not possible to tackle the problems concerned without talking to the alcohol industry – producers, wholesalers and retailers. The Director-General should engage in open, transparent dialogue with the industry. He supported the amendments proposed by the member for Ecuador and endorsed the statement to be made on behalf of the countries of the Region of the Americas. Scientific evidence pointed to benefits from a moderate consumption of alcohol, and it was to be hoped that an appropriate balance could be struck enabling WHO to deal with harmful use without becoming involved in areas beyond its purview.

Dr SÁ NOGUEIRA (Guinea-Bissau), supporting the draft resolution, said that he too favoured retaining paragraph 2(9). In many countries where alcohol was produced by traditional methods, the chemical preparations used were extremely harmful to health. He wondered how that aspect could be reflected in the resolution.

Mr SHUGART (Canada) said that the core of the problem lay in the title. From a logical point of view, the wording was not ideal because of the tautology: if there were public health problems

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

caused by use of alcohol, it must be because some uses were harmful. However, it would be best not to tinker with the language of the draft. The credibility of WHO was an important factor because, once adopted, the resolution would be widely disseminated in countries with different cultures. Whatever it contained could be misinterpreted. However, what was important about the resolution was that it called for further evidence to be gathered of the harmful effects of alcohol. No member of the Board would object to that, or to tools being made available to deal with the consequent public health problems. In that sense, the draft resolution was highly practical. The public health problems were manifest in a variety of settings. Putting the resolution as it stood into practice could only be beneficial in the immediate term, and in the longer term, as consensus grew, the language of the text could be reviewed. Clearly, a sore point was the implication in the title that any and every use of alcohol might have harmful effects, and no consensus would be achievable on that. However, he supported the draft resolution as it was, in the belief that the perfect might be the enemy of the good.

Dr YOOSUF (Maldives) said that he could agree with the member for the United States of America on certain points, specifically on the dangers posed by illicit alcohol production, especially in poorer countries, and the likelihood that the consultations proposed in paragraph 2(9) would be more successful if the producers were involved. He was in favour of retaining the title of the draft resolution.

Dr ANTEZANA ARANÍBAR (Bolivia) said that, for the reasons given by the member for Canada and subject to the reservations expressed about the title, he supported the draft resolution. He also agreed with the remarks by the member for the United States. A convention on the subject would be premature given that much more information of the kind proposed in the draft resolution was needed, before any informed opinion on the matter could be reached.

Dr BRUNET (alternate to Professor Dab, France) said that, as a sponsor of the draft resolution, his country was content with the work so far done by the Secretariat. There was no question of going further than the measures proposed in the draft, such as embarking on a framework convention of the kind adopted for tobacco use.

Ms HALTON (Australia) was in favour of retaining paragraph 2(9). All players, including the alcohol industry, should be involved in devising strategies to reduce the burden of disease and injury caused by the harmful use of alcohol.

Dr CAMARA (Guinea) said that paragraph 2(7) was confusing and should be deleted. The Alcohol Policy Strategy Advisory Committee was simply a body called into existence when there was a specific job for it to do.

Dr OÑORBE DE TORRE (alternate to Dr Lamata Cotanda, Spain) supported the draft resolution but drew attention to a possible discrepancy between the English and Spanish versions.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the countries of the Region of the Americas, said that the effects of alcohol consumption could be either harmful or beneficial, depending on the amount consumed and the individual characteristics and clinical profile of the drinker. A resolution on alcohol use must be balanced, and must take both kinds of effect into account. The countries of the Region were therefore proposing that the title of the draft be altered to "Public health problems caused by alcohol abuse". The concept of abuse or excessive consumption of alcohol should then be reflected in the text, with emphasis on the risk of harm being caused by irresponsible and excessive consumption. The countries also wanted to include recommendations recognizing

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

education to be an effective means of developing healthy habits and a responsible attitude towards alcohol. The resolution should also refer to national measures to prevent the consumption of alcohol by those below the minimum age, according to national law.

Mr PETTERSSON (Sweden)¹ said that he appreciated the remarks by the member for Canada. As a matter of logic, the draft was not dealing with the benefits of alcohol, but rather with its misuse. He was against changing the English title.

Dr DANZON (Regional Director for Europe) said that the subject had been chosen as one of the three technical subjects for the next Regional Committee meeting. In September 2005 the European Region would present an update of the action plan mentioned by the member for the Russian Federation. The Region would coordinate its work with headquarters and with the European Commission.

Dr HUERTA MONTALVO (Ecuador) said that the title of the resolution in Spanish was inadequate. It was the harmful use of alcohol that posed a risk to public health; some consumption was not harmful. There were countries where, for religious or cultural reasons, all alcohol use was regarded as harmful, a point of view WHO could not endorse. There should be a clear distinction in both the title and the text of the resolution between the kinds of use which were harmful to health – such as drinking alcohol during pregnancy – and those which were not.

Dr ABDULLA (Sudan) observed that the Arabic version of the title appeared to be a literal rendering of the English.

Dr LE GALÈS-CAMUS (Assistant Director-General), thanking members of the Board for their guidance and comments, said that the discussion had been a useful reminder of the need for precision at all times, including in the title of the draft resolution. The intention, as clearly emerging from a discussion informed by public health principles, was to deal with the consequences of the harmful use of alcohol. The Secretariat would endeavour to meet that objective on the basis of verifiable scientific data and proven methods, mention having been made of inefficacy of total prohibition of alcohol use and the concomitant evil of illicit alcohol production. Both at headquarters and in the Regions, efforts would therefore continue.

The CHAIRMAN, noting that many of the numerous amendments that had been presented were mutually incompatible, suggested that the Board should adopt only two of them: Pakistan's proposal to insert in the third preambular paragraph, after "violence", the phrase "especially domestic violence primarily targeted against female partners and children"; and Tonga's proposal to delete paragraph 2(7).

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) opposed the deletion of paragraph 2(7).

The DIRECTOR-GENERAL said that he undertook to ensure that the imperative of transparency was embraced, with or without the inclusion of paragraph 2(7).

Dr THAKSAPON THAMARANGSI (adviser to Dr Suwit Wibulpolprasert, Thailand) said that, although transparency was an absolute necessity, he could, in view of the commitment just made by the Director-General, accept the deletion of paragraph 2(7).

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr STEIGER (United States of America) said that he, on the other hand, was reluctant to agree to the proposal. If the Director-General pledged transparency, there could be no harm in putting that commitment into writing. The language of paragraph 2(9) was weak: for it to be acceptable, he would like an assurance of WHO's willingness to engage the industry in a serious way on a partnership basis.

The DIRECTOR-GENERAL affirmed that such discussions had been going on for many years, mainly in the Nordic countries, but the point was that the situation differed from that of the tobacco industry. It was premature to discuss a convention and, in dealing with the alcohol industry, engagement was necessary.

After a brief discussion involving Mr SHUGART (Canada), Dr TANGI (Tonga), Mr KHAN (Pakistan) and Dr BRUNET (alternate to Professor Dab, France), the CHAIRMAN said that he took it that the Board wished to adopt the draft resolution, with Pakistan's amendment to the first preambular paragraph and Tonga's proposed deletion of paragraph 2(7).

The resolution, as amended, was adopted.¹

The meeting rose at 18:50.

¹ Resolution EB115.R5.

EIGHTH MEETING

Thursday, 20 January 2005, at 09:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda

Programme budget 2002-2003: performance assessment report: Item 5.1 of the Agenda (Documents PBPA/2002-2003 and EB115/42)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions concerning the performance assessment report were summarized in paragraphs 7-11 of its report (document EB115/45). Members had cited the difficulty of striking an appropriate balance between strategic and operational performance, expressed concern that some areas of work had been seriously underfunded, and highlighted the importance of providing voluntary contributions in line with the priorities defined in the Programme budget; the need to reflect realistic income projections in the budget figures had also been stressed. Some members had suggested a regular summary assessment of the Programme budget during the biennium, providing information about the pace of budget implementation, the progress of the different initiatives, and their impact on specific diseases. The need to keep track of action taken to implement the "lessons learnt" had also been emphasized.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) expressed surprise that the Secretariat had been unable to provide baseline data for a number of indicators, both in the performance assessment report and in the Proposed programme budget 2006-2007. It should redouble its efforts to establish quantifiable indicators with accurate baselines and feasible and measurable targets, against which performance could be evaluated. The "lessons learnt" sections usefully identified difficulties, including the lack of harmony between global, regional and country priorities, and generalized versus specific results.

The performance assessment process formed a useful basis for the Proposed programme budget 2006-2007: it could help in exploring budget changes, amendments to programmes, and in creating a strategic definition of Organization-wide objectives and expected results which could increase staff empowerment and ownership of the reform process for stakeholders, both within WHO and externally. The data and findings of the report might therefore have been integrated into the Proposed programme budget.

Results-based management was an important way of ensuring integrity and accountability at all levels of programme implementation and resource management. With thorough monitoring and evaluation, it would enable progress to be measured objectively and areas that needed improvement to be highlighted, thus reinforcing an organizational culture of transparency.

Mr LOZINSKIY (adviser to Mr Skotnikov, Russian Federation) said that, as the performance assessment report was the first of its kind in WHO, there was naturally some scope for improvement: countries should be listed by name in the tables showing baseline data and performance indicators rather than the total number being indicated, and the budgetary allocations and expenditure figures should be broken down into regular-budget and extrabudgetary funds, as was done in the Proposed programme budget. That information might help to explain why some areas of work had not received

the funding they required. He would be interested to know how many staff had been employed, on average, over the period 2002-2003.

The large discrepancy between budget allocations and expenditure was a matter of some concern. The amount spent on Emergency preparedness and response, for example, was four times the original allocation and expenditure on Immunization and vaccine development was twice the original allocation. At the same time, important programme areas such as HIV/AIDS, Making pregnancy safer, Women's health and Child and adolescent health had used barely half their allocations, which had adversely affected programme implementation. Although the outbreak of severe acute respiratory syndrome (SARS) had diverted voluntary funding from other areas, there had clearly also been miscalculations in the planning of the budget. WHO should inform Member States if insufficient funds were available for a particular programme area at the end of the first year of each biennium. It was to be hoped that similar miscalculations would not occur in the next budget period.

Dr ANTEZANA ARANÍBAR (Bolivia) referring to the 104% implementation rate shown in the table on page 6 of the report, asked whether the extra 4% had been obtained from an unexpected source or merely charged against the next biennium's budget. He noted that the area of work Informatics and infrastructure services had an implementation rate of 113%, while the figures for Blood safety and clinical technology and Food safety were only 61% and 76%, respectively. How much had been spent on scientific and technical activities, and how much on administration? More information about cases where expenditure had considerably exceeded the allocated budget would be useful: perhaps the budget had been unrealistic. Some cases of overexpenditure could be readily explained, such as that in the area of Emergency preparedness and response.

He noted also the considerable variation in the levels of extrabudgetary funding between the regions and headquarters. Funding from other sources amounted to 50% at headquarters, but only 1% for the Region of the Americas and 4% for the Western Pacific Region. Was that due to donor preferences, or was it a general trend throughout the Organization?

The information relating to specific programmes was generally satisfactory and the report was well presented: the questions he had raised were intended merely to clarify his understanding of the information provided.

Dr BRUNET (alternate to Professor Dab, France) said that the detailed information provided in the report would be useful in discussing the Proposed programme budget for the next biennium. The report highlighted the differences that could arise between the budget which WHO expected to allocate to a particular programme and the resources which were actually forthcoming. The balance to be maintained between voluntary and regular budget contributions was an important issue. If voluntary contributions were much lower than predicted, there would be considerable implications for the programmes concerned, a fact that was clearly brought out in the report. As suggested at the meeting of the Programme, Budget and Administration Committee, the Board should be alerted to potential budgetary problems caused by a lower-than-expected level of voluntary contributions as they arose, rather than having to wait for a performance assessment report once the biennium had finished.

Dr SUWIT WIBULPOLPRASERT (Thailand) said that evaluation of performance in previous bienniums was just as important as discussions of the Proposed programme budget for future bienniums. The performance assessment report was the first to show how WHO had implemented its programme. It was honest rather than diplomatic in tone, and demonstrated the new spirit of transparency and accountability prevailing in WHO.

The discrepancy between the budget approved by the governing bodies and actual expenditure was a matter of some concern. For instance, in the biennium 2002-2003, headquarters had accounted for 44% of total expenditure, as shown in Figure 3 of the report, whereas only 33% had been approved. Both the Board and the Health Assembly spent many hours discussing and approving the budget; who had the authority to change budget allocations so radically after their approval by the governing bodies? Some flexibility was of course required, but the amount involved was 11% of a

total budget of more than US\$ 2000 million. That degree of flexibility was too great. In an emergency situation, a change in the figure approved by the Health Assembly might be justifiable, but the Health Assembly should nevertheless have the opportunity to approve it retroactively. He wondered whether the explanation given to the Programme, Budget and Administration Committee, that much of the budget at headquarters was implemented at country level, was correct, and if so, whether such action was appropriate. But for the assessment report, members might not have realized that only 56%, rather than the 67% that had been approved, had gone to the regional and country offices in the 2002-2003 biennium. He inferred from Figure 2 of the report that the changes might be due to the proportion of voluntary contributions, over which the governing bodies had little or no authority. Those contributions nevertheless affected programme delivery. For example, in the Making pregnancy safer area of work, an implementation rate of only 36.4% had been achieved owing to the shortage of extrabudgetary funds throughout the biennium.

The expected results approved by WHO's governing bodies were not likely to be realized unless sufficient funding was forthcoming; if such a situation persisted, their work would be meaningless. In the interests of clarity, therefore, he requested a breakdown of the expenditure shown in Figures 2 and 3 into assessed and voluntary contributions. Also, what steps could be taken to ensure that the approved budget and expenditure were consistent? In the light of the experience of the 2002-2003 biennium, was the target of 30% of expenditure for headquarters and 70% for regions and countries realistic?

According to a study undertaken by the Oslo Group in 1998, reform of WHO's country offices would result in huge savings. In many countries, including his own, more than half the country budget was spent on maintaining country offices rather than on the countries themselves. Efforts must be made to reduce administrative costs to ensure greater expenditure at the country level.

In view of the decreasing proportion of assessed contributions, currently accounting for only about one third of the overall budget, voluntary contributions were being used in programme areas other than those approved. Unless steps were taken, the assessed contributions would eventually account for less than 5% of the regular budget. The Board had several options open to it: first, to do nothing and accept the situation; secondly, to introduce a 9% increase in assessed contributions and a 14% increase in voluntary contributions, as proposed in the Proposed programme budget 2006-2007, which would slow down the trend; thirdly, to increase the proportion of unearmarked voluntary contributions, only 10% of which were currently unearmarked. To that end, a draft resolution might be drawn up requesting donors to consider increasing the proportion of unearmarked voluntary contributions to about 50% in the next 10 years. Fourthly, a resolution might be drafted to ensure that a proportion of the voluntary contributions earmarked for areas outside the approved programme went to the priority programme areas approved by the governing bodies. The Board might therefore consider setting up a small group of interested parties to seek a constructive solution.

Dr ACHARYA (Nepal) said that the report had helped to emphasize the importance of results and indicators, lessons learnt and critical impediments, and was a useful tool for considering the Programme budget 2006-2007, given the need for clear results and measurable indicators for all areas of work. The assessment results also showed that results-based management was still not fully implemented and that, in some cases, results indicators had not yet been established. It was therefore not clear in which areas of work outstanding achievements had been made and which areas had been less successful.

Mr PÉREZ LÁZARO (alternate to Dr Lamata Cotanda, Spain) said that the 2002-2003 programme assessment report provided useful information for analysing the implementation of the budget during the biennium and the extent to which programmes and activities had met expectations. It also showed the way in which the priorities set by the Health Assembly had been implemented and the operational needs. The data, particularly relating to the imbalance between assessed and voluntary contributions, would also be useful in discussing the Proposed programme budget 2006-2007, as would the questions raised by the member for Thailand.

Ms HALTON (Australia) acknowledged the work undertaken by the Secretariat to make the budget process more transparent, and therefore more accountable, to Member States. Although the process of reform was difficult, it should continue in order to improve efficiency and performance, including in resource allocation.

The performance assessment report should contain a more detailed analysis of specific areas of work. In the absence of such detail, it was difficult to make informed judgements as to which activities should be strengthened and which downgraded. An approach focusing on results and regular reporting on key milestones in the course of delivery would be welcome. Such a step however, would require a change in culture, systems and processes, and real commitment both from the Organization and its Member States.

Mr KHAN (Pakistan) said that the proposed budget for 2006-2007 accurately reflected WHO's country focus initiative and decentralization policy. Enhancement of country office budgets would enable the Organization to achieve its expected results. He welcomed the focus on priority areas and the six areas of work identified as requiring further attention. However, expected results might more easily be achieved by concentrating funds on priority areas rather than spreading them more thinly over a large number of areas of work. There should also be more emphasis on the positive and humanitarian aspects of WHO's work. It was particularly regrettable to see WHO programmes, that had taken years to establish, made redundant by conflict: in the Eastern Mediterranean Region alone some US\$ 45 000 million worth of health infrastructure had been devastated.

The United Nations and its specialized agencies must take the lead in bringing peace to the world. The time had come to draft a resolution calling on countries in conflict situations to respect the integrity of all infrastructures, particularly that of health.

Dr AHMED (Ghana) expressed concern that the approved headquarters' budget had been exceeded, possibly as a result of the Organization's new decentralization strategy. There also appeared to be an increase in the more technical aspects of the budget at country level, which countries might prefer to see reduced. According to the table in the summary of the financial performance section of the report, while the implementation rate of areas of work such as Making pregnancy safer, Women's health and HIV/AIDS had all fallen below 50%, the figures for Human resources development and Immunization and vaccine development were about 200%. The Board might like to review the budgetary allocation to those areas.

Dr YOOSUF (Maldives) endorsed the point made by the member for Thailand regarding the feasibility of making savings by reducing staff and improving efficiency in country offices, given recent advances in communications and information technologies. In Maldives, about 40% of the budget intended for the country went towards running the country office.

Mr SHUGART (Canada) joined previous speakers in supporting the principle of performance assessment. Such assessment rightly included governance and procedures within WHO, and the report of the Programme, Budget and Administration Committee and comments thereon indicated that the decision to consolidate the committee structure had been a good one

Member States had been developing their own performance reporting in health and could contribute usefully to the process in the Secretariat. A best practices approach should be adopted; Canada would be willing to make a contribution if required, and intended to learn from the work involved in producing the Performance assessment report in order to improve its own practices. Conformity between some of the indicators and performance reporting deserved consideration as it could benefit policy-makers when communicating with political leaders.

It was important to recognize that improved performance assessment and reporting required investment in information systems, staff training and wider cooperation with Member States, and that the effort involved would increase over time. Hence, there needed to be a disciplined approach towards selecting priority areas, indicators and reporting techniques. A common theme running

through all the “lessons learnt” sections was the need for systems, planning, information and working across countries, regional offices and headquarters, all of which required expenditure that was open to criticism.

Dr GEZAIRY (Regional Director for the Eastern Mediterranean) said that, in the light of comments in favour of decentralization and the country focus initiative, the suggestion that WHO’s presence at the country level should be reduced seemed contradictory to all the Regional Directors. The role of WHO Representatives was to assist countries in implementing programmes, even those that were independent of WHO. Their presence made it easier to attract support from the Regional Office and headquarters. Moreover, it was an agreed policy to have WHO Representatives at country level; any change would require further consideration.

Mr KHAN (Pakistan) described the assistance that Pakistan had received from WHO and the Regional Office for the Eastern Mediterranean in formulating the syllabus of its medical college and in developing a hepatitis programme. The provision of technical and expert assistance by skilled personnel was crucial at country level.

The CHAIRMAN, speaking as the member for Iceland, said that implementation of a results-based approach was an important step towards increasing accountability and transparency, bearing in mind that that work was still in progress. He endorsed the call for more detailed information, but it would also be helpful to have an executive summary containing quality indicators and a comprehensive overview of the results achieved. The assessments set out in the report provided a horizontal view of WHO’s performance and enhanced its ability to function better as one WHO. The next step might be to look at it from a vertical perspective that would include all three levels of the organization.

Dr NORDSTRÖM (Assistant Director-General) expressed his appreciation for members’ comments and the work of the Programme, Budget and Administration Committee. He emphasized the difficulty of expressing expected results and indicators, baselines and targets comprehensibly and in an aggregated manner and with the right amount of detail. The main objective had been to create a single system to provide guidance to managers on what they were expected to achieve, and for use by the governing bodies. The system, which was still being fine-tuned, would provide Organization-wide expected results and office-specific contributions with a link between strategic planning and operations planning. There had been no targets or baselines in the 2002-2003 programme budget when it had been presented to the Health Assembly; they had been developed by the Secretariat later and used to assess what had been achieved.

Another important requirement was that there should be a clear link between resources and expected results, bearing in mind that delivery of expected results depended on availability of resources.

Some, but not all, of the funding of the integrated budget was guaranteed. There were also certain constraints on the use of some of the resources. With an integrated budget, the Organization had a clear idea of its financial resources and the expected results relating to them.

With regard to comments relating to best practices and the need for a change in culture, systems and processes, WHO was investing in a major management and leadership programme in order to focus more on results and managing resources, and to encourage teamwork and collaboration across the Organization.

It was a matter of considerable concern that the Organization had not been able to raise the resources to fund certain areas of work. However, a recent Secretariat report showed an improvement in the situation in some areas and a systematic effort was being made, including discussions with key partners, to achieve a more equitable distribution of resources across areas of work. For example, expenditure on HIV/AIDS in the 2002-2003 biennium had amounted to less than half the target figure of US\$ 130 million; in the current biennium, expenditure had almost reached the US\$ 217 million

target figure. In the case of Making pregnancy safer, in the 2002-2003 biennium the Organization had managed to raise US\$ 13.539 million out of a target figure of US\$ 37.157 million; in the current biennium, some US\$ 18 million had already been raised (including assessed and voluntary contributions) as of January 2005 towards a target of US\$ 38 million. In future, the Secretariat would provide regular information on its resource situation as the member for France had requested.

Referring to the questions raised by the member for Thailand, he said that, as the report showed, there was a discrepancy between the 33% target set by the Health Assembly for headquarters expenditure and the actual expenditure. However, from the point of view of the regular budget, which would receive 33% of resources, that target had been met, and the Director-General had been given the authority to make shifts of up to 10% within that budget between appropriation sections. No such restrictions applied to voluntary contributions. Part of the challenge in preparing the Proposed programme budget was the lack of control over such contributions, since the areas of the Organization's work for which resources were raised by that method depended on the willingness of partners to provide the resources. The increase to 44% in 2002-2003 was due to the fact that some resources had been managed from headquarters. Efforts were therefore being made to ensure that resources were available wherever required. With regard to strategic resource allocation, which would be discussed at a later stage, he suggested that a more evidence-based approach should be adopted not only for the Organization's strategic objectives, but for the different functions needed to attain them, in order to ensure that those functions were carried out where needed. A more scientific approach would enable the most appropriate ratio between the resources allocated to headquarters and those allocated to regions to be determined. The Director-General was confident that 30% or 25% of total resources would represent a reasonable share for headquarters and enable the Secretariat to be effective.

A breakdown into regular budget and voluntary contributions could be found in document PPB/2006-2007, of which Table 2 showed a breakdown of programme budgets by source of financing and Table 1 indicated resource requirements by group of activities. A more detailed breakdown of the sources of funding for each area of work in terms of both voluntary and assessed contributions was available separately.¹

Responding to the comment by the member for Nepal that the assessment had been performed mainly by the Secretariat, he agreed that it was important that a strong evaluation framework was applied so that a more independent view of the performance and effectiveness of the Organization could be obtained. He confirmed that the performance assessment had been used in the process of preparing the Proposed programme budget 2006-2007.

Dr ANTEZANA ARANÍBAR (Bolivia) expressed appreciation of the performance assessment report, which should be viewed in terms of the programme budget policy followed at the time and not as a reflection of the results of current management. A performance assessment report of the programme budget 2004-2005, based on the same parameters, would provide a clearer and more pragmatic assessment of the achievement of the expected results.

He endorsed the views expressed by the member for Thailand on the discussions that had taken place in the first meeting of the Programme, Budget and Administration Committee, particularly concerning the earmarking of voluntary contributions by donors to fund a specific activity in a specific geographical area. In that respect, any mechanism that the Director-General might wish to introduce to change the situation would need to be taken up with the donors. In that connection, he endorsed the observation made by the member for Pakistan about the important political dimension to WHO's work and that the Organization could make a fundamental contribution to world peace and a better life. The report provided the Organization with an opportunity to reflect on its goals. He looked forward to discussing the Proposed programme budget 2006-2007, the preparation of which had been based on clearer indicators and targets.

¹ Document EB115/INF.DOC./4.

The DIRECTOR-GENERAL thanked Board members for their comments. Replying to the issues raised by the member for Bolivia, he recalled that, before his predecessor, Dr Brundtland, had introduced the comprehensive budget, the Organization's governing bodies had dealt only with the activities, expenditures and income of the Organization that affected the regular budget; voluntary contributions, which had then accounted for some 40% of expenditure, had not been discussed. He himself had introduced further reforms by establishing a procedure for analysing and assessing the performance of past, present and future programme budgets, and for reporting the results of that assessment to the governing bodies in order to improve technical and managerial performance and provide greater accountability. Such reforms were cumulative and the result of discussions of budget issues over many years.

He acknowledged the concern that the earmarking of voluntary contributions might lead to the Organization's agenda being driven by particular funding sources. However, 90% of voluntary contributions, which currently represented some 70% of the total financial resources of the Organization, were made by a small group consisting of some 10 countries; without those contributions, many of the Organization's activities would come to a halt. The generosity shown and efforts made by those few countries to ensure that WHO had the resources it needed should therefore be acknowledged.

As the Chairman of the Programme, Budget and Administration Committee had pointed out, WHO should clearly define its goals. It was also important, however, that the Organization should be able to adjust quickly to any changes in those goals in order to remain effective. Furthermore, although country offices had been successful in building close relationships with governments, particularly health ministries, greater efforts were needed to establish good relationships with other United Nations bodies working in the field.

The CHAIRMAN said that he took it that the Board wished to note with appreciation the performance assessment reports of the programme budget 2002-2003 contained in documents PBPA/2002-2003 and EB115/42.

It was so agreed.

Proposed programme budget 2006-2007: Item 5.2 of the Agenda (Documents PPB/2006-2007, PPB/2006-2007 Add.1, EB115/45, EB115/INF.DOC./3, EB115/INF.DOC./4 and EB115/INF.DOC./5)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the conclusions of the Committee's discussions on the Proposed programme budget 2006-2007 were reported in paragraphs 12-50 of its report (document EB115/45). The Committee had welcomed the results-based approach and the broad strategic directions proposed. It had discussed the specific areas of work in great depth and recommended that: efforts to harmonize all areas of work, particularly to revise the goals in some areas to achieve consistency and to reflect commitments to internationally accepted health goals, should be continued; the expected results for certain areas of work in response to recent Health Assembly resolutions that required actions in 2006-2007 should be revised; the necessary resources to deliver adequately outcomes relating to certain important areas should be considered; the specific requirements for eradicating poliomyelitis should be adjusted to reflect the most recent trends of poliovirus transmission; the Emergency preparedness and response area of work should be revised so as to place greater emphasis on effective preparedness, relief and recovery actions, and to ensure adequate resource allocation, taking into account the tsunami disaster; greater transparency should be ensured; and lastly, the budget allocations to countries, regions and headquarters should be reanalysed so as to reflect the target of 70% to countries and regions and 30% to headquarters for all sources of funds.

The Committee had expressed concern at the rapidly decreasing proportion of the regular budget in relation to the overall budget during the previous decade and its effect on governance structures, ownership and strategic planning in the Organization, and had suggested that a process

should be put in place to identify measures to reverse that trend, through extensive consultation with Member States.

Dr NORDSTRÖM (Assistant Director-General), introducing the Proposed programme budget 2006-2007, affirmed the clear recognition that health was the key to survival. The recently published report of the United Nations Secretary-General's High-Level Panel on Threats, Challenges and Change had linked health to poverty reduction and global security, which was currently a key issue. The Organization faced the challenge of responding to those new and increased expectations. Over the past 10 years, expectations in terms of WHO's performance had increased dramatically.

The decisions of the Health Assembly had been systematically reviewed and, at the request of one Board member, a document had been produced that summarized achievements in, or impediments to, implementing Health Assembly resolutions, with the aim of ensuring that those decisions were reflected in the programme budget. That exercise would serve to define and structure the priorities in that budget.

The strategic directions set out in the Proposed programme budget built on WHO's work over recent bienniums, taking forward the increased activities in certain areas, such as communicable diseases, HIV/AIDS, malaria, and health systems. They also reflected new and emerging areas of global concern, such as enhancing global health security by increasing attention to epidemic alert and response mechanisms, in which it had been suggested that WHO should play a greater role, and expanding activities to reduce maternal and child mortality. There was a continued focus on some major communicable diseases and immunization, which was still the largest programme in the budget; the proposal that its funding should be slightly reduced would need to be reviewed in the light of developments in the current poliomyelitis epidemic. Apart from poliomyelitis, resources for immunization and vaccine programmes were increasing. A substantial increase in resources was also proposed for the surveillance, prevention and management of chronic, noncommunicable diseases and for tobacco control, and there was an increased focus on improving the effectiveness and efficiency of the Organization to enhance programme delivery. It was proposed to strengthen WHO's core presence in countries, increasing investment in knowledge management and information technology, heightening emphasis on oversight, strengthening results-based management and ensuring staff security.

The first estimate of total resource requirements in line with the results-based approach had amounted to US\$ 3500 million, which had been reduced after review to the present budget proposal of some US\$ 3200 million, corresponding to an increase of roughly 12% compared with the previous biennium. It was suggested that the programme budget should continue to be financed through assessed contributions, miscellaneous income and voluntary contributions.

There was concern about the declining share of assessed contributions in the regular budget since, in order to meet growing expectations, secure predictable resources were needed. As could be seen from the performance assessment report for 2002-2003, delivery had been hampered by lack of funds. Assessed contributions were important to support normative work, and to maintain the Organization's integrity by avoiding overdependence on voluntary contributions. It was proposed to allocate the suggested increase to regions and countries, which carried out normative work in addition to that done at headquarters.

At the request of the member for Thailand, a report was being prepared on the status of implementation of the resolutions and decisions adopted at the four previous Health Assemblies, and the information would be incorporated in the documentation submitted to the next Health Assembly.

The approach to improved management was based on effectiveness and efficiency, proper operational planning, staffing and performance monitoring. The key factor was global leadership; the new Global Management System, for example, would facilitate staff analysis by area of work and location. The aim was to achieve a more strategic use of human and other resources.

The Secretariat was constantly seeking savings in all areas. Travel costs, for example, had been reduced, partly as a result of negotiated agreements with travel agencies throughout the United Nations system, and techniques such as teleconferencing were being studied; the aim was to reduce the

current expenditure level of some US\$ 70 million by 10%. Savings in recruitment were being sought by, for example, reducing recruitment time. A new procurement system that would add value for money and outsourcing of some services were also being considered. Further significant economies would result from investment in a global private telecommunication network. Likewise, the overhaul of information technology installations should result in more facilities for staff, at a lower cost; changes in the related servicing charges were expected to reduce costs by more than US\$ 1 million. Printing was another area in which the use of alternative sources could lead to considerable savings.

Lastly, in regard to exchange rate movements, the Secretariat had been largely successful in managing fluctuations by means of hedging. The substantial all-round rise in costs, amounting to some US\$ 100 million over two bienniums, had been absorbed within the resources available.

The CHAIRMAN suggested that, in order to deal with the Proposed programme budget 2006-2007 in the most efficient way, the Board should consider the proposals grouped by areas of work, in the order in which they were presented in document PPB/2006-2007.

Dr TANGI (Tonga) said that the Organization's strength derived mainly from its unique three-level structure. He wondered, however, whether that strength was being used to the best advantage, and whether roles were being defined and allocated in the best way; for example, were there any headquarters activities that should be dealt with at the regional level, or any work done by regional offices that could be handled by countries? Clarity and honesty were required in the allocation of roles, especially at senior level, in order to avoid duplication and the resultant loss of efficiency and increase in costs. With regard to programmes in particular, he sought assurance that the approach was rational: in particular, were funds being used at headquarters that might better be used at other levels?

On the issue of transparency, he noted that the commitment proportion for the biennium 2006-2007 was to have been 75%-25%, not 70%-30% as currently shown, and that an overall increase of 9% in assessed contributions was being proposed. He asked for an explanation in that regard. He also asked whether the proposed increase of 11% relating to surveillance, prevention and management of chronic, noncommunicable diseases would be enough to avert the spread of such diseases, which currently accounted for some 47% of the global disease burden, a figure which, if appropriate steps were not taken, was predicted to rise to more than 60% in less than 15 years.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) drew attention to the fact that, although funds had been committed for much of the action decided in Health Assembly resolutions over the previous five years, there was still room for improvement; for example no funds had yet been allocated in respect of the request in resolution WHA57.19 to declare the theme of World Health Day 2006 to be "Human Resources for Health Development". He asked the Director-General to take steps to rectify that situation. One of the most important aspects of the Proposed programme budget 2006-2007, the 9% increase in assessed contributions, required serious consideration. His country was strongly opposed to the trend that the regular budget had followed in recent years. The matter should be discussed by the Board with a view to formulating a draft resolution for submission to the Health Assembly.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) noted that WHO had refined the process of results-based budgeting and was pursuing efforts to provide more effective indicators and to improve performance and accountability. However, although the new Global Management System was designed to produce more efficient ways of working, it did not appear to free any resources in the short term. It was to be hoped that progressive implementation of that system would nevertheless lead to savings in the 2006-2007 biennium. To that end, the Secretariat, which had been successful in generating resources to meet strategic objectives, should streamline the process for gaining donor support and lowering its transaction costs.

Her country did not support the proposed 9% increase in the regular budget: it would be more realistic to maintain the 2004-2005 level of US\$ 858.5 million for substantive areas of work.

International organizations should display budgetary discipline, accountability and efficiency and prioritize their financial resources. While action should be intensified in the five priority areas identified in the proposed budget, it might be prudent to phase in the increases over several bienniums. The budget as presented had not made sufficiently hard choices about lower priorities or disbanding some areas of work. The discussions of the Programme, Budget and Administration Committee had been fruitful, since information on expected results, indicators and baselines had been produced. At that meeting, her country had suggested some shifting of resources, and had taken the view that it might be wise to maintain funding at current levels in areas where the global community was already committing substantial resources. WHO's contribution needed to be adjusted in the light of the international community's strong commitment to combating certain major communicable diseases.

Dr HANSEN-KOENIG (Luxembourg) expressed appreciation that voluntary contributions had been included in the figures and that a results-based budget had been presented, even if some indicators would in future have to be refined. She supported the Proposed programme budget 2006-2007 and argued in favour of an increase in the regular budget, which had remained unchanged for almost 10 years, while the proportion represented by voluntary contributions had risen sharply to 70% of the Organization's total resources. The fact that the regular budget was tending to account for a decreasing proportion of total resources might undermine the Organization's normative role and its ability to carry out certain technical activities which were not particularly attractive to donors. Given that that role was of utmost importance to the Organization, it was regrettable that the Secretariat had been unable to produce the information document requested on that subject, and she hoped it would be available in time for consideration before the Health Assembly. Member States must realize that maintaining zero growth in the regular budget would ultimately seriously damage the Organization. Financial Regulation XV, on decisions involving expenditures, demanded that the Executive Board should be given more information on the administrative and financial implications of any proposed task that the Organization was requested to undertake. The decentralization process also had to be pursued in order to reach the target of 70% of resources for the regions and 30% for headquarters which had been set by the Director-General for the 2004-2005 biennium, and she looked forward to hearing details of the practical steps taken to achieve a 75% to 25% split during implementation of the 2006-2007 programme budget.

Dr PHOOKO (Lesotho), speaking on behalf of the African group, supported the proposed increase of more than 12% in the overall budget, or 9% in the regular budget, and commended the channelling of more funds to efforts to attain the Millennium Development Goals, and to the regions and to countries. The African group was concerned, however, about the reduction in funds for vaccines and immunization. Some programmes were receiving more than others, whereas priority programmes like HIV/AIDS, tuberculosis, malaria and Making pregnancy safer should all receive increases of the same magnitude. The budgetary allocation for Human resources for health should be increased because of the huge problems facing developing countries. He requested detailed information about estimated increases in assessed contributions to the regular budget.

Mr LOZINSKIY (adviser to Mr Skotnikov, Russian Federation) expressed support for the underlying principles of the Proposed programme budget, which aimed to channel more funds to action at country level and maintain a fair distribution of resources between regions. He welcomed the results-based budget format and agreed with its strategic thrust and priorities. Nevertheless, more work would be required on some of the indicators contained in the budget, as it was not clear what end results the Organization had in mind. It was known that the Secretariat wished to remove the imbalance between assessed and voluntary contributions, but its arguments in support of an increase in the regular budget in the next biennium were unconvincing, especially as the Organization's financial position was stable and voluntary contributions were set to rise. He suggested that financing from the regular budget for Knowledge management and information technology, WHO's core presence in countries and Infrastructure and logistics should be kept at the level of the current budget, since those

were not priority areas for WHO. That would not undermine existing programmes, because the shortfall would be made good by higher voluntary contributions.

The budget was still an interim results-based budget. Although the Secretariat had promised that in future definitive baseline and target indicators would be given, the few shown in the Proposed programme budget 2006-2007 were inexact, or estimated. It was not clear why, in the HIV/AIDS indicators, the baselines referred to 50 countries and the targets to 100, or whether those countries included the Russian Federation or countries of the Commonwealth of Independent States. The countries where WHO was active should therefore be specified. Nor did he agree with the expected results, since they were not consonant with the Global Health-Sector Strategy for HIV/AIDS adopted by resolution WHA56.30. Where was the indicator for the number of people infected with HIV who were receiving antiretroviral therapy? If the target for 2005 was three million, what was the target for 2007? Other important targets were also missing. In order to enable Member States to gauge successes and failures in areas of work, the results expected from activities should reflect the overall strategy decided by the governing bodies, and should remain the same from one financial period to the next; if they were changed, the relevant documentation, and even the results-based budget itself, would be meaningless.

The format of the budget could be improved. The lack of any information about the proposed distribution of assessed contributions according to categories of expenditure, or about budgeting for human resources, made it impossible to express any opinion on those subjects. Such information was useful in the decision-making process in Member States and should therefore be made available at the current session. Similarly, a more detailed breakdown should be provided of the proposed increases to cover costs and inflation.

The meeting rose at 12:40.

NINTH MEETING

Friday, 21 January 2005, at 14:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda (continued)

Proposed programme budget 2006-2007: Item 5.2 of the Agenda (Documents PPB/2006-2007, PPB/2006-2007 Add.1, EB115/45, EB115/INF.DOC./3, EB115/INF.DOC./4 and EB115/INF.DOC./5) (continued)

Dr ANTEZANA ARANÍBAR (Bolivia) said that the introduction to the budget document had provided a useful overview of the new vision for results-based budgeting. The priorities listed were in line with those identified by Member States at the previous Health Assembly and at the recent meeting of the Programme, Budget and Administration Committee, and had been accorded the largest allocations of resources. One of the six specific areas of work, Planning, resource coordination and oversight, heralded a move towards a robust and supportive managerial environment. Management was vital at all three levels of the Organization. Country programmes would not be implemented effectively if Member States lacked managerial capacity.

The Board commented mainly on one third of the overall budget of the Organization, the regular budget, and very little, if at all, on voluntary contributions. To redress the balance, he suggested that a proportion of extrabudgetary resources should be allocated to such agreed expenditures as administration, management and coordination, and to a fund to be used by the Director-General to finance neglected programmes or support countries in particular need, as required, on a case-by-case basis.

The allocations shown in the Proposed programme budget required clarification. For example, in respect of Communicable disease research, 91% of the allocation was for headquarters and only 3% for countries, while for Health information, evidence and research policy the respective figures were 22% and 47%. Research was apparently a centralized concept, but it was unclear whether research capability was considered to be at the headquarters level, or whether it was at that level that the decisions on where and how research was done were to be taken. There was a similar problem with the proposals for Essential medicines. The descriptive text was well presented but the allocation showed 41% for countries, 41% for headquarters and 18% for regional offices. Some explanation was required of the application and consistency of criteria used to determine the various allocations. WHO's normative functions, which could only be fulfilled by the Organization, for example activities on the International Classification of Diseases, biological standardization and International Nonproprietary Names, should be financed from the regular budget. The resulting standards would remain a dead letter, however, unless they were used by Member States. Extrabudgetary funds should therefore perhaps also be earmarked to support the implementation of such standards. Some adjustments were needed, therefore, to rectify the imbalances he had mentioned and provide a budget more consonant with the wishes of Member States.

Dr BRUNET (alternate to Professor Dab, France) expressed appreciation of the rapid response by the Secretariat to the questions raised at the recent meeting of the Programme, Budget and Administration Committee. France supported the Proposed programme budget 2006-2007 on account of its global structure and because the priorities for which an increase in allocations was provided matched its own priorities. It also supported the proposed increase because it endorsed the objectives and was concerned at recent trends in the proportions of the overall budget represented by regular and

extrabudgetary resources. However, the budget as presented did not rectify that situation since it showed a greater increase in extrabudgetary resources. He recognized the efforts made by WHO to improve its management methods and to distinguish between programmes that should be funded from the regular budget and those to be paid for out of extrabudgetary resources. Further progress was to be hoped for in applying the principles of strategic resource allocation. He had some doubts about the application of those principles to the allocation between the three different levels of the Organization. The exercise was not yet complete but the development of a more effective tool for the allocation of regular and extrabudgetary resources was a step in the right direction. Since it was still unclear whether Member States would agree with France's view that a budget increase was required, he endorsed the comments made at the previous meeting by the member for Luxembourg, which accorded with the views of many European countries. For many years Member States, including France, had asked WHO, through the resolutions adopted, to take on more tasks. They must realize the financial implications of those demands, including those presented at the Board's current session. First, it was important to quantify as far as possible the additional funds that the new tasks would require; then it was for Member States to provide the necessary resources. If Member States were not prepared to agree to a budget increase, they would have to determine which activities were to be reduced. That was a difficult exercise; the savings presented so far covered only a few areas of work and some, such as eHealth, did not amount to significant sums. Further savings could clearly be made through improved management, but programme cuts would also be needed. France could not accept any cuts in allocations to the priority programmes.

Mrs LE THI THU HA (Viet Nam) said that the programme budget documents showed an integrated, strategic approach to planning and budgeting and established clear Organization-wide priorities and objectives for the biennium. She noted with satisfaction the incorporation of some proposals made by Member States at the 2004 meeting of the Regional Committee of the Western Pacific. Despite the critical health challenges it was facing, Viet Nam supported the proposed increase in the overall budget of 12.8%. At the Regional Committee meeting, Member States had expressed concern that the proposed allocation to the Region showed an increase of only 0.3% compared with the previous biennium, the smallest increase among the regional allocations. The Region was the most populous and bore the dual burden of communicable and noncommunicable diseases: it had four countries out of the 22 with a high burden of tuberculosis, and HIV/AIDS was spreading rapidly. It had also been hard hit by the severe acute respiratory syndrome (SARS) and avian influenza in 2003 and 2004, and was prone to similar outbreaks that might well spread globally and do substantial economic and social harm to Member States in other regions. The countries of the Western Pacific therefore considered that the Region deserved a larger allocation.

Ms HALTON (Australia) reiterated her country's commitment to budgetary restraint and efficiency in all United Nations organizations, including WHO. It was sometimes difficult to justify regular and extrabudgetary contributions to the Australian public; improved performance information would facilitate that task. The pressures faced by the countries of the Western Pacific Region mentioned by the previous speaker were of significant concern and should be taken into account. She could support a modest increase in the Proposed programme budget, but not one of the size proposed by the Director-General. It was appropriate to give priority to the six areas targeted for intensified activity but more detailed justification was needed for the specific budgets being sought. It remained unclear what the increased funding would actually achieve. Although economizing in a range of areas, including travel and information technology, was commendable, there was scope for further savings. She concurred with the member for the United States of America that consideration should be given to terminating some programmes, although clearly such a task would not be easy. Priority should go to new measures that would facilitate the diversion of existing resources to the six priority areas.

Mr PÉREZ LÁZARO (alternate to Dr Lamata Cotanda, Spain) observed that, as more was being demanded of the Organization and adjustments had been made in respect of programmes that were no longer of high priority, the next logical step was to ask Member States to increase their contributions,

as indicated in the Proposed programme budget 2006-2007, in order to rationalize multilateral support. The proportion of the overall budget accounted for by extrabudgetary resources had risen to around 70%, which, inter alia, endangered the financial independence and normative role of the Organization. There were undoubtedly further programmes and areas of work whose priorities needed adjustment; that should permit some cuts in allocations in the short and medium term, any savings being redirected to areas pertinent to achievement of the Millennium Development Goals.

Mr KHAN (Pakistan), speaking on behalf of the countries of the Eastern Mediterranean Region, commended the efforts made in formulating the Proposed programme budget 2006-2007 and the consultations with the Regions. He welcomed the progress made in developing guiding principles for strategic resource allocation across the Organization as requested by the Health Assembly; all programmes should be results-based and health indicators improved. Good governance, a primary concern for developing countries, was also essential.

Greater weight should be given to population size and disease burden in determining resource allocations, with bigger allocations to country offices. In the Region, disease patterns were changing, with many countries experiencing the dual burden of communicable and noncommunicable diseases; countries had also been experiencing increased turmoil due to conflict in the past decade that had destroyed health infrastructures, prevented the collection of health information and led to the reduction or disappearance of human resources for health. Some 100 million people lacked access to essential medicines. Pakistan was under pressure from some 2.5 million refugees from Afghanistan, although the numbers had halved from an earlier peak. That situation, together with migratory labour, had hampered poliomyelitis eradication efforts. Countries in Asia were, in addition, dealing with the tsunami crisis. WHO had remained strong and its regional and country activities, for example in Afghanistan, Somalia and Sudan, were filling health service gaps. However, countries were struggling to cope and needed more resources. Health was directly linked to poverty, and improved health status could boost economic growth. It was a major focus of Pakistan's poverty reduction programme.

The budget process, albeit commendable, could be further improved. In addition to its continuing programmes, WHO was being asked to take on new tasks and needed the concerted support of Member States. He fully supported the proposed budget increase. Health could not be divorced from politics, and clear leadership and sound policies were needed in the current difficult times. WHO and the United Nations must take serious action to alleviate suffering around the world, especially among women and children.

Dr ACHARYA (Nepal) said that the budget document showed strong commitment to effective and efficient programme implementation. He welcomed the proposed 9% increase in assessed contributions and the six priority areas of work. It was uncertain whether the Regional Office for South-East Asia would receive the proposed increase in voluntary contributions. Of the total budgeted amount from headquarters of US\$ 191.5 million over the biennium 2004-2005, only about US\$ 113 million had so far been secured, and receipts were unlikely to exceed 80% of the budgeted figure by the end of the biennium. It was also unlikely that the budgeted figure of US\$ 229 million in voluntary contributions for 2006-2007 would be received. Moreover, the amount received by each area of work also depended on resource mobilization in new areas of work such as Epidemic alert and response, Surveillance, prevention and management of chronic, noncommunicable diseases, Making pregnancy safer and Child and adolescent health. As those areas had not traditionally received large sums in voluntary contributions, the budgeted increase in funding might not be realized. His Region was continuing to question the distribution of funds to the Region and any additional funds. He would have liked to see a breakdown of the budget by country.

Dr QI Qingdong (alternate to Dr Yin Li, China) praised the clarity and conciseness of the budget document and the results-based approach adopted, and expressed full support for the efficiency measures proposed. He had no objection to the six priority areas but said that he hoped that their choice would not result in reduced funding for other areas of concern to the international community, especially HIV/AIDS, Tuberculosis, Malaria, and Immunization and vaccine development. He

understood the rationale for the budget increase – to enable WHO to meet current health challenges and achieve the Millennium Development Goals – but the amount of the increase should be decided on the basis of wide-ranging consultations with Member States. He supported the proposed transfer of funds to regional and country offices, and would like to see a target for the transfer set at an early date. He shared the concern that the increase in the budget for the Western Pacific Region was only 0.3%. The capacity of country offices to improve public health should be strengthened, with less emphasis on administration and personnel. In due course, an assessment should be made of the performance of country offices, in order to identify scope for improvement.

Mr SHUGART (Canada) also welcomed the efforts to prepare an integrated results-based programme budget, and the issue of the first-ever performance assessment report. The programme budget was essentially a work in progress, which could be further refined before the Fifty-eighth World Health Assembly. Canada remained committed to a policy of budgetary discipline. It was important to monitor the process of setting priorities, and the link between those priorities and the resources available. He was well aware of the demands placed on WHO to take on increasingly complex areas of work. Even so, some opposition had been voiced to the proposed budget increase, and the Programme, Budget and Administration Committee had identified areas in which goals and targets should be rethought, clarified or reformulated, and had suggested possible changes to the budget. Canada was also concerned about the amount of crucial work being funded from voluntary contributions, since those resources were vulnerable. He had no immediate solution to offer, other than emphasizing the importance of setting realistic and reasonable targets. He asked the Director-General, in consultation with Member States, to identify clearly, before the next Health Assembly, those core functions that would be compromised if the regular budget funds were not forthcoming. In that light, Member States could decide how likely it was that those needs could be met from voluntary contributions, whether the demands placed on the Organization should be reduced, or what further efficiencies could be proposed. Consultations should thus continue actively on the programme budget before the Health Assembly. Member States and Board members had a responsibility to cooperate with the Director-General in the consultations, and his country would play its part in that process.

Dr BUSS (Brazil) concurred with the identified priorities. He attached special importance to the role of the regional and country offices. He supported the proposed 9% increase in assessed contributions, but stressed that his country's support was conditional on the regional offices receiving the bulk of the increase, as part of the process of decentralization and an acknowledgement of the importance of WHO's presence in the regions.

The CHAIRMAN, speaking as the member for Iceland, said that his country supported the proposed increase in the programme budget, as did the other Nordic countries, Denmark, Finland, Norway and Sweden. A substantial increase was essential in order to meet global health needs and demands placed on WHO. The Organization had a key role to play in worldwide efforts to meet the Millennium Development Goals, and its financial resources must be increased accordingly. He welcomed the move towards implementing the Director-General's commitment to increasing the regional and country share of the budget; the least developed countries and countries with the highest disease burden should be given priority. Decentralization had been slower than planned, but progress was being made. The global mandate of WHO indeed required a significant regular budget, and the move away from the zero nominal growth policy was overdue. The impact of the falling United States dollar on the programme budget was a matter of some concern, as was the growing imbalance between regular and voluntary contributions, which reduced the influence of the governing bodies on the direction of the Organization's work and its priorities. It should also be borne in mind that the transaction costs of voluntary contributions were high in comparison with regular contributions. The Secretariat should continue to strive for improved efficiency in its management procedures, in order to facilitate an increase in financial contributions. Member States could also help through greater harmonization. WHO's funding partners must avoid earmarking contributions. If a broad consensus

were reached on priorities for the work of WHO, it might be possible to direct contributions to programme activities approved by the governing bodies.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the countries of the Region of the Americas, welcomed the participatory process for preparing the budget and the decision to draw up guiding principles on regular budget allocations to regions.² Moving from the model contained in resolution WHA51.31 had resulted in an increase in the regular budget for the Region of the Americas, bringing it up to a level similar to that for the biennium 1998-1999. He was also glad to see a better balance in the Proposed programme budget between regular and extrabudgetary resources for the Region compared with the three previous bienniums, in which the Region had lost income from the regular budget and had had less access than other regions to income from voluntary contributions. In spite of that, the Region still received the lowest percentage of the Organization's budget, at 6.6% of the total. The countries of the Region were confident that the policy of allotting increasing proportions of the budget to the regions every biennium would bring about an equitable distribution of funds, to the benefit of all regions. The work done by WHO in the Region of the Americas, was much appreciated, but the special needs of that Region, where poverty was rife in many countries, warranted a better balance in the distribution of budget resources.

Ms SOLTANI (Algeria)¹ welcomed the fact that the proposed increase in the regular budget would be allocated to essential activities in regions and countries, as part of the efforts to decentralize the work of the Organization, and, in particular, that the share of the budget allocated to headquarters would not in future exceed 20% of the total, in line with the recommendation of African health ministers at the previous session of the Regional Committee for Africa. The extra funds for country offices thus made available would enable them to strengthen their skills and capacities, enhance their national health systems and achieve their national goals for health and development. The WHO country office in Algeria had certain achievements to its credit, but the demands placed on it by the health authorities were beyond its resources. It was to be hoped that the constraints on its work would be lessened by the new budget commitments.

Ms MAFUBELU (South Africa)¹ expressed full support for the remarks by the member for Lesotho. She also supported the Proposed programme budget, and especially the proposed increase of 9% in the regular budget and 12% in total spending. She shared the concerns about the declining proportion of the regular budget. A secure, sustainable and predictable budget was crucial to ensuring implementation of the Organization's decisions and its strategic objectives. South Africa appreciated the generosity of donor countries in making voluntary contributions to the work of WHO, but urged them to limit the earmarking of donations, so as to give the Director-General more flexibility in making budgetary allocations in line with the priorities of the Organization and the wishes of Member States. Any consultations on the Proposed programme budget before the forthcoming Health Assembly should be inclusive.

Dr NORDSTRÖM (Assistant Director-General), replying to the member for Tonga, said that there was indeed more to be done to take full advantage of the strengths of the Organization; the results-based management framework would be reconsidered in order to define better the strategic direction and functions of the Organization, and where those functions could best be performed. It had been pointed out that expected results could not always be achieved in a single biennium; a longer time frame was needed. The Programme, Budget and Administration Committee had stressed the need to streamline the budget, and action would be taken in accordance with expected results, indicators and baselines.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Decision WHA57(10).

The question of financial discipline was taken seriously, and new work was not contemplated unless resources were available or funds could be reprogrammed; for example, no funds would be available for further work on alcohol unless it was decided to allocate resources for that purpose, or to do less work in another area. On the issue of cost categories raised by the member for the Russian Federation, staff costs and the cost of travel and equipment had indeed been analysed retrospectively and lessons drawn from the exercise; but there was no intention of setting predetermined spending limits for any particular item. Results-based efficiency meant looking for the best way to achieve particular results: in the case of staff, that would sometimes mean recruiting staff, and sometimes entering into a contract with another institution. However, as a knowledge-based organization providing expertise and new knowledge to others, WHO could be expected to incur high staff costs.

Inflation was a difficult issue; the historical rate worldwide was about 2.5%, but the cost to the Organization of the depreciation of the United States dollar had been high. As for the country perspective, an issue raised by the member for Bolivia, WHO had a country cooperation strategy for 90% of countries, and the country strategy in turn informed the overall direction of its work.

As to whether the work of WHO was less needed in the context of a global society, on the contrary, it was more necessary than ever, because expectations in terms of immunization and combating HIV/AIDS and tuberculosis had increased, and investment in those areas itself increased the need for the technical support that WHO was able to provide. With regard to the need to avoid earmarked contributions, the dialogue recently undertaken with donor countries on that point had been most encouraging and it seemed likely that in future voluntary contributions could be aligned more closely with the priorities set by the governing bodies.

The DIRECTOR-GENERAL said that WHO's programme budgeting used a "bottom-up" approach, with contributions from Member States and Regions. He remarked on the size of the budget; it was not huge in absolute terms – merely sufficient to run a medium-sized hospital in Switzerland. No matter what its size, however, the budget could not actually reduce poverty or eliminate countries' health problems. Developments in recent years, such as the creation of the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Global Alliance for Vaccines and Immunization, together with bilateral programmes implemented by Member States, also increased the demands made on WHO. It had to be recognized that the funds WHO allocated to small poverty-stricken countries were a mere drop in the ocean. WHO's strength was in working with international or national agencies or governments. In addition to WHO's traditional donors, which strongly supported the Organization, some countries played dual roles as both donors and recipients of funding. That was a positive development.

Questions had been raised about the allocation of funding between regions and countries. He agreed that measures should be taken to channel more funding directly to countries and regions, but that should not be to the detriment of headquarters. Having worked at all levels of WHO, he believed that it was important to have a strong headquarters. If headquarters could do its work with only 10% of overall resources, all well and good; but the main point was to achieve a healthy and effective distribution of resources throughout the Organization. It would be a mistake to stick arbitrarily to a given percentage allocation. On the basis of the general direction desired for WHO, good judgement must be exercised and adjustments made. The Proposed programme budget 2006-2007 envisaged a 25% allocation of the overall budget to headquarters, but as time went on that allocation could be reassessed. It was gratifying to note that, over the years, Board members had come to view WHO as an entity, rather than merely in terms of narrower national, regional or sectoral interests.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America), referring to the increasing demands on the Organization, said that in the intervals between budget deliberations, little information was provided about the budgetary implications of actions by the Health Assembly. It would be useful if more information on financial implications could be provided to the Board and the Health Assembly in the intersessional periods. She noted that the expected results and indicators for HIV/AIDS, malaria and other diseases did not take account of WHO's work in support of institutions such as the Global Fund to Fight AIDS, Tuberculosis and Malaria. That omission should be corrected.

The DIRECTOR-GENERAL conceded that such activities could be more clearly reflected in the budget. He cited the specific example of Spain, which had been raising the possibility that US\$ 5 million of its contribution to the Global Fund to Fight AIDS, Tuberculosis and Malaria should be used to cover the technical requirements of WHO's work in relation to that Fund, a procedure that was not permitted under the Fund's financial regulations and rules.

Orientations 2006-2007 by area of work

Communicable disease prevention and control; Communicable disease research; Epidemic alert and response; Malaria; Tuberculosis; HIV/AIDS

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation), referring to Epidemic alert and response, said that, as result of the tsunami in south Asia, voluntary funding was likely to be significantly more generous than the amount foreseen when the budget had been prepared. Would the budgetary figures be revised accordingly? If so, at the same time, some indicators on HIV/AIDS might usefully be improved.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) observed that the largest budgetary allocation was to the areas of work under consideration. Programme effectiveness, or the capacity to translate funds into health gains, was the key concern and a major challenge. Even the large amount of resources committed could never hope to meet the huge challenges of diseases such as HIV/AIDS, tuberculosis and malaria. WHO needed to work closely at country level with other development partners to attract additional funds to the Global Fund to Fight AIDS, Tuberculosis and Malaria and from other bilateral donors. In channelling huge resources into any country, a major concern was how to translate them into better health outcomes for the population. It was also necessary to ensure long-term programmatic and financial sustainability, especially in areas of work that relied heavily on extrabudgetary resources. WHO must provide for an uninterrupted flow of extrabudgetary resources beyond the 2006-2007 biennium; donor commitment over the long term was essential.

Dr BUSS (Brazil) said that, although malaria was certainly a major problem in Africa, the final version of the budget document should also take account of the extent of the disease in the Americas. The indicators currently referred only to the African countries.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the goals, objectives and indicators for the Communicable disease research area of work were aimed at the developing countries, yet only 3% of the budget was allocated to countries, as compared to the 91% allocated to headquarters. It seemed contradictory to have indicators for public health benefits in developing countries when the bulk of the budget was going to headquarters; particularly as more than 90% of voluntary contributions were allocated to headquarters. He requested clarification of that matter.

Dr SAM (Gambia) said that some 90% of the expected resources for malaria control were budgeted to come from voluntary contributions. Governing bodies had full control only over the regular budget component. If programmes were funded heavily by resources over which such bodies did not have full control, they might not be implemented, since the funds, which were not officially committed, might not be forthcoming. He asked whether the contents of the draft resolution on malaria currently being elaborated could be reflected in the final budget document to be submitted to the Health Assembly.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) said that the Epidemic alert and response area of work accorded insufficient attention to disaster preparedness. The expected results and targets needed to be better enunciated.

Dr NORDSTRÖM (Assistant Director-General) said that the HIV/AIDS area of work clearly needed to be improved to express better WHO's role and function and delineate more clearly the expected results. Similarly, the Epidemic alert and response area of work needed to be better presented, as did Emergency preparedness and response, in the light of WHO's role and experiences during the recent events, and the request from the United Nations High-Level Panel on Threats, Challenges and Change that it should be active in those areas. WHO's role within the wider United Nations system also needed to be more sharply defined. Although WHO was not a funding agency, an absorptive capacity issue arose when it provided technical support in certain countries. Dependence on voluntary contributions and the long-term sustainability of funding efforts were indeed matters for concern. The current momentum of increased investment in official development assistance for health had to be preserved and resources distributed fairly and equitably across the various efforts to address health needs.

Dr ASAMOA-BAAH (Assistant Director-General) said that the discussion showed that the Board strongly supported the spirit of the budget proposal but wished to see further work on Emergency preparedness and response and on refining of indicators. The Director-General was proposing a major budgetary increase for the communicable diseases sector following the tsunami in south Asia. WHO's work to support national authorities in promoting disaster preparedness provided further justification for the increase.

The Communicable disease research area of work might appear to be very centralized, but it also covered the work of the UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases. More than 80% of that Programme's resources were grants, most of which went to developing countries. However, it was not easy to predict, two years before the event, precisely how those grants would in due course be allocated.

Dr CHOW (Assistant Director-General), welcoming the comments and constructive criticism, said that some indicators for the three areas of HIV/AIDS, Tuberculosis and Malaria would be refined. The member for Thailand had advocated translating money into health gains: to that end, assiduous efforts were being made to promote concerted action by financial institutions, expert bodies and implementing authorities at the country and community levels. WHO was working in partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank, other United Nations specialized agencies and bilateral donors in order to promote such action.

Regarding malaria in the Americas, the next version of the budget document would make appropriate reference to regions other than Africa where malaria was endemic. As to the comment by the member for Gambia regarding extrabudgetary resources, the capacity of the Roll Back Malaria partnership to mobilize more resources was being strengthened. An important partnership under way with the Global Fund would show that WHO's input yielded heightened output in terms of prevention and treatment of malaria.

Mr AITKEN (Director, Office of the Director-General) said that an effort would be made to reflect the contents of the draft resolution on malaria in the new budget text, bearing in mind that the resolution would still need to be submitted to the Health Assembly for consideration.

Surveillance, prevention and management of chronic, noncommunicable diseases; Health promotion; Mental health and substance abuse; Tobacco; Nutrition; Health and environment; Food safety; Violence, injuries and disabilities

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand), noting the focus of those areas of work on normative action, stressed the need for a clear link between normative functions and programme activities at country level, funded from Member States' own resources or by bilateral and multilateral donors; that required more advocacy.

Dr TANGI (Tonga), said that, as those areas of work represented 57% of the disease burden in the world, the corresponding budget allocation was insufficient. He asked whether, in general, the budget figures in document PPB/2006-2007 could be changed before the Proposed programme budget was submitted to the Health Assembly.

The CHAIRMAN, speaking as the member for Iceland, said that the high priority that Member States had given to violence and injuries prevention over the past years should be properly reflected in the Proposed programme budget.

Dr BUSS (Brazil) expressed concern that the relations between WHO and UNEP, both of which dealt with health and environment matters, were not reflected in the Proposed programme budget, despite references to other organizations such as UNICEF and FAO.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) noted that the performance assessment report for 2002-2003 had indicated a lack of political will regarding funding for Tobacco: the Proposed programme budget 2006-2007 pointed to a 45% increase. She advocated a more realistic approach that balanced funding and political considerations. The indicators for Nutrition were too vague and WHO should concentrate more on identifying malnutrition and promoting healthy nutrition and diet, and less on the complex matter of setting standards on nutrition.

Ms MAFUBELU (South Africa)¹ asked whether the proposed budget allocation for Tobacco of about US\$ 29 million took into account the proposed models due to be considered at the second session of the Intergovernmental Working Group on the WHO Framework Convention on Tobacco Control.

Dr NORDSTRÖM (Assistant Director-General), replying to the member for Tonga, confirmed that the Proposed programme budget document could indeed be changed in respect of both the quality of the contents and the allocations. The Secretariat was seeking a balance between the regular budget allocations and the voluntary contributions for different areas of work, as some areas focused more on implementation within countries, calling for a larger share of voluntary contributions. Guidance from Member States on whether to increase the regular budget or make reductions in other areas would be appreciated.

Dr TANGI (Tonga) requested an increase in the budget allocation for noncommunicable diseases in view of the growing magnitude of the problem, especially in developing countries.

Dr LE GALÈS-CAMUS (Assistant Director-General) said that WHO was aware of the importance of transforming normative activities into programme actions. In collaboration with the regional advisers and country representatives, indicators had been established and expected results outlined. Any necessary modifications would be made. It would be desirable to see a significant increase in the budget allocated to the Tobacco area of work. The question of models raised by the representative of South Africa was an open issue, leaving some degree of uncertainty, but the Proposed programme budget reflected the Secretariat's concern to clarify WHO's role in that area and to keep up the pace of the Organization's activities in tobacco control. Much remained to be done with regard to nutrition indicators, and discussions were in progress with the regional offices to propose a revised version, taking into account the views and comments expressed.

Dr LEITNER (Assistant Director-General) said that turning normative activities into specific programme actions was also relevant to the area of Health and environment, and considerable efforts

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

to do so were being made with the regional and country offices. She agreed that the problem of noncommunicable diseases should be addressed urgently rather than waiting for it to grow out of proportion, and that physical environmental factors often contributed to ill health. A serious difficulty lay in adopting a sufficiently selective approach. References to UNEP and UNICEF would be included in the programme budget document. Although the Secretariat worked closely with both organizations, it should seek to be more systematic in its collaboration with partners in the United Nations system.

Reproductive health; Making pregnancy safer; Gender, women and health; Child and adolescent health; Immunization and vaccine development

Dr ANTEZANA ARANÍBAR (Bolivia) remarked on the discrepancy between the title of the programme “Reproductive health” and the phrase “reproductive and sexual health” in the first sentence of the Issues and challenges. With regard to indicators for reproductive health, the names of the countries might be included if not an indication of the relevant institutions.

Ms HALTON (Australia) expressed concern at the proposed 12% reduction for Immunization and vaccine development. In the absence of any comparison of the effects of changes in the Proposed programme budget, it was hard to comment on relative priorities. Given that the gains made in that area had been fragile, particularly in the Western Pacific Region, she was keen to see continued support for WHO’s efforts, with appropriate funding, in order to sustain those gains and strengthen health systems and practices. Despite impressive achievements in immunization, the Region remained vulnerable to vaccine-preventable diseases.

Dr HUERTA MONTALVO (Ecuador), referring back to the communicable disease areas of work, pointed out the lack of reference in the Proposed programme budget to avian influenza, which might represent a considerable health threat, and asked whether any budget allocation would be made in that area.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) requested the Director-General to examine the Immunization and vaccine development programme more closely because, in the Programme budget for 2002-2003, the emphasis had been on vaccine trials. Industry partners had done too little to lower the price of vaccines, which some developing countries simply could not afford. Concerned international entities, including UNICEF, should be asked to try to make vaccines more affordable for low-income countries.

Dr HANSEN-KOENIG (Luxembourg) shared the concerns expressed by the members for Australia and Thailand concerning Immunization and vaccine development and welcomed the proposal to organize a vaccine programme with UNICEF and other organizations. That strategy might be organized within the proposed budget provisions.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) said that Immunization and vaccine development was one of WHO’s fundamental programme areas. A comparison with the Programme budget for 2002-2003 showed that the financing of that area of work had increased considerably, yet not all the indicators under that heading had been met. He sought clarification of the fact that in the Proposed programme budget 2006-2007 only seven out of the original 10 indicators were still listed, despite the higher budget allocation. Poliomyelitis still existed in six countries, whereas the target for the end of the campaign had been to eradicate the disease completely. He asked whether that meant an increase in voluntary contributions for poliomyelitis and whether the indicators would have to be reviewed.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica), agreeing that the Immunization and vaccine development programme should be reviewed because immunization coverage was

declining, observed that the programme area was important for attainment of the Millennium Development Goals.

Dr BUSS (Brazil) shared the concern about avian influenza and asked what measures were to be taken concerning a SARS vaccine. As to the price of vaccines, the problem was how to put pressure on industries. That objective should be included in the Proposed programme budget 2006-2007 along with costing indications.

Dr SAM (Gambia) said that, although it was not WHO's role to set vaccine prices, the Organization was working hard to make them affordable. Much money was invested in research and development, after which the vaccine was manufactured and went through trials before being pronounced safe for use. The trials were conducted in developing countries on "study subjects", people without whom the vaccines could never be used. On ethical grounds, therefore, those developing countries should have a say in the cost of the vaccine. Overall, vaccine prices should come down.

The CHAIRMAN, speaking as the member for Iceland, said that his country was strongly committed to attaining the Millennium Development Goals, to which WHO should continue to give top priority. He expressed concern that there was little increase in the budget allocation for Reproductive health, an area also important for attainment of the Goals.

Mr HILMERSON (Sweden)¹ expressed support for the Proposed programme budget 2006-2007 in general but was concerned at the low budget allocation for Reproductive health. Many of the Millennium Development Goals would not be achieved unless reproductive health problems eased. He requested that that be reflected in the budget document.

Ms MIDDELHOFF (Netherlands)¹ supported the views expressed by the previous two speakers.

Dr TANGI (Tonga) agreed with the comments of the members for Australia and Thailand on immunization. Referring to the Making pregnancy safer area of work, he questioned the allocation of 17% of the total budget to headquarters when the need was for professionals taking charge of pregnant mothers at country level, in order to reduce maternal mortality.

Dr ASAMOA-BAAH (Assistant Director-General), responding to the members for Ecuador and Brazil, said that work on avian influenza would come under general work on influenza.

Mrs PHUMAPHI (Assistant Director-General), referring to questions on reproductive health, said that the phrase "reproductive and sexual health" corresponded to the definition established by the United Nations International Conference on Population Development (Cairo, 1994). An effort was being made to use proxy indicators that reflected the global targets to measure country use of reproductive and sexual health services; they did not necessarily reflect the work of WHO. It was not always easy for those targets to be met or for every country to commit itself to them. For that reason, naming countries in the programme budget was difficult, but WHO negotiated with as many countries as possible in order to be able to use country targets matching the global targets. Regarding the concern expressed about under-resourcing of that area of work, she said that not all the expected voluntary contributions had been forthcoming in the past and the prioritization of WHO's programmes by countries made it difficult to obtain more funding.

Regarding the evaluation of the outcomes of the Immunization and vaccine development programme and the justification for WHO's heavy investment in that area, the bulk of the resources

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

went to the countries themselves. The high target for global immunization had made the process even more costly, as children in remote or inaccessible areas had to be reached. Increasing coverage therefore also increased costs. She appreciated the views on the cost of vaccines for developing countries and the need for all partners involved, including WHO, to negotiate price reductions. WHO was actively engaged in that process.

The draft global immunization strategy was not included in the Proposed programme budget because it had not yet been approved by the Health Assembly. Regarding some of the indicators shown in the 2002-2003 budget but not appearing in the Proposed programme budget 2006-2007, protracted negotiations with the countries and regions during preparation of the proposed budget had resulted in some of the indicators used earlier being dropped. Even so, the relevant work had not necessarily stopped as certain functions in support of countries in vaccine development and immunization programmes would continue. Much remained to be done in revising the indicators, on which the Secretariat would be working with countries and regions. Reference had been made by the member for Brazil to the cost of advocacy and she agreed on its importance, especially with the proposed immunization strategy that would be submitted to the forthcoming Health Assembly.

There were problems in falling coverage, as the member for Jamaica had said, and attention must, on ethical grounds, go to making vaccines available to countries that had participated in vaccine trials. The Secretariat would continue to address those areas with partners. Collaboration was continuing in respect of an influenza vaccine and surveillance was being strengthened. China in particular was collaborating in the development of a SARS vaccine. In response to the question by the member for Ecuador on avian influenza, she said that, although no budget was yet available, the Secretariat was working energetically in that area.

Ms LINKINS (Polio Eradication Initiative), replying to the question by the member for the Russian Federation on poliomyelitis eradication, said that when the Proposed programme budget was originally prepared poliomyelitis was endemic in six countries. Unfortunately, during 2004, because one country endemic for the disease in Africa had stopped immunization campaigns for more than 12 months, poliovirus was imported into 11 countries, jeopardizing targets. The overall objective, nevertheless, was the complete eradication of the disease and intensified efforts in that direction would continue in 2006-2007.

The DIRECTOR-GENERAL said that, apart from the allocation of US\$ 180 million for poliomyelitis eradication, the rest of the immunization budget was US\$ 50 million higher than in the previous biennium. As the target of zero transmission of poliovirus by the end of 2005 had been set, it had not been logical to increase the poliomyelitis element in the 2006-2007 budget. The problem in Nigeria had been dealt with and the major campaigns in Africa were showing results. Clearly, there was very strong international support for poliomyelitis eradication. Over 16 years US\$ 3000 million had been spent and the end was in sight. In order to confirm that poliomyelitis had been eradicated, once viral transmission had been stopped, three years of surveillance were required. Substantial resources were therefore needed. On the question of vaccine prices, he explained that manufacturers had to recoup their research and development costs. That made new vaccines very expensive. The Global Alliance for Vaccines and Immunization could support vaccine purchases for some three to five years until the price fell; that principle had been applied to the *Haemophilus influenzae* type b and, currently, the new rotavirus vaccines. The international finance facility, supported by the Governments of the United Kingdom of Great Britain and Northern Ireland and France and to be launched shortly, was intended to raise funds on the international capital markets, and could provide a major financing mechanism for work towards attaining the Millennium Development Goals.

Mr SHUGART (Canada), referring to the question on clinical trials raised by the member for Gambia, wondered where responsibility for those issues lay in the Secretariat.

Mr CAPRON (Director, Ethics, trade, human rights and health law) replied that the coordinating responsibility for the issues lay with the department of Ethics, trade, human rights and health law,

which worked closely with the Special Programme for Research and Training in Tropical Diseases, the Special Programme of Research, Development and Research Training in Human Reproduction and the vaccine initiatives.

Essential medicines; Essential health technologies; Policy-making for health in development; Health system policies and service delivery; Human resources for health; Health financing and social protection; Health information, evidence and research policy

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) said that the Health system policies and service delivery area of work did not appear to include technical support for universal coverage or social health insurance, on which a resolution was being considered by the Board, and there needed to be some reprogramming. Considerable opportunities existed to facilitate collaboration between developing countries in health system development, owing to the similar nature, culture and historical background of their health systems. His country had already requested programme activity and a budget for World Health Day 2006, the theme of which was to be Human resources for health, as decided by resolution WHA57.19.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) said that, in the section on Human resources for health, about half the allocations were financed from voluntary contributions. The absence of many of the indicators would make it difficult to judge how far targets had been reached. With regard to strengthened leadership, he requested clarification regarding the number of staff shown in the baselines and target columns.

Ms MAFUBELU (South Africa)¹ said that the breakdown by source of financing for the area of work Human resources for health in the 2004-2005 biennium had shown a proportion of 70% from the regular budget and 30% from voluntary contributions, whereas in the Proposed programme budget 2006-2007 there was a significant shift to 53% and 47%, respectively. In addition, it was proposed to reduce the regular budget amount for the 2006-2007 biennium by around 22%. In view of the ambitious goals for that area of work adopted in resolution WHA57.19, and given the unpredictability of voluntary contributions, was the Secretariat confident that the 47% voluntary contribution would be received and would the proposed budget of US\$ 78 million, an increase of about 3%, suffice to produce the expected results, in particular to implement the resolution? Did the budget take into account the activities of World Health Day and *The world health report*, both of which would focus on human resources for health?

Dr AHMED (Ghana), stressing the importance of essential medicines for all countries, recommended that more resources should be made available at country level. He requested clarification of the statement that WHO would emphasize access to all essential medicines, with a focus on expanding access to antiretroviral agents to meet the “3 by 5” target, which he understood to be a 2005 programme.

Dr EVANS (Assistant Director-General) said that he had noted the point made by the member for Thailand on collaboration between developing countries. The social health insurance work should progress if the draft resolution were adopted. On Human resources for health, the targets identified by the member for the Russian Federation with regard to leadership related to the health leadership service, which was a priority programme of the Director-General. Funding had been received for the first group of leaders who were expected to begin their two-year service with WHO in the coming months. Ultimately, 65 fellows would be involved in the programme during the biennium. Regarding significant shifts between regular and voluntary contributions, he said that in 2004-2005 work on

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

health systems had been covered by three areas of work; in 2006-2007 it would come under five. Pointing to the decrease of US\$ 20 million in the regular budget for those areas of work in 2006-2007 compared with 2004-2005 and the expected increase of US\$ 75 million in voluntary contributions in 2006-2007, he added that considerable work would be needed to meet the challenge. The decisions relating to World Health Day and *The world health report* had come after the initial plans for the 2006-2007 biennium. Those events would therefore be reflected in the budget estimates submitted to the Health Assembly.

Dr LEPAKHIN (Assistant Director-General), replying to the member for Ghana, stressed the need to be realistic in terms of prioritizing activities and make the best use of available resources when preparing the budget. More could be done and would be done if the necessary budget resources were made available. Although more of the budget had been shifted to countries and regions, it had not yet been possible to reach the target of a 25:75 split between headquarters and the regions, because there was a higher percentage of global normative work in the area of health technology and pharmaceuticals than in other areas. Most global normative work would be very difficult to conduct at the regional level and impossible to do at the country level. The Secretariat would nevertheless continue to involve experts from all regions in that work while paying closer attention to work in countries; the Department of Technical cooperation for essential drugs and traditional medicine had been created for that purpose.

Emergency preparedness and response; WHO's core presence in countries

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) said that WHO's core presence in countries should focus on staffing levels and budget allocations for country offices in crisis countries.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) said that there seemed to be agreement that further work was required on the indicators relating to WHO country presence. The budget in that area was being increased by 25% and it was clear from the targets that there was a 25% rise in satisfaction level among WHO Representatives. He requested some more tangible information. Since, in Russian at least, "satisfactory" meant "less than good" or "passable", he suggested using a more appropriate adjective for targets.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) commented on the large increase of US\$ 45 million for WHO's core presence in countries. Needs and demands on the Organization differed widely between countries. Her country wished to see sharing among regions and countries to ensure that best practices were used and advantage taken of economies of scale and shared costs.

Dr LEITNER (Assistant Director-General), responding to the member for Thailand, said that the situation in crisis countries demanded much of WHO's attention and that the relevant country offices should probably have been singled out as needing attention from the regional offices and headquarters jointly. A common approach was needed to organizing WHO's presence at country level, which was not easy if prescriptiveness were to be avoided. An effort would be made to respond to the concern. The Director-General had stated his belief that there was room for greater United Nations system collaboration at the country level. The situation at that level might well be better than it looked from headquarters. She agreed with the member for the United States of America that collaboration should seek economies of scale, on a case-by-case basis. In reply to the member for the Russian Federation, she explained that there was a satisfaction level of around 25% among clients, namely national health ministries, with the revamped country offices; the aim was to raise that proportion to at least 75%.

Dr NABARRO (Representative of the Director-General for Health Action in Crises), responding to the member from Thailand, said that WHO was fully involved in the analyses of the

specific needs of “fragile” States being conducted by ministers and officials of the countries themselves, development banks, bilateral donors and the United Nations system. The particular importance of those needs was increasingly being recognized and an effort made to ensure that they received proper attention in any analytical work and any proposals for modified development approaches.

Dr BUSS (Brazil), referring to WHO’s presence in countries, suggested that more attention should be devoted to horizontal cooperation between WHO regions. For example, the eight lusophone countries in four regions of the world could form an important network. Relations between WHO regions should be reflected in the budget, although it was not immediately clear how that concern could be expressed in terms of indicators.

Knowledge management and information technology; Planning, resource coordination and oversight; Human resources management in WHO; Budget and financial management; Infrastructure and logistics; Governing bodies; External relations; Direction; Miscellaneous

Professor FIŠER (Czech Republic), observing that funds for the new headquarters building would presumably be drawn from the Real Estate Fund, asked whether it was planned to increase headquarters staff numbers once construction of the new headquarters building was completed.

Mr DELVALLÉE (alternate to Professor Dab, France) commended the remarkable progress made in the presentation of the budget. Further progress could be made in terms of the indicators and the amount of detail provided, not only to justify WHO’s requirements, but above all to help Members to negotiate the terms of the budget with their respective finance ministries. Two examples were Miscellaneous income and exchange-rate hedging mechanisms, both of which were important indicators of an organization’s cash-flow management. It would be interesting to have figures on them in the next version of the Proposed programme budget.

France had already referred to the need to decide which costs must be covered by the regular budget. For instance, two-thirds of the budget for staff security came from voluntary contributions, an enormous proportion for an area that had been discussed at great length by the United Nations General Assembly before being made a budget priority for each United Nations body, including WHO. It was essential that staff security should come under the regular budget.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) noted that there would be a decrease in Miscellaneous income in the 2006-2007 biennium. WHO should explore other creative financing mechanisms, such as endowment funding, to augment the regular budget.

Dr ANTEZANA ARANÍBAR (Bolivia), referring to the area of work Human resources management in WHO, said that those resources were the knowledge, skills and intelligence of the Organization’s personnel. How they were managed could therefore spell the difference between the success or failure of a task. The indicator under WHO objectives for Human resources management in WHO was “operational excellence in the timely delivery of high-quality human resources services at headquarters and in regional and country offices”, yet only 1% of the budget was assigned to the country level. Did that mean that all WHO staff in the country knew all they had to know and needed no further training, or that funds for that purpose were transferred from headquarters to the country? Also, there was no regular budget allocation at the country level, and all funds would come exclusively from voluntary contributions.

Dr NORDSTRÖM (Assistant Director-General), responding to the question about the new headquarters building, said that a loan from the Swiss Government would be repaid at the rate of 1 million Swiss francs per year for the next 50 years. There would be no increase in headquarters staff; quite the contrary: in view of the budget situation, the number of staff was more likely to fall. Staff

working offsite would return to the main building and some of the temporary buildings would be removed.

The request from the member for France for more detailed figures would be followed up separately.

Security was a major concern for WHO, which had actively supported the Secretary-General's suggestion for improved security measures for all staff of United Nations bodies and for a move away from the current cost-sharing mechanism. Because that suggestion had not been approved by the General Assembly, security costs for WHO had increased by US\$ 3.5 million for the current biennium and would increase substantially in the next biennium as well. The voluntary contributions were in fact drawn from the programme support costs and therefore only partly took the form of direct voluntary contributions. WHO was exploring new mechanisms and possibilities for resource mobilization and new funding modalities. With regard to the question by the member for Bolivia, the indicators listed in the budget reflected WHO's strong commitment to human resources management, and the figure of 1% reflected the costs of that management; the administration costs of managing human resources in countries were covered under the "WHO's core presence in countries" area of work.

The CHAIRMAN recalled that, under Article 55 of the Constitution, the Director-General prepared and submitted to the Board the budget estimates of the Organization, and the Board considered and submitted to the Health Assembly those estimates with any recommendations that it might deem advisable. He suggested that the Board should request the Director-General to take its comments and views in to account in any revision of the budget that he intended to submit to the Health Assembly. The only contentious issue appeared to be the amount of the increase: 11 members appeared to be in favour of the 9% increase, others were in favour of a smaller increase and one was opposed to any increase. He asked whether the Board could agree to the use of words such as "appropriate" or "reasonable" in respect of the budget.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) asked for clarification of the Chairman's understanding of the procedure that the Board was being invited to follow.

Ms HALTON (Australia) pointed out that the Board was not adopting a budget for submission to the Health Assembly. The essence of the debate was that members could not agree whether there should be an increase. It was up to the Director-General to undertake the difficult task of incorporating members' comments into the Proposed programme budget for submission to the Health Assembly. It was not for the Board to seek consensus on an acceptable form of words.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) said that it was his impression that most members were in favour of abandoning the status quo but had been unable to agree on a figure. There was still time for further consultation before the close of the session.

Dr CAMARA (Guinea) observed that many members had stressed that few resources were allocated to areas such as Immunization and vaccine development and Essential medicines, and to work towards the Millennium Development Goals. That amounted to a tacit plea for more resources, particularly in the absence of any proposal to the contrary. Perhaps the Board could recommend that the programme budget should be increased but that the amount of the increase should be left to the discretion of the Health Assembly.

Mr SHUGART (Canada) said that, given the variety of comments on the budget, including those contained in the report of the Programme, Budget and Administration Committee, the Director-General needed more time to refine the proposal. It would be impossible for the Board to come up with an appropriate figure in the time available. Furthermore, it was traditional for the Director-General to submit the budget to the Health Assembly. The Board should stand ready to assist the Director-General in that task.

Dr TANGI (Tonga), while endorsing Australia's view, also recalled the provisions of Article 55 of the Constitution; the Director-General would have to prepare another proposal for consideration by the Board.

Mr TOPPING (Legal Counsel) said that Article 55 of the Constitution was to be construed to mean that the Board did not revise the budget, but transmitted the Director-General's budget to the Health Assembly, together with any recommendations it deemed advisable. In recent bienniums, the Board had submitted not a single recommendation but rather a consolidation of the various views expressed. The Health Assembly had not considered that Article 55 prevented the Director-General from preparing a revised budget on the basis of those recommendations, a procedure set forth in Financial Regulation 3.8.

Dr ABDULLA (Sudan) said that there was no need to agree on an exact figure at the current stage of the budget approval process. Most members had been in favour of an increase. The Director-General should be given the opportunity to consult Board members on the amount of the increase, in order to be able to submit an exact figure to the Health Assembly.

Dr BRUNET (alternate to Professor Dab, France) said that no member had objected to the way in which the budget had been calculated in the light of the priorities set by the Secretariat. The disagreements expressed concerned the amount of any increase. The Director-General should therefore submit to the Health Assembly a budget revised in the light of the Board's deliberations. The Board would fulfil its mandate by informing the Health Assembly that it agreed with the calculations made for the budget but that priorities might have to be redefined if the Health Assembly decided to reduce the budget.

The CHAIRMAN pointed out that Article 55 of the Constitution did not oblige the Board to make a recommendation to the Health Assembly. If there was no consensus, it should make no recommendation.

Dr TANGI (Tonga) said that the best course was for the Secretariat to collate members' comments into a recommendation from the Board to the Health Assembly.

Dr BUSS (Brazil) said that, although account could be taken of objections to the 9% increase, it was difficult to agree on overall resource allocations in the absence of precise ideas on how much should go to particular programmes. The Board should first decide whether a budget increase was needed and, secondly, make more specific suggestions regarding allocations.

The CHAIRMAN suggested that the Board should either leave the item open and seek a consensual form of words or let the Director-General submit the budget to the Health Assembly without any comments.

Dr HUERTA MONTALVO (Ecuador) said that it was not for the Board to quantify any increase, but rather to decide whether the budget met the requirements for guaranteeing adequate health for all. On the question of the amount of allocations to headquarters, the Director-General had ably defended his position with a reminder that he was the Director-General not only of headquarters but of the entire Organization, and that much of the headquarters allocation was ultimately used to provide support for countries and regions. Since some important areas, like avian influenza, lacked any budget provision, there would be grounds for discussing further increases.

The DIRECTOR-GENERAL, noting the importance of incorporating the outcome of the day's discussion of the budget level, said that he would engage in dialogue with Board members and Member States and hoped to arrive at an understanding of what represented an acceptable level, which was a political decision. At the Health Assembly, Member States would express their views and,

failing agreement, the figures would have to be adjusted. One solution was to rely on expected extrabudgetary income, but it would be preferable to shift the burden from just a few to all countries through contributions to the regular budget.

The CHAIRMAN proposed closing the debate on the understanding that the Director-General would proceed as just indicated.

It was so agreed.

The meeting rose at 19:10.

TENTH MEETING

Saturday, 22 January 2005, at 09:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

1. PROGRAMME AND BUDGET MATTERS: Item 5 of the Agenda (continued)

Guiding principles for strategic resource allocations: Item 5.3 of the Agenda (Documents EB115/14 and EB115/INF.DOC./7)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, drew attention to paragraphs 51-54 of document EB115/45, which set out the Committee's observations on the guiding principles. The Committee had welcomed the approach taken to set strategic resource allocation within the broader context of the results-based management framework, while recognizing the challenge of aligning detailed allocations with strategic objectives. It had recommended that the consultative process with Member States should continue, and that a new draft should be submitted to the Board at its 116th session.

Speaking as the member for Maldives and also on behalf of the members for Nepal and Thailand, he said that the South-East Asia Region was the only one to have established a formal mechanism for the consultative process foreseen in decision WHA57(10). A regional working group, in which all 11 countries of the Region were represented, had met three times to review the previous allocation model based on UNDP's human development index and examine the guiding principles proposed. There had been consensus on the approach that WHO should take in the future allocation of budget resources among regions. Moreover, there had been a high degree of consistency between the guiding principles set out in document EB115/INF.DOC./7 and the recommendations of the working group, namely that a transparent and collegiate consultative process between headquarters and the regions would be a key element of the guiding principles; that the outcome of simulations through a model or mechanism would strengthen the collaborative decision-making process; that such a model or mechanism should be based on the health needs of countries or regions, socioeconomic status and disease burden; that the breakdown of regional resources between countries would continue to be decided by regions, based on overall Organization-wide benchmarks; and that further consultations should be foreseen for the next session of the Board.

Views had diverged about the stage at which an objective, needs-based model or mechanism should be applied in the allocation process. The working group had considered that WHO's strategic planning process would not necessarily be able to reflect competing health needs in various regions. For that reason, it would be preferable for a broad allocation between regions to be made on the basis of health indicators and technical needs, taking into account the guiding principle of a collegiate consultative process, before a more detailed allocation to areas of work according to a results-based framework and the principles set out in document EB115/INF.DOC./7. It did not really matter whether a model was applied at the beginning or end of the process, provided that the results were fed into the next consultation loop. He was confident that it would be possible to avoid a divisive debate on the issue, particularly as the new allocation principles would not take effect until the biennium 2008-2009.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the comments and recommendations made on the guiding principles for resource allocation during the general discussion of the budget should be included in the new draft to be submitted to the Board at its 116th session to ensure that all Member States were able to participate in what was termed the global management process, and have their various needs and priorities reflected in the guiding principles eventually adopted.

Dr THINLEY (Bhutan)¹ recalled that the countries of the South-East Asia Region agreed that resource allocation should be based on technical and health needs, and results-based management. Those needs should be identified using objective and internationally accepted indicators, such as disease burden, health-related Millennium Development Goal indicators, poverty, education and access to essential health-care services. The earlier model based on the human development index no longer sufficed. Although the guiding principles proposed by the Secretariat took into account many concerns of Member States, the results-based budget and management framework appeared to be the mainstay for resource allocation, with health needs a secondary consideration.

The strategic resource allocation policy did not accurately reflect the competing health needs in the regions. Some countries did not have the capacity to identify requirements and develop plans, and their actual needs might not be reflected in the strategic programme on which resource allocation was to be based, while others did not have the appropriate means to implement and monitor plans. Since resource allocation would also take into account performance, countries lacking such capacity might be caught in a vicious circle. In order to address the issues of equity, efficiency and performance, and to support countries in greatest need, it would be preferable to allocate the resources available only after the health needs of countries and regions had been identified and appropriate strategic plans drawn up.

Ms MAFUBELU (South Africa),¹ speaking on behalf of the African group, said that its members had always argued for guiding principles that took account of factors such as level of development, the needs of the least developed countries, the state of health systems and the Region's disproportionate share of the global burden of disease. The proposed guiding principles focused sharply on performance, an indicator that was difficult to measure; although important, it should not overshadow other principles such as equity, efficiency and support to countries in greatest need. Health systems in Africa were often weak, even nonexistent, and might therefore be deemed to be performing badly, putting some countries at a disadvantage. In developing the guiding principles, the needs of the least developed countries must be taken into account.

The CHAIRMAN said that he took it that the recommendations of the Programme, Budget and Administration Committee that the Secretariat should continue the consultation process with Member States and that a new draft should be submitted to the Board at its 116th session were acceptable.

It was so agreed.

General Programme of Work 2006-2015: review of process and draft outline: Item 5.4 of the Agenda (Document EB115/15)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had discussed the General Programme of Work 2006-2015: review of process and draft outline, and its conclusions were to be found in paragraphs 3-6 of document EB115/45. The Committee had welcomed the new scope of the General Programme, noting the importance of having a document outlining the future of public health, defining a global health agenda and clarifying the role of WHO and other actors. It had made numerous comments on the outline, including the positioning of health, emphasis on well-being rather than on health, partnerships and the increased role of civil society, and the need for WHO to build on its strengths, and had suggested that the title of the General Programme should relate to partnerships in health in an interdependent and globalized world. Input from Member States and partners would be essential in preparing the next phase of the General Programme.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Dr BUSS (Brazil) said that the draft outline in document EB115/15 of the direction WHO might follow in the period 2006-2015 was of prime interest to policy-makers, whom it would assist in health planning. The Board must be given clear information on what was planned, as the Eleventh General Programme of Work was designed to cover a 10-year period and would have to deal with a wide range of health issues, from the general, such as the effects of environmental degradation, to the particular, such as immunization programmes. There would be need to work together with other United Nations organizations. More details of the process proposed were needed, notably concerning the consultations at regional level that were due to take place during February and March 2005. Board members needed adequate information on the process at the current stage to enable them to assess its results in the course of the year with a view to submitting a proposal to the Fifty-ninth World Health Assembly in May 2006.

Dr HUERTA MONTALVO (Ecuador) said that, although it was accepted that health and development were closely linked, the budget was defined solely in terms of health. WHO should align itself with the Millennium Development Goals, which linked health to poverty and the environment, and ensure that the development factor was incorporated. It was not clear how the Proposed programme budget 2006-2007 would tie in with the General Programme of Work 2006-2015. The Board should be given more advance information on the schedule for the regional consultations.

He noted the absence of conclusions in the document and took it that as soon as any were reached they would be submitted to Member States for comment.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) welcomed the involvement of Member States in formulating the General Programme of Work which in turn enabled them to adjust their own health systems' development to meet future challenges. Estimates of total resource requirements and the potential resource availability should be made in order to identify resource gaps and alert development partners and countries to the need for appropriate action. He supported the draft outline; his country wished to be fully involved in the drafting process.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) commended the comprehensive nature of the General Programme of Work 2006-2015, which set out not only the work of the Organization, but also the objectives of various areas of work. He had been pleased to note that a task force composed of staff from headquarters and regional offices was assisting in the process of preparing the General Programme, and that external consultants, academics and other experts had also been involved. The recommendations of the regional committees to improve approaches to drawing up the General Programme and planning its strategic directions had also been taken into account.

In keeping with the practice followed in other United Nations agencies, the General Programme of Work should contain criteria and mechanisms for monitoring and evaluating the effectiveness of measures taken and programmes implemented at the global, regional and country levels, mechanisms which should involve nongovernmental and civil society organizations and the private sector. He drew attention to the importance of determining time frames for implementing the results of the evaluations and suggested a time frame of two years, in order to reflect the budget cycle.

He endorsed the draft outline contained in document EB115/15.

Dr STEIGER (United States of America) said that in its final form the General Programme of Work should be consistent with previous corporate strategies and plans already adopted. The corporate strategy and core functions approved by the Fifty-second World Health Assembly remained valid, and should be retained as the basis for the Eleventh General Programme. The draft outline contained many vague expressions; the language needed to be more precise to avoid conflicting interpretations.

At the core of the General Programme of Work lay the need for WHO clearly to identify its role and comparative advantage within the United Nations system. There was still too much overlap between the different agencies connected with health. The different scenarios presented in paragraph 9 were confusing and might even jeopardize the success of the programme: thus, the third scenario, based on market-driven approaches, and the fourth scenario, based on multilateral cooperation, were

not mutually exclusive. He concurred with the member for Ecuador that the General Programme of Work should focus on the Millennium Development Goals, and notably on the internationally agreed health-related goals of the Millennium Declaration. WHO had to be careful not to commit itself to trying to solve all the world's problems, and should guard against the tendency to become involved in headline news stories merely to demonstrate that it remained relevant; it should rather focus on its core mandate.

He strongly endorsed the emphasis by the member for the Russian Federation on the importance of monitoring and evaluation, because it was not clear to what extent the objectives set in the previous General Programme of Work had been achieved. He also supported the calls for more detailed information on the consultation process to be provided well in advance of the Fifty-ninth World Health Assembly.

Mr SHUGART (Canada) said that the report gave a clear picture of the process so far and was a good basis for future work. The Secretariat should continue to focus on areas it was familiar with, while becoming fully involved in the consultative process. By monitoring progress in attaining targets and making the necessary adjustments to new circumstances, WHO would be able to stay focused on its priorities.

Whatever the final draft of the General Programme of Work might contain, it should support and reinforce the Millennium Development Goals. In an increasingly complex global situation, WHO should continue to maximize its potential as a knowledge-based, technical organization, while developing partnerships in which its presence contributed added value.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho) welcomed the outlined direction of the General Programme of Work, but said that it should reflect some of the outcomes of work already done in the African Region. The consultation process needed to involve regions, countries and other stakeholders in health and the private sector, in order to build internal capacity and ensure the success of the Programme. Political and social instability and poverty might usefully be included as key challenges in Chapter 3. Another important area for consideration was the need to strengthen health information systems as a prerequisite for scenario modelling, which depended on reliable data. He supported previous speakers on the importance of establishing effective systems of monitoring and evaluation, and agreed that the process had to be adaptable and responsive to changing situations.

Dr TANGI (Tonga) emphasized reliable, independent monitoring and evaluation at every level in the reform process.

Ms MAFUBELU (South Africa)¹ strongly endorsed the views expressed by the member for Lesotho. Referring to paragraph 11 on the consultations that would be held in February and March 2005, she wondered how the views of the Health Assembly would be obtained, as the item was not on the provisional agenda of the Fifty-eighth World Health Assembly. That omission should be rectified.

Dr NORDSTRÖM (Assistant Director-General) confirmed that in preparing the Eleventh General Programme of Work the Secretariat had built on the corporate strategy and core functions of the previous Programme, modified or updated where necessary. The outcomes of other processes, such as work towards the Millennium Development Goals, the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004), and the work of the Commission on Social Determinants of Health, would also be incorporated into the process. The relevant literature would also be reviewed in order to take account of the current state of knowledge.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

The health scenarios presented were not intended to be mutually exclusive; their purpose was to trigger discussion. In the current complex environment there was increasing recognition of the interdependence of the traditional health and other sectors, and that the latter could contribute to improving the underlying determinants of health. The work of the Commission on Social Determinants of Health would facilitate progress in that direction. The methods used to develop the scenarios could be applied for other purposes. A more precise definition of the role of WHO would be an important outcome of the process, since the Organization's working relationship with its partners had changed dramatically over the past 10 years.

The link between the long-term vision, as expressed in the General Programme of Work, and the strategic allocation of resources would be provided by a proposed organization-wide strategic plan, discussed under the previous agenda subitem, that would provide direction to WHO over five or six years instead of the current two years. A new draft of the guiding principles and approach to the proposed strategic plan would be submitted to the Board at its 116th session.

It was important to ensure that internal monitoring and evaluation systems were strengthened, and that systems were in place to monitor the progress made in implementing the General Programme of Work and to identify more precisely the role of WHO. The Secretariat made a clear distinction between monitoring and evaluation; the former being an internal exercise, and the latter an external one in order to ensure independent performance assessment.

Regional consultations on the preparation of the General Programme would take place in the regions in February, March and April 2005, starting in the Region of the Americas. It had initially been planned to hold informal technical discussions during the Fifty-eighth World Health Assembly, but consideration was being given to the Board's view that it would be more appropriate to include the item on the agenda of the Health Assembly to allow an open discussion involving all Member States. The outcome of subsequent discussions by the regional committees would be submitted to the Fifty-ninth World Health Assembly. Further consultations were being considered, including meetings with other organizations of the United Nations system, banks, private sector entities, civil society organizations and academia. He invited Member States to submit further views and ideas concerning the consultative process, and urged them to participate in the extensive work involved in the exercise in view of the limited resources available at headquarters for that purpose. The consultation schedule would be put on the WHO web site as soon as possible.

Dr LOPEZ ACUÑA (Director of Program Management, Regional Office for the Americas) said that the General Programme of Work had been and would continue to be on the agendas of his Region's committees. The regional consultations were also being linked to the deliberations of the Working Group on PAHO in the 21st Century, an intergovernmental working group mandated by the Regional Committee for the Americas. The meeting, to be held from 14 to 16 February 2005, with the participation of all the Member States of the Region and all relevant stakeholders, would consider the latest draft of the General Programme. Other topics for discussion would be the comparative advantage of WHO in the United Nations system, the relevance of recent recommendations, such as those contained in the report of the United Nations Secretary-General's High-Level Panel on Threats, Challenges and Changes, and the bearing that the Rome Declaration on Harmonization had on the consultations. The relevance and importance of WHO's contribution to the attainment of the Millennium Development Goals would also be discussed.

The CHAIRMAN said that he took it that the Board wished to take note of the report contained in document EB115/15, the contents of the report of the Programme, Budget and Administration Committee of the Executive Board and the timetable.

It was so agreed.

Real Estate Fund: Item 5.5 of the Agenda (Document EB115/41)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the conclusions of the Committee's discussions on the Real Estate Fund were set out in paragraphs 55-59 of its report (document EB115/45).

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) said that the question of security of premises was on the agenda of many specialized agencies of the United Nations system, and asked why that was not the case for the Executive Board. He requested that the sums being spent on WHO premises in order to provide a minimum level of security should be reflected separately in the budget so that the financing of security measures could be discussed further.

Dr NORDSTRÖM (Assistant Director-General) replied that WHO had been closely involved in the discussions held in the United Nations General Assembly on the management and strengthening of security. The revised version of the Proposed programme budget 2006-2007 would indicate more clearly the increases in security costs in relation to premises, including headquarters, and to staff.

Dr STEIGER (United States of America) asked whether there were any plans to amalgamate the office of the Regional Office for Africa in Harare and that in Brazzaville into a single site.

The CHAIRMAN replied that the Secretariat would answer that question at a later date.

Decision: The Executive Board, having considered the report of the Director-General on the proposed programme budget for the financial period 2006-2007: Real Estate Fund¹ and the report of the first meeting of the Programme, Budget and Administration Committee of the Executive Board,² decided to request the Director-General to report on progress made on elaboration of a 10-year capital master plan and development of a long-term mechanism for the financing of this plan to the Board at its 117th session.³

The CHAIRMAN said that he took it that the Board wished the Programme, Budget and Administration Committee to review at its second meeting, to be held immediately before the Fifty-eighth World Health Assembly, the proposals for construction projects at locations in countries of the Eastern Mediterranean Region, and report directly to the Health Assembly thereon. He also took it that, in accordance with the proposal of the member for the Russian Federation, the Board wished the Secretariat to prepare a report on the security of those premises.

It was so agreed.

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

eHealth: Item 4.13 of the Agenda (Document EB115/39)

Dr BUSS (Brazil) fully supported the draft strategy for eHealth, which was of considerable significance for the development of health systems and would benefit health professionals. In many countries, health professionals worked in isolated areas and had no access to information and communication technologies or to training in their use for public-health purposes. He urged the Board

¹ Document EB115/41.

² Document EB115/45.

³ Decision EB115(10).

to support the initiative and to request the Director-General to continue to work on the strategy. He also urged it to support the ePort initiative, a project within the framework of eHealth designed to benefit lusophone countries in four regions, which together had a population of more than 220 million, with the aim of promoting information exchange between Portuguese-speaking health professionals. Participation in the project would provide valuable early experience of the overall eHealth strategy.

Dr AL-SAIF (alternate to Dr Al-Jarallah, Kuwait), supporting the draft resolution, said that eHealth would strengthen health systems, facilitate the provision of health care, and help to control epidemics throughout the world. A mechanism such as the Health Academy, launched by WHO in 2003, and soon to be extended to the regions, would also improve health care and health development.

Mrs IORDACHE (alternate to Professor Cinteza, Romania) strongly supported the draft resolution as it marked the beginning of an important process of innovation and partnership among countries. Access to information had taken on new importance with the emergence of the Internet as a basic tool for learning, and it was essential that the technology should be available to everyone, regardless of race, gender, income or age. Information and communication technologies would bring about fundamental changes in all aspects of health, leading to a more citizen-centred, personalized health-delivery system.

The Health Academy was an innovative approach to improving health through technology and a model for a new method of working in the information society era, linking ministries of health, education and technology in a partnership aimed at achieving Target 18 of the Millennium Development Goals.

Romania shared WHO's vision of eHealth and recognized the importance of its decision to play a leading role in that area. A global eHealth strategy would benefit both low- and high-income countries, for many countries would offer support in promoting the Health Academy within the framework of eLearning at the national level, in association with international partners. She urged that eHealth should be a regular item on the agendas of the Executive Board and of the Health Assembly as a means of ensuring good access to information and regular opportunities to monitor and evaluate progress.

Dr QI Qingdong (alternate to Dr Yin Li, China) agreed that information technology should be used to enhance the quality and effectiveness of health services. All countries should strive, in accordance with their respective levels of information technology use, to prepare and promote eHealth strategies. To help to control the spread of communicable diseases in particular, he proposed the addition of a new subparagraph in paragraph 1 of the draft resolution, that would read: "to consider establishing and implementing national public health information systems and to improve, by means of information, the capacity for the surveillance of and rapid response to, disease and public health emergencies". Furthermore, in the interests of standardizing health information, he proposed an additional subparagraph in paragraph 2, that would read: "to promote the development, application and management of standards of health information, collect and collate available information and its standards with a view to establishing progressively a globally standardized health information system".

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that the rapid growth and spread of information and communication technologies, and the broadening access to them, as reflected in the Millennium Development Goals, offered unlimited prospects for the development of public health services and exchange of information, penetrating even the remotest areas, and for the promotion of epidemiological surveillance. As a result, the effectiveness and efficacy of medical care were being speedily enhanced. He supported the amendments proposed by the member for China and further proposed that, in paragraph 2(3) of the draft resolution, the words "and best practices" should be followed by "in particular where telemedicine technology is required".

The technology in question might be costly, and he asked for information in that regard.

Dr KHALFAN (alternate to Dr Abdul Wahab, Bahrain) said that the application of information and communication technologies to public health strategy opened up great horizons, but would require much investment both in human resources and in equipment and technology. WHO should contribute by making its own experience and information available. The requirements would include an expanded database and software; in addition, relevant periodicals and other information sources should be made available on the Internet.

Dr STEIGER (United States of America) said that, although the draft strategy was a good first step in helping countries to provide better health care, a more focused approach was needed so as to avoid the risk of dissipating the Secretariat's resources. What method would be used for setting priorities, since the Secretariat could not become involved in every aspect, and what did "safe and reliable applications" mean? At the 112th session of the Board he had opposed the idea of WHO managing a ".health" Internet domain, endorsing health information outlets or defining health technologies. It seemed premature and pre-emptory for WHO to set technological norms and standards; many countries had their own standard-setting processes, and other international bodies, such as the International Organization for Standardization, had a mandate for setting technology standards; the ultimate arbiters would be consumers and the marketplace. For those reasons, not to mention that of cost, he could not support China's proposed amendment. Also, it was not clear what the nature, purpose, scope of activity and resource implications of a global eHealth observatory would be. There, too, care must be taken not to duplicate activities already being undertaken elsewhere in the Organization.

In the draft resolution, he proposed that the words "governance, finance, education," and "economic" should be deleted from the second preambular paragraph. The third preambular paragraph should end with the words "for health", and the rest should be deleted. In the fifth preambular paragraph, the words "developing both eHealth policies internationally and" should be deleted; the last preambular paragraph should be deleted in its entirety. In paragraph 1(2), the word "ensure" should be replaced by "promote"; in paragraph 1(4), the words "while guaranteeing maintenance of" should be replaced by "to improve"; and in paragraph 1(8), the word "individualized" should be deleted.

Ms HALTON (Australia) agreed with the previous speaker that, although WHO should take an interest in the development of information and communication technologies for health strategies, its approach should be cautious. Experience in Australia had shown that, even at the national level, the preparation of norms, standards and particularly guidelines could be both controversial and complicated. Therefore, and with the budgetary aspects in mind, it was difficult to see what key role WHO would assume, how activities would be delimited and how they would be paid for. Every country should, of course, recognize and develop its own potential, which meant that WHO should take care to confine its activity to areas where its own role was unique.

Mr SHUGART (Canada) said that the Secretariat could be helpful in the field of information and communication technology for health strategies, provided that its activities were focused. It was important, particularly at the outset, to avoid exacerbating the problem of resources. WHO's services could always be expanded at a later stage, if suitable opportunities came to light, but such a step would need to be viewed in the context of budgetary appraisal.

Dr ACHARYA (Nepal) said that eHealth was of the utmost interest to Member States such as Nepal, where communications were poor and the terrain difficult. Full technical support should be given to countries where necessary, for the speediest possible development of the relevant policies and strategies.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) welcomed the proposed establishment of a global eHealth observatory, but expressed concern about the implications of the draft resolution for developing countries in particular, given the need for a well-established infrastructure and skilled personnel. He therefore proposed that the words "which include appropriate

legal framework and infrastructure as well as encouraging public and private partnership” should be added at the end of subparagraph 1(1), and that subparagraphs 1(2), 1(3) and 1(6) should be deleted. Subparagraphs 1(7) and 1(8) should be merged to form a single subparagraph that would read “to mobilize multisectoral collaborations for determining evidence-based eHealth standards and norms and to evaluate eHealth activities to share the knowledge of cost-effective models thus ensuring quality, safety and ethical standards”. He supported the rest of the text as it stood.

Dr AHMED (Ghana) said that, having developed a policy on information and communication technologies, Ghana welcomed the potential advantages to developing countries in areas such as the sharing of health information and the cost-effective provision of health care in remote areas, and the opportunities for training in the skills that many developing countries lacked. WHO should nevertheless take account of the differing levels of national development. He requested clarification of the term “speak with one voice” as a component of the strategy.

Dr BRUNET (alternate to Professor Dab, France) broadly concurred with the members for Australia, Canada and the United States of America and acknowledged the needs of the less well-resourced countries and their call for WHO support. For that reason the draft resolution required considerable amendment.

Experience in the European Union had shown that, after a spectacular start, targets had had to be scaled back because Member States had found it hard to harmonize standards against a backdrop of rapidly changing market forces on the one hand and peoples’ expectations on the other. Political initiatives had often been overtaken by developments. Hence his country also favoured a cautious approach. It was likewise sceptical about the need for a global eHealth observatory and was uncertain what role it would play, especially as other bodies were already active in the fields of standard setting, methodology, product and service evaluation and the promotion of research and development. Moreover, while the question of cost effectiveness was important, the report had somewhat underestimated the aspect of patients’ expectations. The Secretariat should therefore pursue consultations on the subject with a view to determining the added value of each component, ensuring complementarity of goals and activities and clarifying coordination mechanisms. In addition, efforts should be made to establish partnerships with the private sector and to clarify the responsibilities of potential providers of funds. Therefore, while WHO should remain highly involved in that field, it should be wary about devising tools that exceeded its capacity. All countries should display equal moderation when contemplating the budgetary implications of resolutions dealing with subjects that were not, perhaps, one of WHO’s main priorities, and which might add greatly to its workload.

Dr TANGI (Tonga) said that over the years the small island developing states in the Pacific had experimented with telemedicine and eHealth and had been advised by experts to develop tools in accordance with their needs, but no help had ever been forthcoming. Ultimately WHO and the Government of Japan had assisted in the establishment of an information network. Unaware of the latest standards, those States welcomed such support and trusted that it would continue.

Dr SÁ NOGUEIRA (Guinea-Bissau) said that given the important role that information technology and the Internet could play in the strengthening of health personnel, he supported the draft resolution. Guinea-Bissau would be interested in sharing the benefits of cooperation programmes that might be established in that area. However, WHO would need to take into account questions of accessibility and the languages used for communication in order to ensure that such programmes were widely used. He therefore proposed amending the draft resolution by inserting a new subparagraph in paragraph 2 to read “to support regional and interregional eHealth initiatives or the eHealth initiatives of groups of countries that share a common language”.

Dr YOOSUF (Maldives) said that scope for use of eHealth in health-care delivery was broad and rapidly expanding. However, if eHealth and eLearning were to be successful and have equitable distribution, the Secretariat would need to collaborate with Member States, international

telecommunication organizations and the private sector to seek a reduction in costs, especially in developing countries where there was often only a single service provider.

Information technology was already widely used within traditional WHO activities, such as disease surveillance, research and data management, health education and in-service training. Maldives was using information technology in several ways, for example, to access public health web sites, including those of WHO, during public health emergencies, to hold national telephone conferences to educate staff and the general public, and to give advice and support in the area of clinical management to health professionals in peripheral hospitals. Further development of such services was limited by the cost of telecommunications.

He supported the draft resolution with the amendments proposed by the member for Thailand but further proposed the insertion of a new subparagraph in paragraph 1 to read: “to work with international telecommunication agencies and other partners to strive to bring down the telecommunication cost to make eHealth successful”.

The CHAIRMAN, speaking as the member for Iceland, said that, although eHealth was already having a substantial impact on health systems by making services more efficient and improving access to care in some countries, many parts of the world had little possibility of using eHealth technologies. The eHealth strategy should concentrate on equity and quality and be based on the principles of the Charter of the United Nations. The Secretariat should also focus on providing Member States with support in establishing safe and reliable eHealth applications. The proposed global eHealth observatory could play a vital role in that process, but it should be established in close cooperation with the private sector. His country supported the draft resolution and many of the proposed amendments.

Dr BEHBEHANI (Assistant Director-General) said that account would be taken of the views expressed. eHealth was likely to expand exponentially and would involve the use of new technologies. A committee representing UNAIDS and all levels of the Organization had therefore been set up in order to examine how Member States’ requirements could best be met. Regional meetings had been held to consider countries’ recommendations. The aim was to produce a plan of action before May 2005.

Dr EVANS (Assistant Director-General), recognizing the complexity of the area, said that the eHealth strategy was still in its early stages, but there was an increasing demand from constituents for guidelines and advice. The strategy would continue to evolve dynamically. The global eHealth observatory would not be a building, but a network modelled on observatories already operating in the Region of the Americas in the area of human resources for health, and in the European Region in the area of health systems in transition. Such networks synthesized the experiences of collaborative institutions in their regions; they were not heavily resource-intensive, but offered great benefits in terms of guidance and advice to Member States.

In terms of the benefits of eHealth, there were significant opportunities for cost savings in the area of human resources for health, where dramatic shortages meant that more staff had to be quickly trained. Tapping the possibility of distance learning and telemedicine would make it possible to ease other bottlenecks and constraints.

Dr LEPAKHIN (Assistant Director-General) added that, in the field of health-care delivery, teleconsultations reduced patients’ travel costs, eliminated unnecessary referrals and improved access to services. The savings achieved by teleconsultations depended on geographical factors and patient numbers. Furthermore, patients from remote areas could receive otherwise unobtainable specialist advice through teleconsultations; in the aftermath of the recent tsunami, primary health-care doctors in the affected areas were having to treat patients who would normally have been referred to specialist medical services which no longer existed. One of WHO’s practical responses to that situation was to offer an eHospital project, run in cooperation with the European Space Agency and the World Bank. As part of that project, laptop computers with electronic health records would be supplied to 50 relief

and medium-term primary health-care centres in the stricken areas, providing Internet and e-mail access in order to support communication and relief coordination, and to maintain contact with networks of medical specialists and consultation services that could supply online and offline advice on communicable diseases, paediatrics, obstetrics, dermatology, injuries and psychiatry. The cost would depend on how the project was organized. Many partners were supplying their services practically free of charge. eHealth would contribute to the discovery of ways of helping people and countries in the most cost-effective manner.

The DIRECTOR-GENERAL said that, although eHealth clearly offered many benefits, it was plain that a more focused approach was needed and that Member States would have to be more closely consulted.

The CHAIRMAN said that a new paper would be prepared, incorporating the suggested amendments and that the agenda item would be reconsidered at a later meeting.

It was so agreed.

(For adoption of the resolution, see summary record of the twelfth meeting, section 7.)

Rational use of medicines by prescribers and patients: Item 4.14 of the Agenda (Document EB115/40)

The CHAIRMAN invited the Board to consider the report contained in document EB115/40. Speaking as the member for Iceland, he drew attention to a draft resolution, originally drawn up by the Nordic countries, and submitted by his own country and by Austria, Canada, China, Cyprus, Czech Republic, Denmark, Ecuador, Finland, Gabon, Germany, Ghana, Guinea, Hungary, Ireland, Jamaica, Kenya, Kuwait, Lesotho, Libyan Arab Jamahiriya, Lithuania, Luxembourg, Maldives, Nepal, Netherlands, Norway, Pakistan, Romania, Sweden, Switzerland, Thailand, Tonga, United Kingdom of Great Britain and Northern Ireland, United States of America and Viet Nam, which read:

The Executive Board,

Having considered the report on rational use of medicines by prescribers and patients;¹

Acknowledging that the containment of antimicrobial resistance is a prerequisite for attaining several of the internationally agreed health related goals contained in the United Nations Millennium Declaration;

Recalling the recommendations of the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 2004);

Recalling also the findings from the WHO report in 2004 on “Priority Medicines for Europe and the World”,² and the Copenhagen Recommendation from the European Union conference on “The microbial threat” (Copenhagen, 1998);

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

The Fifty-eighth World Health Assembly,

Having considered the report on rational use of medicines by prescribers and patients;

¹ Document EB115/40.

² Document WHO/EDM/PAR/2004.7.

Acknowledging that the containment of antimicrobial resistance is a prerequisite for attaining several of the internationally agreed health-related goals contained in the United Nations Millennium Declaration;

Recalling the recommendations of the Second International Conference on Improving Use of Medicines (Chiang Mai, Thailand, 2004);

Recalling also the findings from the WHO report in 2004 on “Priority Medicines for Europe and the World”, and the Copenhagen Recommendation from the European Union conference on “The microbial threat” (Copenhagen, 1998);

Aware that the spread of antimicrobial resistance recognizes no national boundaries, and has reached proportions that require urgent action at national, regional and global levels, especially in view of the decreasing development of new antimicrobial agents;

Recalling previous resolutions WHA39.27 and WHA47.13 on the rational use of drugs, WHA51.17 on antimicrobial resistance, and WHA54.14 on global health security;

Recognizing the efforts of WHO in collaboration with governments, universities, the private sector and nongovernmental organizations to contain antimicrobial resistance, thereby contributing to the prevention of the spread of infectious diseases;

Noting that, despite some progress, the strategy for the containment of antimicrobial resistance¹ has not been widely implemented;

Wishing to intensify efforts to contain antimicrobial resistance and to promote rational use of antimicrobial agents by providers and consumers in order to improve global health security;

Re-emphasizing the need for a coherent, comprehensive and integrated national approach to promote the containment of antimicrobial resistance;

Convinced that it is time for governments, the health professions, civil society, the private sector and the international community to reaffirm their commitment to ensure that sufficient investment is made to contain antimicrobial resistance;

1. **URGES Member States:**

- (1) to ensure the development of a coherent, comprehensive and integrated national approach to implementing the strategy for the containment of antimicrobial resistance and, where appropriate, taking account of financial incentives in policies for prescribing and dispensing;
- (2) to mobilize human and financial resources in order to minimize the development and spread of antimicrobial resistance, in particular by the promotion of the rational use of antimicrobial agents by providers and consumers;
- (3) to monitor regularly the use of antimicrobial agents and the level of antimicrobial resistance in all relevant sectors;
- (4) to share knowledge and experience actively on best practices in promoting the rational use of antimicrobial agents;

2. **REQUESTS the Director-General:**

- (1) to strengthen the leadership role of WHO in containing antimicrobial resistance;
- (2) to accelerate the implementation of resolutions WHA51.17 and WHA54.14 concerning the containment of antimicrobial resistance by expanding and strengthening the provision of technical support to Member States, at their request;

¹ Document WHO/CDS/CSR/DRS/2001.2.

- (3) to support other relevant programmes and partners in strengthening their efforts to promote the appropriate use of antimicrobial agents by scaling up interventions proven to be effective;
- (4) to support the development and sharing of knowledge and experience among stakeholders on how best to promote the rational use of antimicrobial agents;
- (5) to report to the Sixtieth World Health Assembly, and subsequently on a regular basis, on progress achieved, problems encountered and further actions proposed in implementing this resolution.

The draft resolution did not attempt to deal with the whole subject of rational use of medicines, but instead focused on antimicrobial resistance, which posed one of the most serious threats to global health security.

Professor FIŠER (Czech Republic) said that increasing rates of antimicrobial resistance had been recorded in his country since the mid-1990s, putting it into the group of European countries with a serious resistance problem. In 2001, in a document on strategy for containment of antimicrobial resistance,¹ WHO had recognized antimicrobial resistance as a worldwide problem that jeopardized human health and caused immense economic damage, and had recommended the formation of national and international interdisciplinary groups to study it. His country's Ministry of Health had incorporated rational use of antimicrobial medicines by prescribers and patients into its national antibiotics policy, as part of its biennial collaborative agreement with WHO's Regional Office for Europe for the period 2004-2005. Also included were training of physicians in the rational prescription of antibiotics and a proposed patient information project.

Ensuring the rational use of medicines, which should include the provision of information, surveillance, cost-effectiveness analyses and interdisciplinary coordination was the responsibility of individual governments. The report and draft resolution were, therefore, important for all countries.

Dr ANTEZANA ARANÍBAR (Bolivia) asked for clarification of certain points in the draft resolution. First, did the words "taking account of financial incentives in policies for prescribing and dispensing", at the end of paragraph 1(1) mean that prescribers had to be given financial incentives to prescribe medicines? Medicines should be prescribed and dispensed only on the basis of the patient's well-being and therapeutic effectiveness, not for financial incentives. Secondly, he understood the question of leadership role in paragraph 2(1) to refer to that of WHO as a whole, and not just the Secretariat. Thirdly, did the reference in paragraph 2(4) to stakeholders mean the Member States, the regulatory authorities and those responsible for correct use of antibiotics? There might be others, but the term should be clearly defined. Lastly, there were few references to developing countries, yet that was where misuse of antibiotics posed the greatest problem. Those countries would need all the support and instruction they could get, and he asked whether the new department set up to provide technical support to developing countries would be supporting them in that area.

Dr STEIGER (United States of America) noted with interest that the item under discussion was the only one on the agenda to mention "patients" – i.e. people – rather than governments, health systems or WHO itself. Even then, the title of the item implied that patients were doing something wrong, namely not taking their medicines properly, although the report acknowledged that health systems did not always provide the best medicines at the right time or help patients to use them rationally. Mistakes by health-care providers and patients cost lives and money: the Institute of

¹ See document WHO/CDS/CSR/DRS/2001.2.

Medicine in the United States of America had found some years before that medication errors in the country cost US\$ 128 000 million a year, one quarter of which was attributable to preventable errors.

His country had sponsored the draft resolution because WHO's expertise in surveillance could be put to good use in coordinating regional and international efforts to monitor the alarming rise in antimicrobial resistance.

An important point in the report was the reference, in paragraph 23, to the unregulated dispensing of medicines by pharmacies in many countries. Citizens of his own country often bought medicines in neighbouring countries, where the dispensing regulations were less strict.

The financial incentives in prescribing and dispensing referred to by the previous speaker certainly existed: they might, for example, influence a pharmacist's choice of which medicine to dispense. It might be more apposite to refer to "financial and other incentives".

Promotion and advertising, referred to in paragraph 26, were useful sources of information for patients, but must be monitored to ensure accuracy and adherence to national laws and standards.

There was a general assumption throughout the report that the price of medicines was always determined by the manufacturer: there should perhaps be a reference to the mark-up added by retailers and taxes or tariffs imposed by national governments as well.

The role played by complementary and alternative medicines also deserved consideration. In his country, some 40% of people used such medicines, often without informing their physician. He was surprised therefore that the report made no reference to the World Alliance for Patient Safety, launched by WHO in 2004 with funding from the United Kingdom of Great Britain and Northern Ireland.

The problem of the rational use of medicines was complex and there were no clear standards of measurement, but there was a need for evidence-based, practical advice for physicians and pharmacists. In paragraph 1(2) of the draft resolution, the term "rational use" should be clearer; the most rational use did not necessarily result in the lowest cost. He therefore suggested that it should be replaced by "use of pharmaceuticals in such a manner that the outcomes of therapy, both clinical and economic, are optimal, given the current state of knowledge".

Mrs LE THI THU HA (Viet Nam) said that all countries should establish effective programmes to combat antimicrobial resistance. She supported the draft resolution

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that, in view of the increasing incidence of antimicrobial resistance, there should be a reference in paragraph 1(1) of the draft resolution to increased controls on the dispensing of medicines in pharmacies, particularly prescription-only medicines containing antibiotics and synthetic antibacterial agents. He endorsed the remarks of the member for the United States of America on that subject.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that the inappropriate use of medicines had become a serious public-health problem. Strict regulations and directives were required, along with an effective monitoring system, to combat it. WHO should play a greater role in promoting the implementation of policy, surveillance and measures to combat resistance as well as advocacy and education. He supported the draft resolution.

Dr GAKURUH (Kenya) said that Kenya had sponsored the draft resolution on the understanding that it constituted just one component of efforts to enhance the rational use of medicines. Although it had a legal framework for medicines, it needed to advocate and strengthen regulatory mechanisms and vigorously promote rational use. There was also an urgent need for interventions to counter antimicrobial resistance; such action ought to lead to the formulation of a more comprehensive framework for the rational use of all medicines, along the lines indicated in the report. The Director-General should enhance support to Member States in strengthening their regulatory and information provision capacities. The resistance to antimalarial agents seen over the past decade in sub-Saharan African countries had obliged Kenya to review its malaria treatment policy

every five years, and was a specific illustration of the need for more rational use of medicines generally.

Dr SANDA (alternate to Professor Cinteza, Romania) expressed support for the draft resolution, which Romania had helped to draft. She recalled that, as a general practitioner, she had always tried to give her patients the most rapid, effective and inexpensive treatment possible, but her patients had been convinced that the more painful the treatment, the more effective it would be. Patient's expectations were often at variance with the physician's prescription. The need for coordinated research on the question and continuing education for health professionals should be given more emphasis.

Mr PÉREZ LÁZARO (alternate to Dr Lamata Cotanda, Spain), endorsing the remarks by the previous speaker, said that Spain attached great importance to the training of doctors and pharmacists in the quality, safety, efficiency and effectiveness of medicines. He shared the doubts expressed by the member for Bolivia about paragraph 1(1) of the draft resolution. Presumably the sponsors had intended to refer to the fact that financial or other vested interests should play no role in policies for prescribing and dispensing medicines. That intention might be clearer if the last phrase of the subparagraph was amended to read: "and, where appropriate, to take measures in respect of financial or other incentives that may adversely affect policies for prescribing and dispensing". The aim was to ensure ethical relations between doctors and pharmacists, on the one hand, and the pharmaceutical industry on the other.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) strongly supported the draft resolution and acknowledged the extension of the scope of the resolution to cover all antimicrobial agents. That was essential, given the increasing resistance to medicines, especially those used against HIV/AIDS, tuberculosis and malaria. However, resistance was only one aspect of the rational use of medicines, and he urged the Secretariat, in collaboration with all stakeholders, to consider incorporating other important elements of that topic. He suggested that the Commission on Intellectual Property Rights, Innovation and Public Health, which had been appointed by the Board to deal with many of the aspects of essential medicines, including availability and affordability, should be asked to incorporate rational use into its work.

Dr NSIAH-ASARE (alternate to Dr Ahmed, Ghana) supported the extension of the scope of the topic beyond the problem of antimicrobial resistance. Ghana had already adopted the concept of rational use of medicines, and experienced its benefits. With social health insurance systems becoming more widespread, guidelines were needed for monitoring and evaluating the use of medicines.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) stressed the need to ensure rational use of medicines, and especially antimicrobial agents. Attention should be paid to the education of consumers and the continuous training of health-service providers. Quality assurance systems should include monitoring the rational use of medicines.

Dr ACHARYA (Nepal) said that irrational use of medicines not only prevented the full potential of medicines in health care from being realized; it also created other problems, including the emergence of resistance through improper use of antibiotics. Pilot projects to promote rational use had proved successful, but had yet to be successfully translated to the national level. Multidimensional interventions were needed, because a single intervention could have unintended consequences, such as the irrational use of another medicine. A broadly based insurance system, including regulation, supervision and monitoring, was crucial in ensuring the rational use of medicines. The fact that in the private sector in countries in the South-East Asia Region medicines were almost always dispensed by prescribers provided a strong incentive for irrational use, since the more they dispensed, the greater their income. Most countries in the Region also focused strongly on the supply of medicines, deferring consideration of the question of rational use until adequate supplies were available. Yet the two issues

must be handled together. Health insurance systems were not common in the Region, but they were the most important factor in encouraging the rational use of medicines. He strongly supported the draft resolution.

Dr ABDULLA (Sudan) strongly supported the draft resolution and asked for Sudan to be added to the list of sponsors.

Ms PATTERSON (alternate to Ms Halton, Australia) supported the draft resolution and asked for Australia to be added to the list of sponsors.

Dr NDONG (Gabon) also supported the draft resolution. He proposed the addition, in paragraph 1, of the words: “to strengthen their legislation on availability of medicines in general, and antimicrobials in particular”. The sale of pharmaceuticals without a prescription was one of the causes of irrational use of medicines in general, and especially of antimicrobial agents. Such informal distribution of medicines should be discouraged.

Dr AGARWAL (India)¹ said that his country was concerned at the extensive use of antimicrobial agents, which led to pathogen resistance. That trend, together with the increasing prevalence of chronic diseases, and the growing need for lifelong treatment of HIV/AIDS, made it a matter of urgency to identify successful interventions to promote more cost-effective long-term use of medicines and adherence to chronic treatment. The medical fraternity must be sensitized to the need for appropriate use of medicines. A project had been launched in India, with the assistance of the World Bank, to build capacity for the quality control of medicines and safe food. Rational use of medicines was one of the areas covered by awareness-raising measures under the project, which involved all stakeholders.

Ms ALVES (International Pharmaceutical Federation), speaking at the invitation of the CHAIRMAN, said that the main activities of pharmacists were to supply medicines and other health care products of assured quality, and to help people to use them safely and rationally by providing appropriate information and advice or by monitoring their effects. Pharmacists had adopted a patient-centred approach, which ensured that patient care and economic considerations were properly balanced. Appropriate advice empowered patients to gain responsibility in their own healing process and improved adherence to treatment. Therapy with prescribed medicines was a collaborative process between patients, physicians, pharmacists and other health-care providers, but it presupposed a partnership based on mutual trust and the acceptance of shared responsibility for the outcome. Her Federation therefore urged national and international organizations and governments to recognize the importance of promoting and implementing an integrated approach to treatment with medicines involving all those concerned. Pharmacists’ contribution to the promotion of rational and economic prescribing and appropriate use of medicines must be acknowledged. They should have access to any system for reporting adverse events, medication errors, defects in product quality and detection of counterfeit products. Reporting should include information supplied by patients and health professionals directly or through pharmacists.

Dr GHEBREHIWET (International Council of Nurses), speaking at the invitation of the CHAIRMAN, said that nurses, pharmacists and physicians were together responsible for the prescribing, dispensing and administering of medicines and their rational use. Health professionals must ensure that patients received safe compounds, appropriate to their clinical needs, in the correct doses, for an adequate duration, and at the lowest cost to the patient and the community. Extensive misuse of antimicrobial agents was resulting in widespread resistance in pathogens. In addition,

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

extensive use of injections in non-sterile conditions was contributing to the spread of infections, in particular with hepatitis B and C viruses. The increasing presence of counterfeit and substandard medicines contributed to the spread of resistance, including resistance to antiretroviral therapy. Policies and mechanisms of WHO and governments promoting the rational use of medicines should include: establishment of multidisciplinary bodies to regulate and monitor use of medicines; monitoring of prescribing behaviour with a view to avoiding unnecessary use of antimicrobials and injections; raising awareness of counterfeit and substandard medicines; educating patients and communities on the proper use of medicines; developing and disseminating evidence-based clinical guidelines for health professionals; and maintaining appropriate levels of staffing and supplies of medicines.

Mr MISRA (Consumers International), speaking at the invitation of the CHAIRMAN and also on behalf of Health Action International, said that urgent action was needed to combat the inappropriate selection and use of medicines by providers and consumers. Regulators must seek to ensure that the financial interests of pharmaceutical manufacturers and sellers did not conflict with public health needs.

Regulation of drug promotion to prescribers and strengthening of education to increase awareness of its potentially adverse effects were important strategies. Health Action International had collaborated with WHO to develop a database on drug promotion to monitor efforts to influence prescribers. Physicians had also played a role, for example, by setting up a web site providing tools to mitigate drug promotion and its effects.

Informed consumers also had a vital role to play in the rational use of medicines and health systems. Quality, accuracy and independence of information were crucial to avoid exploitation of vulnerable consumers. WHO and governments should provide clear guidance and comparative information on the best interventions and their appropriate use. National committees had been established to draw lessons from two recent incidents that had undermined public confidence in medicines safety. Guidelines for interaction between the public, patient groups and others involved in the provision and use of medicines were also needed. Irrational use of medicines undermined health systems in rich and poor countries alike and threatened to reverse valuable health gains.

Dr LEPAKHIN (Assistant Director-General) said that, in general, physicians did not understand medicines well enough to use them rationally in treatment, and acknowledged that they were offered financial incentives to prescribe some rather than others.

Rational use of medicines involved such factors as proper prescription including avoidance of drug interactions, and dispensing, appropriate information for patients, and their compliance with treatment regimens. Irrational use was a complex problem requiring the involvement of health ministries, nongovernmental organizations of the kind addressing the Board, consumers and patients, organizations in the United Nations system, WHO collaborating centres and other stakeholders.

The entire draft resolution was directed at patient safety and effective treatment. Improper treatment indeed caused resistance, not just to antibacterial but also to antiretroviral and other antimicrobial agents. With regard to medical error, deaths due to erroneous prescription were certainly unacceptable, besides which drug-related complications had huge economic consequences.

With regard to misuse of medicines and support for countries to make proper use of drugs, two new departments had been created in the Secretariat: one for global policy and standards and the other for technical support for countries. Responding to the member for Romania, he observed that people often preferred strong and even painful medicine on the assumption that it was more effective. Many present-day oral formulations, however, were just as effective as injections.

On the asserted need to highlight training, he said that the project to be carried out, if the draft resolution were adopted, would include a strong training component, one of the most cost-effective ways of promoting rational use.

Thanking the countries that had sponsored the draft resolution with its helpful guidance, he said that the Secretariat would attempt to integrate their efforts to promote the rational use of antimicrobial agents within the much wider programme on expanding effective interventions to promote the rational

use of medicines in general. Fund-raising would be stepped up to ensure availability of the financial and human resources necessary for the activities outlined in the draft resolution.

Mr AITKEN (Director, Office of the Director-General) noted that Bolivia had decided to join the sponsors. The amendments proposed were: in paragraph 1(1), the words “and other” should be inserted after “financial” and the words “which might have a negative impact” inserted between “incentives” and “in policies”; and a new paragraph, to be inserted after paragraph 1(1), reading “to consider strengthening their legislation on availability of medicines in general and antimicrobial agents in particular;”, was to be inserted.

Mr SHUGART (Canada) suggested that, in the first amendment, the word “harmful” would be preferable to “negative”.

The CHAIRMAN said that he took it that, with those amendments, the text was acceptable.

The resolution, as amended, was adopted.¹

International Plan of Action on Ageing: report on implementation: Item 4.15 of the Agenda (Document EB115/29)

The CHAIRMAN drew attention to a draft resolution on strengthening active and healthy ageing, proposed by Australia, Bolivia, Brazil, Canada, China, Germany, Ghana, Iceland, Israel, Italy, Jamaica, Japan, Netherlands, Russian Federation, Spain, Thailand, United Kingdom of Great Britain and Northern Ireland, and the United States of America, which read:

The Executive Board,
Having considered the document on International Plan of Action on Ageing: report on implementation,²

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

The Fifty-eighth World Health Assembly,
Having considered the document on International Plan of Action on Ageing: report on implementation;

Noting that more than one thousand million people will be over 60 years old by 2025 and that this figure is expected to double by 2050, the vast majority in the developing world, which will lead to increasing demands on health and social-service systems worldwide;

Recalling resolution WHA52.7 on Active ageing that called upon all Member States to take appropriate steps to carry out measures that ensure the highest attainable standard of health and well-being for the growing numbers of their older citizens;

Recalling also United Nations General Assembly resolution 58/134 of 22 December 2003, which requested the organizations and bodies of the United Nations system and the specialized agencies to integrate ageing, including from a gender perspective, into their programmes of work;

Recalling further United Nations General Assembly resolution 59/150, which called on governments, the organizations of the United Nations system, nongovernmental

¹ Resolution EB115.R6.

² Document EB115/29.

organizations and the private sector, to ensure that the challenges of population ageing and the concerns of older persons were adequately incorporated into their programmes and projects, especially at country level, and invited Member States to submit, whenever possible, information to the United Nations database on ageing;

Acknowledging the active ageing policy framework, WHO's contribution to the United Nations Second World Assembly on Ageing, and its vision for the framing of integrated intersectoral policies on ageing;¹

Mindful of the important role of WHO in implementing the objectives of the Madrid International Plan of Action on Ageing, 2002, particularly Priority Direction II: Advancing health and well-being into old age;

Recognizing the contributions older persons make to development and the importance of lifelong education and active community involvement for older persons;

Stressing the important role of public health policies and programmes in enabling the rapidly growing numbers of older persons in both developed and developing countries to remain in good health and maintain their many vital contributions to the well-being of their families, communities and societies;

Stressing also the importance of developing care services, including eHealth services, to enable older persons to remain in their homes for as long as possible;

Underlining the need for incorporating a gender perspective into policies and programmes relating to active and healthy ageing;

Welcoming WHO's focus on primary health care, such as the development of "age-friendly" primary health care;

1. URGES Member States:

- (1) to develop, implement and evaluate policies and programmes that promote healthy and active ageing and the highest attainable standard of health and well-being for their older citizens;
- (2) to consider the situation of older persons as an integral part of their efforts to achieve the internationally agreed development goals of the United Nations Millennium Declaration, and to mobilize political will and financial resources for that purpose;
- (3) to take measures to ensure that gender-sensitive health policies, plans and programmes recognize and address the rights and comprehensive health, social-service and development needs of older women and men, with special attention to the socially excluded, older persons with disabilities, and those unable to meet their basic needs;
- (4) to pay special attention to the key role that older persons, especially older women, play as caregivers in the family and community, and particularly the burdens placed on them by the HIV/AIDS pandemic;
- (5) to enact and enforce legislation and to strengthen legal efforts and community initiatives designed to eliminate abuse of elderly people;
- (6) to develop, use and maintain systems to provide data, throughout the life-course, disaggregated by age and sex, on intersectoral determinants of health and health status in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health interventions relevant to older persons;
- (7) to undertake education and recruitment measures and incentives, taking into account the particular circumstances in developing countries, in order to ensure sufficient health personnel to meet the needs of older persons;

¹ Document WHO/NMH/NPH/028.

- (8) to strengthen national actions in order to ensure sufficient resources to fulfil their commitments to implement the Madrid International Plan of Action on Ageing, 2002, and related regional plans of action relating to the health and well-being of older persons;
 - (9) to support WHO's advocacy for active and healthy ageing through new, multisectoral partnerships with intergovernmental, nongovernmental, private-sector and voluntary organizations;
2. REQUESTS the Commission on Social Determinants of Health to include issues related to active and healthy ageing throughout the life-course among its policy recommendations;
3. REQUESTS the Director-General:
- (1) to raise awareness of the challenge of the ageing of societies, the health and social needs of older persons, and the contributions of older persons to society, including by working with Member States and nongovernmental and private-sector employers;
 - (2) to provide support to Member States in their efforts to fulfil their commitments to the goals and outcomes of relevant United Nations conferences and summits, particularly the Second World Assembly on Ageing, related to the health and social needs of older persons, in collaboration with relevant partners;
 - (3) to continue to focus on primary health care that is age appropriate, accessible and available for older persons, thereby strengthening their capability to remain vital resources to their families, the economy and society for as long as possible;
 - (4) to provide support to Member States, by promoting research and strengthening capacity for health promotion and disease prevention throughout the life-course, in their efforts to develop integrated care for older persons, including support for both formal and informal caregivers;
 - (5) to undertake initiatives to improve the access of older persons to relevant information and health-care and social services, particularly to reduce their risk of HIV infection, improve the quality of life and dignity of older persons living with HIV/AIDS, and to support family members affected by HIV/AIDS, as well as their orphaned grandchildren;
 - (6) to provide support to Member States, upon request, for compiling, using and maintaining systems to provide information, throughout the life-course, disaggregated by age and sex, health status and selected intersectoral information, on determinants of health, in order to underpin the planning, implementation, monitoring and evaluation of evidence-based health-policy interventions relevant to older persons;
 - (7) to strengthen WHO's capacity to incorporate work on ageing throughout its activities and programmes at all levels and to facilitate the role of WHO regional offices in the implementation of United Nations regional plans of action on ageing;
 - (8) to cooperate with other agencies and organizations of the United Nations system in order to ensure intersectoral action towards active and healthy ageing;
 - (9) to report to the Sixtieth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

Dr STEIGER (United States of America), thanking the sponsors of the draft, said that his country had initially put forward the text not only because improving the lives of its older citizens and their families was a national priority but also to encourage the Secretariat and all United Nations agencies and Member States to begin to give effect to the commitments set out in the International Plan of Action on Ageing adopted at the United Nations Second World Assembly on Ageing (Madrid,

2002). The resolution was intended to guide the Organization's action and should be seen as a positive step.

At the request of members for countries in the Region of the Americas, he said that in the Spanish version of the draft resolution, the words "*personas mayores*" should be replaced by "*adultos mayores*"; and in paragraph 1(5), the words "physical and mental" should be inserted before "abuse". In the English version, he requested that in paragraph 1(5) the words "abuse of elderly people" should be replaced by "elder abuse" to reflect common parlance in the United Nations system.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) said that, with the sector of the population referred to as "older persons" growing much faster than the general population in many parts of the world, including the Caribbean, measures were needed to promote healthier ageing and enable health-care systems to provide for and be "friendly" to the elderly, many of whom would have few or no resources to cover the cost of their care. Countries had to ensure access not only to primary health care in institutions but also to home care and self-care, with effective planning. The WHO/PAHO Collaborating Centre on Ageing and Health at the University of the West Indies, which was also involved in the postgraduate family medicine distance-learning course based at the University, was working with the Merck Company Foundation on training in issues of ageing in the Caribbean.

Since active and healthy ageing was becoming a major public health concern, she proposed that the words "to provide progress reports on the status of older persons and on active and healthy ageing programmes in the country reports" be inserted after paragraph 1(8) of the draft resolution.

Dr GAKURUH (Kenya), noting that there would be more than 1000 million people over the age of 60 by 2025 and, most importantly, that the traditional African social structure for support of the ageing was collapsing, expressed both appreciation and support for the report and the resolution. Nuclear and extended families had been the main structure for care and support of the ageing in Kenya and in much of Africa, but, owing to the prevailing social and economic environment, that structure was rapidly falling apart. In some countries the problem was compounded by emerging and re-emerging diseases and civil strife. Where possible, it was fundamental to emphasize home-based care and support from within the community, as did the HIV/AIDS strategy. She proposed that the words "with an emphasis on existing community structures where applicable" be inserted after "to continue to focus on primary health care" in paragraph 3(3) of the draft resolution.

Dr SANDA (alternate to Professor Cinteza, Romania) expressed support for the focus on primary health care and making social and health care part of a holistic approach. Romania had contributed much to geriatrics and gerontology through the work of Professor Aslan, a noted physician and researcher. In gerontology, continuous training at undergraduate and postgraduate levels was essential.

Efforts by the Secretariat and Member States to promote palliative care would be particularly important. She endorsed the steps outlined in the plan of action and strongly supported the draft resolution.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation), whose country was a sponsor of the draft resolution, said that the report rightly identified HIV/AIDS as one of two new areas in the important issue of ageing and health, but the interpretation of the relationship between ageing and the HIV/AIDS pandemic was somewhat one-sided. Older people did bear an additional burden as carers in families, but age in itself did not rule out illness due to HIV, even with the availability of antiretroviral therapy. While the specific characteristics of the spread of HIV among older people should undoubtedly be given more attention, the importance for such people of all the preventive, treatment, care and support measures that were being developed and implemented as part of the global strategy to combat HIV/AIDS should be taken into account, and, therefore, highlighted in draft resolution.

The report referred to a pilot research project in Zimbabwe which, he understood, had led to a report on the effect of HIV/AIDS on older people in Africa that had been issued in December 2002. Another project, to develop methodology for the study and assessment of the impact of HIV/AIDS on older people, was to be carried out in three other African countries. Which project was the subject of paragraph 10 and, most importantly, when and how was that project to be “replicated”, as stated in paragraph 10, in other countries?

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that integration of the International Plan of Action on Ageing into the primary health care system had proved to be very beneficial. Its successful implementation required clear government policy, adequate resources, and integration into a primary health-care system with appropriately trained human resources. A monitoring and evaluation system must be established to ensure good quality and coverage. Community participation was the key to enabling older persons to live independently with a good quality of life.

As a sponsor of the draft resolution he proposed that in paragraph 1(5), the word “enact” should be replaced by “consider establishing an appropriate legal framework”; in paragraph 2, the word “include” should be amended to read “consider including”; and that the respective subparagraphs of paragraphs 1 and 3 should be merged in order to produce a more concise and comprehensible text.

Dr AHMED (Ghana) said that even in some developing countries people were living longer. The threat to the traditional way of life posed by globalization would also effect older persons. He queried the report’s focus on primary health care, as a broader view was necessary. Moreover emerging issues (paragraphs 10 and 11 of the report) should be examined more closely, and further research should be carried out on the role of groups in traditional societies in caring for older persons, especially in sub-Saharan Africa.

Mr RECINOS TREJO (El Salvador)¹ said that the countries of the Region of the Americas welcomed the report and supported any global initiative aimed at the care of older people, particularly strategies that included primary health care and protection against physical and mental abuse. Efforts to provide the growing population of older people with the best possible level of health and well-being must be continued, and the countries of the Region therefore supported the draft resolution, together with the amendment proposed by the United States of America on its behalf.

The CHAIRMAN, speaking as the member for Iceland, said that the draft resolution was intended to have a positive impact on the promotion of healthy ageing and quality of life and independence in old age. It concentrated on prevention and treatment of age-related diseases, the social environment of elderly people, and social implications.

Dr LE GALÈS-CAMUS (Assistant Director-General), acknowledging the clear and constructive guidance, said that the Secretariat was making every effort to increase the effectiveness of its work on ageing and to ensure that older people benefited from the best possible conditions, including health conditions. The draft resolution and related proposals complemented WHO’s work. Much remained to be done, but WHO had sought to give priority to primary health services, as most of the ageing population lived in communities, making access to primary health care essential. The factors that determined access to, and supply of, primary health-care services had also been analysed. WHO’s regional work in that context should be strengthened, particularly regarding primary health-care guidelines. She noted the emphasis in both the report and the draft resolution on the specific consequences of HIV/AIDS for older people and the problems of health care for older people in the context of HIV/AIDS. The pilot project carried out in Zimbabwe had been completed and was in

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

process of analysis. Unfortunately, it was not the difficulty of reproducing the methodology in the four countries in question that created an obstacle, but simply the lack of resources.

Mr AITKEN (Director, Office of the Director-General) read out the proposed amendments. Paragraph 1(5), as amended, would read: “to consider establishing an appropriate legal framework and to enforce legislation and strengthen legal efforts and community initiatives designed to eliminate physical and mental elder abuse”. A new subparagraph 8*bis* would read: “to provide progress reports on the status of older persons and on active and healthy ageing programmes when making country health reports”. Paragraph 2, as amended, would read: “REQUESTS the Commission on Social Determinants of Health to consider including issues related to active and healthy ageing throughout the life-course among its policy recommendations”. The beginning of paragraph 3(3), would be amended to read: “to continue to focus on primary health care with an emphasis on existing community structures where applicable, that is age appropriate ...”. In addition, the changes made to the Spanish text would be taken into account.

The resolution, as amended, was adopted.¹

The meeting rose at 14:00.

¹ Resolution EB115.R7.

ELEVENTH MEETING

Monday, 24 January 2005, at 09:10

Chairman: Mr D.Á. GUNNARSSON (Iceland)

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

Ministerial Summit on Health Research (Mexico City, 16-20 November 2004): Item 4.16 of the Agenda (Document EB115/30)

Dr SAM (Gambia) said that in the area of health research the role of WHO, as a knowledge-based organization, was to ensure that research was carried out according to a uniform set of ethical and other standards and guidelines that were both acceptable and replicable worldwide. Knowledge obtained through research had led to the introduction of highly successful and cost-effective, preventive public health interventions, particularly in the field of preventable childhood diseases. For vaccines, one of the most serious problems was not their availability but access to them where they were most needed. A further problem was the development and introduction of new vaccines against diseases that caused the death of millions of children worldwide, for example malaria, HIV infection or pneumonia. Health research was the best strategy at the current stage, but it was important to ensure that the findings fulfilled the original objective of controlling targeted diseases.

Developing countries, including Gambia and other west African countries, appreciated the efforts of, among others, WHO and other United Nations agencies, the Global Alliance for Vaccines and Immunization, The Vaccine Fund, the Global Fund to Fight AIDS, Tuberculosis and Malaria and all those supporting them in setting up financing mechanisms to ensure availability of expensive vaccines to the people who would not otherwise have access to them. However, certain difficulties were emerging in the implementation of those mechanisms that were beyond the control of the partners concerned. Donor fatigue and unstable macroeconomic influences were additional threats. Research into vaccines covered not only technologically complex manufacturing processes, but also the clinical trials necessary to ensure safety and effectiveness before vaccines were introduced onto the market. Vaccines also had to comply with ethical and human rights standards, as well as trade regulations, to ensure that developing countries benefited from the knowledge obtained from clinical trials in which they had participated. The recent establishment of the Department of Ethics, trade, human rights and health law, represented a step towards acknowledgement of the role of developing countries in health research, particularly vaccine development.

In the draft resolution, he proposed the insertion of three new subparagraphs: the first, in paragraph 1 would read: “to encourage collaboration with other partners in health research so as to facilitate the conduct of such research within their health systems”; the second, in paragraph 2, would read: “to recognize the need to involve the relevant authorities in the countries concerned in the initial planning of health research projects”; and the third, in paragraph 3, would read: “to facilitate transforming health research findings into policy and practice”. He further proposed that the Director-General facilitate communication for negotiations between all parties involved in vaccine development, possibly through the new Department.

Dr STEIGER (United States of America) said that, because of the late issue of document EB115/30, he had not yet had the opportunity to digest the outcomes of the Ministerial Summit or consider the Mexico Statement. Moreover, that Statement had not been approved by all delegations at the summit, and should not be seen as a consensus document. He therefore proposed either that the Board take up the issue again at its 116th session, or that consideration of the draft resolution be

postponed until Board members had had sufficient time to examine the text and make proposals that could be incorporated into a revised version for submission to the Health Assembly. Failing that, he would propose several amendments to the current text. If the Board preferred to proceed with the agenda item, he suggested that a working group be established to produce a consensus version.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) recalled that those attending the Ministerial Summit had been advised by WHO that what came to be known as the Mexico Statement on Health Research would be approved, and that the Executive Board would subsequently recommend its endorsement to the Fifty-eighth World Health Assembly. More than 50 countries had attended the Summit, of which at least 28 were represented at the current session of the Board. The Statement had been agreed on after four days of extensive discussion.

The Mexico Statement could be regarded either as a “stand alone” recommendation by all the countries that had attended the Summit, in which case it could be referred to in any international discussion on health research and did not necessarily require the endorsement of the Health Assembly, or as a draft resolution submitted by the countries attending the Ministerial Summit to the Health Assembly for endorsement, as the Secretariat had chosen to do. The Statement should in that case have been submitted to the Board unchanged so that members could amend it as they saw fit and transmit it to the Health Assembly.

The present agenda item referred specifically to the Ministerial Summit on Health Research, not to health research generally. The Secretariat therefore had no authority to modify the Mexico Statement before presenting it to the Board. Furthermore, in preparing the draft resolution set out in paragraph 7 of its report, the Secretariat had deleted from the “Call for action” section of the Mexico Statement paragraph 5 (which had been proposed by Thailand), paragraph 9 (proposed by ministers from many African countries) and paragraph 10 (part of which had been proposed by Pakistan), and had modified other paragraphs. All those paragraphs had been approved by the many countries attending the Ministerial Summit, and it was not up to the Secretariat to make such changes. In so doing, it fostered an atmosphere of mistrust, and Thailand, for one, would think carefully before accepting another WHO invitation to attend a ministerial summit.

He therefore proposed that the Board either endorse the Mexico Statement as it stood and recommend its endorsement by the Health Assembly; or, if it wished to consider the text submitted by the Secretariat, it should make two concurrent decisions, namely to endorse the Mexico Statement as it stood and recommend its endorsement by the Health Assembly, and to amend the draft resolution prepared by the Secretariat before submitting it to the Health Assembly for consideration, together with its endorsement of the Mexico Statement, in which case, the three paragraphs deleted from the Mexico Statement should be incorporated into the draft resolution.

Dr SANDA (alternate to Professor Cinteza, Romania) said that Romania, having been represented at the Summit, endorsed the Mexico Statement on Health Research as it stood. Its National Institute for Health Research and Development, with the support of the Ministry of Health, was preparing a national policy for an evidence-based health research system. In the light of the Mexico Statement, a national health management information system to enhance the effectiveness of the health system would be developed with European Union funding.

Mr SHUGART (Canada) emphasized that knowledge generation was central to improving health and dealing with the challenges facing the health sector worldwide. What would be the implications of deferring the item for WHO, and in particular would the work come to a complete stop? Despite the need for a consensus on such an important issue, it would be a pity to sacrifice the momentum that had been generated thus far.

Dr THIERS (Belgium)¹ said that he had attended the Ministerial Summit on Health Research and had been disappointed to note the presence of only 20 health ministers, of whom two were from the European Region. Given the weight of the subject, it was important to ascertain why. He supported the draft resolution and congratulated the Secretariat on having captured the essential points of the Mexico Statement. However, given the significance of the subject, and the fact that the Board had received document EB115/30 so late, there did appear to be a case for reconsidering the draft resolution at a later stage.

The CHAIRMAN, noting the short amount of time remaining at the current session, invited members to consider continuing the debate by electronic means with a view to preparing a consensus text for submission to the Fifty-eighth World Health Assembly.

It was so agreed.

Influenza pandemic preparedness and response: Item 4.17 of the Agenda (Documents EB115/44 and EB115/44 Corr.1)

The CHAIRMAN invited the Board to consider the report contained in documents EB115/44 and EB115/44 Corr.1 and a draft resolution proposed by Belgium, Canada, China, Denmark, Finland, France, Germany, Hungary, Iceland, Ireland, Israel, Italy, Japan, Luxembourg, Malta, Monaco, Netherlands, Poland, Portugal, Russian Federation, Slovakia, Slovenia, Spain, Switzerland, Turkey, United Kingdom of Great Britain and Northern Ireland, United States of America and Viet Nam, which read:

The Executive Board,
Having considered the report on influenza pandemic preparedness and response;²
Recognizing the grave and increasing threat to the world's health posed by pandemic influenza,

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

The Fifty-eighth World Health Assembly,
Having considered the report on influenza pandemic preparedness and response;
Recalling resolutions WHA22.47, WHA48.13, WHA56.19 and WHA56.28, and the global agenda for influenza surveillance and control;
Acknowledging with growing concern that the evolving, unprecedented outbreak of H5N1 avian influenza in Asia represents a serious threat to human health;
Stressing the need for all countries, especially those affected by highly pathogenic avian influenza, to collaborate with WHO and the international community in an open and transparent manner in order to lessen the risk that the H5N1 influenza virus causes a pandemic among humans;
Mindful of the need to address the limited progress being made in development of influenza vaccines and transit to the production stage;
Emphasizing the importance of strengthening surveillance of human and zoonotic influenza in all countries in order to provide an early warning of, and a timely response to, an influenza pandemic;

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Documents EB115/44 and EB115/44 Corr.1.

Noting the gaps in knowledge and the need for additional research on various aspects of the spread of influenza and for influenza preparedness and response;

Acknowledging that communication with the public must be improved in order to increase awareness of the seriousness of the threat that an influenza pandemic represents, and of the steps in basic hygiene that citizens can and should take in order to lessen their risk of contracting and transmitting influenza;

Concerned that organizations responsible for animal and human health, at local, national and international levels, are not collaborating closely enough on human and zoonotic influenzas;

Aware of the need to expand the availability of influenza vaccine so that protection in a pandemic can be extended to populations in more countries, with particular attention to requirements in developing countries;

Recognizing the need to prepare for international interventions during the initial stages of a pandemic, particularly in the event of inadequate stockpiles of vaccine and antiviral medications;

Recognizing further that influenza antiviral drugs will be an important component of a containment strategy, but that additional studies are required to establish their appropriate use in containment;

Recognizing also that a global stockpile of these agents is lacking and few countries have established national stockpiles,

1. URGES Member States:

- (1) to develop and implement national plans for pandemic-influenza preparedness and response that focus on limiting health impact and economic and social disruption;
- (2) to develop and strengthen national surveillance and laboratory capacity for human and zoonotic influenzas;
- (3) to achieve the target set by resolution WHA56.19, Prevention and control of influenza pandemics and annual epidemics, to increase vaccination coverage of all people at high risk, which will lead to availability of greater global vaccine-production capacity during an influenza pandemic;
- (4) to seriously consider developing domestic influenza-vaccine production capacity, based on annual vaccine needs, or to work with neighbouring States in establishing regional vaccine-production strategies;
- (5) to ensure prompt and transparent reporting of outbreaks of human and zoonotic influenzas, particularly when novel influenza strains are involved, and facilitate the rapid sharing of clinical specimens and viruses through the WHO Global Influenza Surveillance Network;
- (6) to communicate clearly with their citizens about the potential threat of an influenza pandemic and to educate the public about effective hygienic practices that may protect them from influenza virus infection;
- (7) to strengthen linkages and cooperation among national health, agriculture and other pertinent authorities in order to prepare for, including by mobilizing resources, and respond jointly to, outbreaks of highly pathogenic avian influenza;
- (8) to support an international research agenda to reduce the spread and impact of pandemic influenza viruses, to develop more effective vaccines and antiviral medications, and to advance, among various population groups, vaccination policies and strategies, in close consultation with the communities concerned;
- (9) to contribute, as feasible, their expertise and resources to strengthen WHO programmes, bilateral country activities and other international efforts to prepare for pandemic influenza;

2. REQUESTS the Director-General:

- (1) to continue to strengthen global influenza surveillance, including the WHO Global Influenza Surveillance Network, as a crucial component of preparedness for seasonal epidemics and pandemics of influenza;
- (2) to seek solutions with other international and national partners, including the private sector, to reduce the present global shortage of influenza vaccines and antiviral drugs for both epidemics and pandemics, including vaccination strategies that economize on the use of antigens, and development and licensing of antigen-sparing vaccine formulations;
- (3) to provide Member States with technical support and training in order to develop health-promotion strategies in anticipation of, and during, influenza pandemics;
- (4) to draw up and coordinate, in collaboration with public and private partners, an international research agenda on pandemic influenza;
- (5) to assess the feasibility of using antiviral-medication stockpiles to contain an initial outbreak of influenza and to slow or prevent its international spread, and, as appropriate, to develop an operational framework for their deployment;
- (6) to evaluate the potential benefit of personal protection measures, including the wearing of surgical masks, to limit transmission in different settings, especially health-care settings;
- (7) to establish joint initiatives for closer collaboration with national and international partners, including FAO and the Office International des Epizooties, in the early detection, reporting and investigation of influenza outbreaks of pandemic potential, and in coordinating research on the human-animal interface;
- (8) to report to the Fifty-ninth World Health Assembly, through the Executive Board, on progress made in implementing this resolution.

Dr STEIGER (United States of America) said that the recent rise in the number of cases of avian influenza in Viet Nam highlighted the urgent need for heightened vigilance in east and south-east Asia and for all countries to make the necessary preparations in readiness for the possible emergence of a new strain of influenza virus. The United States continued to be extremely concerned about the possibility of the causative avian influenza virus mutating into a human strain to which people had virtually no resistance. Following consultations with several Member States not represented on the Executive Board but who wished to join in its work, he proposed the insertion of “especially people with immunodeficiencies such as HIV-infected and AIDS patients” at the end of paragraph 1(8) of the draft resolution, and the addition of a new subparagraph following paragraph 2(6) that would read: “to continue to develop WHO’s plans and capacity to respond to an influenza pandemic and ensure clear communication with Member States”.

He congratulated WHO on having ensured communication so effectively. The United States was proud to have provided financial and technical support to the Strategic Health Information Centre and looked forward to continuing to cooperate with the Organization in the future.

Professor FIŠER (Czech Republic) commended the excellent report. He recalled that the 1918 influenza pandemic had claimed more lives than the First World War. Contemporary means of transport increased the speed at which a pandemic could spread in a globalized world, but, on the other hand, the results of recent research, including the mapping of the 1918 influenza pandemic virus, its recreation in the laboratory and investigation of antiviral agents in the United States of America, had provided an instrument with which to manage a potential pandemic more effectively. His country had had a national plan for influenza pandemic preparedness in place for several years; it wished to be included among the sponsors of the draft resolution.

Mrs LE THU THI HA (Viet Nam) commended the report and endorsed the amendments to the draft resolution proposed by the member for the United States of America. Viet Nam had either

already implemented, or intended to implement, actions described in paragraphs 1(1), 1(2), 1(5), 1(6) and 1(7). With regard to paragraph 1(7), her Government had decided to establish an interagency avian influenza working group, consisting of technical experts and senior staff from the ministries of health and of agriculture and rural development, FAO and WHO, to enhance prevention, surveillance and control of avian influenza in Viet Nam. The group's terms of reference were to provide advice and technical support on contingency and pandemic preparedness planning and to act as a focal point for coordination of donor support for avian influenza activities and for communication and liaison between the two ministries and United Nations agencies on matters relating to avian influenza.

The draft resolution did not cover the important issue of availability and affordability of antiviral medicines. In the absence of an effective vaccine, antiviral medicines could prove valuable in the treatment and prevention of avian influenza, but current availability was limited and the products were expensive. However, experience gained in the use of antiretroviral agents in the treatment of HIV infection had demonstrated that such a situation could be changed. The problem was difficult, but it should not be ignored.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that the recent outbreak of avian influenza in Asia had already caused a number of deaths, and the possibility of its further spread was an alarming prospect. The seriousness of the situation should not therefore be underestimated. In the event of a pandemic, international and cross-sectoral cooperation should be central to countries' preparedness strategies. During the past 10 years, China and WHO had cooperated effectively in terms of surveillance and the provision of virus specimens for laboratory analysis.

The member for Viet Nam had drawn attention to the importance of improving the availability and accessibility of vaccines. The production of vaccines was confined to a few developed countries, while production capacity in developing countries, which were far more prone to outbreaks of the disease, was inadequate. The challenge facing the global community was therefore to ensure that all countries had adequate stocks of vaccine when it was required. Antiviral agents were an effective way of treating and controlling disease due to *Influenzavirus A*, but their high cost would prevent some developing countries from acquiring them; that was an area where WHO's intervention could have a positive impact. As part of a long-term strategy, WHO might also consider establishing a not-for-profit international research network for the benefit of all Member States. At the same time, it should support countries in developing production capacity and in improving quality, enabling them to produce high-quality, affordable vaccines quickly when they were needed.

He supported the amendments to the draft resolution proposed by the member for the United States of America.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) welcomed the inclusion of the topic on the agenda, and commended the report. There was indeed a risk of a historically unprecedented influenza pandemic. Antigenic shifts in influenza virus could lead to the appearance of a new strain that could quickly cause a sharp increase in morbidity and mortality, which would require rapid implementation of unprecedented measures to ensure proper epidemiological surveillance and preparation at national and global levels to deal with a possible pandemic. The long-term measures specified in the draft resolution should be adopted urgently and constituted priority areas of activity for WHO. The Regional Office for Europe and the European Commission planned to hold a meeting of Member States of the European Region to prepare national plans for dealing with an influenza pandemic. At the end of 2004 his country's chief medical officer had issued a document on preparedness against pandemic influenza whose contents were fully in line with the draft resolution.

Dr AHMED (Ghana) said that the current outbreaks of avian influenza had not so far affected Africa, but frequent travel made its spread to the African continent and other parts of the world more likely. He commended the report and endorsed both the draft resolution and the proposed amendments.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) affirmed the high and imminent risk of a global influenza pandemic and its likely catastrophic impact, with widespread economic and social disruption. Africa and Asia would be most seriously affected because of the large numbers of people immunosuppressed by HIV infection. That threat made global and national preparedness through global alert and warning systems vital. National preparedness was particularly lacking, and Member States should, therefore, with the support of WHO, take action in three areas. First, they should begin preparing non-medical intervention measures, including plans for the training of health-care workers and the education of the general public in how to restrict transmission by such means as improved personal hygiene, international travel restrictions, quarantine and contact tracing – measures that could be put into effect the moment WHO declared a global pandemic. Secondly, the development of a vaccine against a pandemic virus was vital. Thirdly, it was essential to ensure that prophylactic antiviral agents were affordable by and available to developing countries for strategic use in conjunction with vaccines.

Most developing countries, however, could not afford vaccines or antiviral agents. Even if money were available, there might be no adequate products on the market during a pandemic. An immediate task would be the identification of the pandemic strain of influenza virus in order to develop a vaccine. WHO should support an increase in vaccine production capacity in developing countries to ensure an adequate response to global pandemics, since nearly all the 300 million doses of seasonal vaccine, manufactured by only three producers all based in the developed world, were used in developed countries. WHO should also support countries in introducing compulsory licensing of vaccines and antiviral agents, in order to ensure their affordability and adequate supply in public health crises.

He endorsed the draft resolution, and suggested that in paragraph 1(6) the words “their citizens” be replaced by “health-care workers and the general public”, and that the words “and other public health interventions” be inserted before “that may protect them”. He also proposed that a new paragraph 1(10) be added, reading: “to ensure that during the global pandemic, there are timely and adequate supplies of vaccines and antiviral drugs through the application of compulsory licensing, in view of public health crises”. With regard to paragraph 2(5), in view of the serious cost implications of stockpiling antiviral agents and the operational problems connected with their distribution during a second or third wave of outbreaks, Thailand would welcome further assessment of the feasibility of using such stockpiles.

Ms HALTON (Australia) commended both the report and the draft resolution for highlighting the risk of an imminent occurrence of an influenza pandemic and the need for preparedness. WHO’s convening of a meeting in November 2004 of influenza vaccine manufacturers, national licensing agencies and others to consider mobilizing manufacturing capacity was a significant contribution to influenza pandemic preparedness. The recent outbreaks of severe acute respiratory syndrome (SARS) and avian influenza in her region had brought home to Australia that the risk of a pandemic, with its potential health impact in terms of damage to health and social disruption, was immediate.

Australia was currently updating its national plans and had reviewed its vaccine-manufacturing contracts, particularly in regard to stockpiling. It recognized the crucial role played by animal health experts in planning national influenza pandemic action and was finding ways to collaborate with them more closely. The research effort on pandemic influenza and its role in the international pandemic research agenda were of crucial importance. She supported the amendments proposed by the member for the United States of America, and asked for her country to be included among the sponsors of the draft resolution.

Dr BRUNET (alternate to Professor Dab, France) supported the views of the previous speaker and endorsed the proposed amendments to the draft resolution. France welcomed the role being played by WHO in rapidly disseminating information and in organizing meetings in Geneva and in the regional offices that had served to clarify the situation and to define difficulties to be expected in the event of a pandemic. France would be participating in a European research programme that would

include a substantial influenza component, and would allow for the development of strong international cooperation.

The problem of supplies of antiviral agents and vaccines was acute. Although in general France favoured the flexibilities provided for under the Doha Declaration on the TRIPS Agreement and Public Health, it did not believe that compulsory licensing for a vaccine that did not yet exist was the solution. Most European countries were far from attaining the recommended immunization coverage for at-risk populations with the influenza vaccines currently available. If Europe had an overall immunization coverage rate of more than 70%, as recommended by WHO, it would be in an infinitely better position rapidly to increase production capacity. No country could complain of insufficient production capacity if it had not taken the steps needed to improve it.

The member for Thailand had highlighted the problems that could arise in countries already affected by avian influenza: immediate efforts should be made to ensure that such countries had the response capacity to enable them at least to limit its spread, since in the event of a pandemic 30% of the world's population could be infected in a few weeks. The Organization had a crucial role to play in that regard, and France would do all it could to assist in that effort.

Dr SANDA (alternate to Professor Cinteza, Romania) said that her country endorsed the draft resolution and wished to be included among its sponsors. In paragraph 2(3), the words "in anticipation of, and during, influenza pandemics;" should be replaced by "in relation to influenza pandemics prevention and containment;".

Dr ANTEZANA ARANÍBAR (Bolivia) said that certainly an influenza pandemic could have serious consequences, but at the same time it had to be recognized that there were limits, especially in the developing countries, to what could be done to respond adequately. The answer lay in increasing production capacity, transfer of technology and, above all, solidarity, and in that respect, WHO headquarters and regional offices had an extremely important role to play, as the problem was not confined to a few countries or regions but had the potential to become worldwide.

He too supported the draft resolution with the amendments proposed.

Mr SHUGART (Canada) fully endorsed the draft resolution. Canada would provide all possible assistance to WHO in planning for pandemic influenza preparedness, and he emphasized the urgency of international research to reduce the pandemic's spread and impact. Canada had undertaken several actions as part of the Global Health Security Initiative that would benefit WHO, including a commitment to share preparedness plans and the first international table-top exercise in containing and preventing the international spread of an influenza pandemic.

Dr YOOSUF (Maldives) said that vaccines and antiviral agents were an important component of pandemic preparedness. However, current global vaccine production was insufficient to cover the needs of developing countries and an alternative solution needed to be found that resulted in affordable vaccines and antiviral agents. He supported the amendments proposed by the members for Thailand, the United States of America and Romania, and requested that his country be included among the sponsors of the resolution.

Mr DE CASTRO SALDANHA (alternate to Dr Buss, Brazil) said that his Government attached great importance to influenza pandemic preparedness. He endorsed the amendments proposed by the member for Thailand.

Dr HUERTA MONTALVO (Ecuador) said that, although a global fund facilitating solidarity on health security issues would be useful, a stronger initiative was needed to alert health authorities globally to the potential of an influenza pandemic. A component for financing continued activities on pandemic preparedness must be included in the Proposed programme budget 2006-2007, with consideration even being given to the use of extrabudgetary funds. Even if the capacity for the production of vaccines and antiviral agents was increased, their high cost made them accessible only

to wealthier countries. Nevertheless, those countries remained vulnerable to diseases for which there was as yet no vaccine. Responsibility therefore lay with all countries in the face of a pandemic, which could have even more serious repercussions than the HIV/AIDS pandemic. He requested that Ecuador should be included as a sponsor of the draft resolution.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica), endorsing the draft resolution, said that Jamaica recognized the importance of preparedness, surveillance and strengthening national capacity to deal with an influenza pandemic, particularly in the light of recent experience of the SARS epidemic.

The CHAIRMAN, speaking as the member for Iceland, said that he too fully supported the draft resolution. Referring to the second preambular paragraph, he suggested that, since the resolutions cited all related to communicable diseases and influenza except resolution WHA56.28, reference to that last resolution should be transferred to the end of the paragraph, followed by the words “on the revision of the International Health Regulations”.

Dr OMI (Regional Director for the Western Pacific) said that the latest information on avian influenza supported WHO’s assumption that the H5N1 influenza virus had become entrenched in parts of Asia, despite the efforts of the Member States concerned to control its spread. The two major outbreaks of avian influenza in Viet Nam had claimed 20 lives, although the efforts of that country’s Government had almost contained the second outbreak. Nonetheless, since December 2004, 23 provinces in Viet Nam had reported outbreaks of influenza among poultry, and already in 2005 eight human cases had been confirmed, while some suspected cases were being investigated. As in 2004, most cases had occurred at the time of the lunar holiday season. The continued outbreaks called for urgent and increased efforts by all Member States concerned.

To tackle that type of zoonosis, closer collaboration between the agriculture and public health sectors was urgently needed. The South-East Asia and Western Pacific Regions, in collaboration with headquarters, were preparing a bi-regional Asian strategy involving the agriculture sector in order to address the key issue of improving animal husbandry practices, which would be discussed by the regional committees concerned in September 2005.

Mr PARK (Republic of Korea)¹ said that his country had been the first to report H5N1 avian influenza outbreaks among poultry in December 2003, which it had done its best to contain. The Republic of Korea was keen to strengthen its capacity for pandemic-influenza preparedness and response and appreciated WHO’s leadership. He supported the draft resolution and proposed amendments, and requested that his country’s name be added to the list of sponsors.

Dr ASAMOA-BAAH (Assistant Director-General) welcomed the draft resolution; the existence of the H5N1 strain, with its pandemic potential, demanded the utmost preparedness and measures to minimize its impact. Despite positive developments in many countries, the world as a whole was ill-prepared. He therefore agreed with the member for Bolivia on the need for global solidarity. The discussion had usefully pointed to some of the areas on which countries expected WHO to focus. The programme was one of the oldest in WHO, and all were keen to make it fully responsive. WHO was clearly expected to continue its surveillance and to do more in supporting Member States in pandemic preparedness. Many members had spoken of the importance of dialogue with the pharmaceutical industry in developing and developed countries, and with national regulatory authorities, to ensure that vaccines were both available and affordable. That industry had been supportive and responsible in its approach.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Many speakers had mentioned the importance of animal health and the need to work with that sector, stressing the need for preparedness to be intersectoral rather than confined to the health sector. He was grateful for all the comments and all support, both to date and future. In view of the volume of resources needed, the draft resolution would help to ensure that the influenza problem received the attention it deserved.

Dr STÖHR (Coordinator, Global Influenza Programme) said that the situation was unprecedented because avian influenza had already caused great economic damage. Resources were increasingly being committed to control measures, especially in Thailand and Viet Nam. There was no doubt, however, that the disease would remain a major challenge in Asia for many years, having moved from poultry to other species. It was important, therefore, for the international community to act together in combating that global problem. Many countries were directly supporting control of the disease in Asia regarding poultry, while public health authorities were collaborating in surveillance and response. The key to the solution rested with the agricultural sector; there would be little or no long-term progress without a profound change in farming practices, and the risk to human health would remain as long as the virus circulated in Asia.

Dr VIROJ TANGCHAROENSATHIEN (adviser to Dr Suwit Wibulpolprasert, Thailand) asked to what extent avian influenza was being transmitted to pigs. The prospect of transmission of the H5N1 virus was alarming and a major issue that affected Asia as a whole.

Dr STÖHR (Coordinator, Global Influenza Programme) replied that the virus had first been found in pigs in August 2004. So far, there was no indication that it had established itself in any porcine population in Asia. If that occurred, the risk to humans would increase. Research at country level was urgently needed to determine the potential role of pigs as a reservoir for the H5N1 virus.

Dr STEIGER (United States of America) said that he could not support the wording of new paragraph 1(10) as proposed by the member for Thailand because there should be no implication that compulsory licensing was the only answer. Interested members should hold informal consultations to agree on more suitable wording. He requested updated information on the global sample vaccine shipment fund.

Dr ASAMOA-BAAH (Assistant Director-General) said that, in addition to the funds provided by the United States of America, the Government of the United Kingdom of Great Britain and Northern Ireland had pledged an almost equal amount, and it was hoped that further contributions would be made.

The CHAIRMAN suggested that further consideration of the item should be deferred until the next meeting to allow time for informal consultations.

It was so agreed.

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

2. FINANCIAL MATTERS: Item 6 of the Agenda

Assessed contributions: Item 6.1 of the Agenda

- **Status of collection, including Members in arrears in the payment of their contributions to an extent that would justify invoking Article 7 of the Constitution:** Item 6.1 of the Agenda (Document EB115/16)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions on the item were set out in paragraphs 60-64 of its report (document EB115/45). The Committee had noted the report contained in document EB115/16, and had studied developments since 31 December 2004. It had welcomed the improved rate of collection and the reduction in arrears, and had stressed the importance of timely payment of assessed contributions in order to ensure full implementation of the regular budget. It had been particularly concerned about the level of long-term arrears, for which a solution must be found with the Member States concerned. Some, it had noted, were making use of special arrangements to meet their obligations, but others were having problems with such arrangements. The Secretariat had advised that some Member States had already made proposals to be submitted to the Committee for consideration in May 2005, with a view to submitting recommendations to the Health Assembly. The Committee had requested information about amounts that Member States were entitled to claim for the adjustment mechanism and details of claims made.

Dr ANTEZANA ARANÍBAR (Bolivia), referring to the adjustment mechanism mentioned in document EB115/16, asked whether an adjustment of 60% for 2004 had been achieved, to what contribution level that adjustment corresponded, and whether the process would be continued at a level of 40% for 2005 and 2006, and 30% for 2007.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) noted that Member States had claimed benefit from an assessment mechanism for 2004-2005 in an amount higher than that envisaged in resolution WHA56.34. He also noted the importance of regular budget allocations for each programme area, as that would mean less dependence on voluntary contributions. In that regard, one way of raising the level of regular budget funds would be to refrain from claiming benefit under the adjustment mechanism, since such absence of claims would equate to an additional contribution of US\$ 12.7 million, or 1.5% of the regular budget for 2004-2005.

Dr NORDSTRÖM (Assistant Director-General), referring to the question by the member for Bolivia, confirmed that the adjustment mechanism was being applied and would continue to be implemented, in accordance with the relevant resolution. If the mechanism were not used, however, the budgetary benefits would in fact be as the member for Thailand had pointed out.

The CHAIRMAN said that he took it that the Board wished to note the report, on the understanding that a further update of Member States in arrears would be provided at the next meeting of the Programme, Budget and Administration Committee in May 2005, when it would formulate the necessary recommendations for the Health Assembly.

It was so agreed.

• **Assessments for 2006-2007** (Documents EB115/17 and EB115/INF.DOC./8)

The CHAIRMAN invited the Board to consider a draft resolution prepared by the Secretariat on assessments for 2006-2007, which read:

The Executive Board,
Having considered the report on the Assessed contributions: Assessments for 2006-2007,¹

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

The Fifty-eighth World Health Assembly,
Having considered the report of the Director-General,

1. ADOPTS the scale of assessments of Members for the biennium 2006-2007 as set out below:

Members and Associate Members	WHO scale for 2006-2007
	%
Afghanistan	0.00200
Albania	0.00500
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

¹ Document EB115/17.

Members and Associate Members	WHO scale for 2006-2007
	%
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
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

Members and Associate Members	WHO scale for 2006-2007
	%
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
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

Members and Associate Members	WHO scale for 2006-2007
	%
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
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

Members and Associate Members	WHO scale for 2006-2007 %
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
Venezuela (Bolivarian Republic of)	0.17100
Viet Nam	0.02100
Yemen	0.00600
Zambia	0.00200
Zimbabwe	0.00700
Total	100.00000

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were set out in paragraphs 65-67 of its report (document EB115/45). The Committee had noted that, by resolution WHA57.15, the Health Assembly had decided to adopt the latest United Nations scale for application at WHO in 2005, and that the same scale had been proposed for 2006-2007. It had also noted that the adjustment mechanism established by resolution WHA56.34 would continue to operate in 2006-2007.

The CHAIRMAN said that, in the absence of comments, he took it that the Board wished to adopt the draft resolution.

The resolution was adopted.¹

Amendments to the Financial Regulations and Financial Rules: Item 6.2 of the Agenda (Document EB115/43)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were set out in paragraphs 68-72 of its report (document EB115/45). The Committee had noted that a wide-ranging review of all financial policies and procedures was under way within the framework of best practice accounting standards such as the International Public Sector Accounting Standards and the International Financial Reporting Standards which the United Nations system was considering for future use. The Committee had noted the proposed deletion of paragraphs 4.5a and 4.7 so that, instead of carrying forward unliquidated obligations from one financial period to another, amounts accrued at a period end would be carried forward to pay for all goods and services previously contracted. Implementation of the amendments would result in improved implementation of the programme budget and provide the potential for a lower level of savings on unliquidated obligations, which might, however, reduce the future level of Miscellaneous Income. The Secretariat had confirmed that the amendments would apply to all the Organization's financial transactions.

¹ Resolution EB115.R8.

The CHAIRMAN invited the Board to consider the draft resolution contained in the report.

The resolution was adopted.¹

3. MANAGEMENT MATTERS: Item 7 of the Agenda (continued)

Governing body matters: Item 7.3 of the Agenda

• **Working methods of the Health Assembly** (Document EB115/20)

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries Bulgaria, Croatia, Romania and Turkey, thanked the Director-General for his report, consideration of which provided a welcome opportunity for members to influence the strategic course of the Organization and for the best possible use to be made of the Health Assembly.

Ms DENG Hongmei (alternate to Dr Yin Li, China) said that she appreciated the concern to enhance efficiency in the Health Assembly's deliberations but could not agree to a change in schedule whereby the Director-General and certain other speakers would address the Health Assembly before the agenda was adopted. Only procedural matters should be taken up before the agenda was adopted; but the contributions of the speakers in question would be an important part of the substance and should therefore immediately precede any substantive discussion. Otherwise the position of Member States would be weakened and the integrity of the entire Health Assembly's procedure impaired. It could also lead to confusion about whether the current or a previous Health Assembly was being referred to in the statements concerned. The practice followed to date should therefore not be abandoned.

The Health Assembly should not be divided into two parts. The provisional agenda and the supplementary items should, according to the rules, be considered by the General Committee, and indeed the two parts were connected. An attempt to separate them could prolong discussion and impair Member States' rights in considering the agenda. She appreciated the Secretariat's intentions, but urged a more practical approach, in particular, trying to avoid instances of political dissension such as had hampered recent Health Assemblies. Measures should also include steps to strengthen the authority of the General Committee and ensure that Health Assembly decisions were upheld.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) supported the curtailment of the general discussions in Health Assembly plenaries in order to allow more time for the work of Committees A and B. The round tables had been a useful means of sharing experiences; he therefore proposed that they should be continued at the level of senior public health officials, on condition that they were moderated in a manner that ensured an interactive debate on the chosen theme between the officials, WHO experts and representatives of civil society organizations. He supported the proposed timetable, with the exception of the proposed scheduling of Committees A and B: the Committees should commence their work at the same time. The provisional agenda should be amended to ensure consistency with the Executive Board agenda and the recommendations of previous Health Assemblies. For example, it should include a discussion on the Board's recommendation, made at the present session, on the establishment of World Blood Donor Day.

¹ Resolution EB115.R9.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) said that the proposals could streamline the work of the Health Assembly and increase its efficiency. She supported the changes in scheduling of the statements by the Director-General and by invited speakers, but expressed reservations at the proposal that the General Committee should consider possible supplementary agenda items only after the closure of the general discussion. Memories of the occurrences on the opening day of the Fifty-seventh World Health Assembly had no doubt prompted the proposal, but the General Committee should give fair and equitable consideration to all proposals for supplementary agenda items at the opening of the Health Assembly, taking into account their potential impact on the course of discussions. The General Committee should therefore consider the provisional agenda as a whole at one meeting.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho), speaking on behalf of the African group, expressed support for efforts to improve the working methods of the Health Assembly but noted that it would be unusual to schedule the statements by the Director-General and by invited speakers, which were agenda items, before the agenda itself had been adopted and before the address by the President. The General Committee should discuss the entire provisional agenda at one meeting; separate discussion of the provisional agenda and supplementary items, as proposed, would not be an efficient working procedure.

Mr HASAN (alternate to Mr Khan, Pakistan) said that the agenda set the course for the discussions to be held during a session and its importance must not be underestimated. He therefore opposed the proposed division of consideration of the Health Assembly provisional agenda by the General Committee into two parts; the existing procedure should remain unchanged.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) supported the proposals to avoid prolonged discussion and overloading of the provisional agenda. He also supported the proposals to discontinue the ministerial round tables, to enhance the work of Committees A and B, and to improve provision of information to delegations, in particular on the transfer of items between the two main committees. In those Committees delegates should deliver brief statements from written texts, to facilitate simultaneous interpretation. The Secretariat should make Health Assembly documentation available electronically no later than one month before the start of the Health Assembly so that countries could prepare their statements and proposals in writing well in advance.

Dr ANTEZANA ARANÍBAR (Bolivia) said that it was important to bear in mind the main aim of the Health Assembly, namely to highlight the public health situation around the world and the challenges faced by countries, with a view to fostering appropriate international cooperation to achieve health gains. The ministerial round tables had not produced the desired results and should therefore be discontinued, or continued only at the level of senior public health officials. He supported arguments for consideration of the provisional agenda at one meeting by the General Committee, before the general discussion. It was important to improve the working methods of Committees A and B; a time limit for speakers would be useful. The proposal that interventions should be prepared in writing in advance was of doubtful benefit, however. Participants should interact and exchange opinions; in other words, they should hold a true debate. If everything were to be prepared in advance, statements could simply be circulated electronically or in printed form and there would be no point in holding a meeting.

Mr BASSE (Senegal)¹ supported the replacement of the ministerial round tables by bilateral meetings, but did not favour scheduling the statements by the Director-General and the invited speakers for delivery before the adoption of the agenda, of which they were an integral part.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

Moreover, it would be unusual and inappropriate for the statement of the head of the Secretariat to take precedence over that of the President of its main governing body. He also opposed the proposal for a two-stage procedure for consideration and adoption of the provisional agenda, which might result in differential treatment for items proposed by the Executive Board and proposed supplementary agenda items. In addition, the first two days of the Health Assembly would be dogged by uncertainty as delegations would not know which items were going to be included on the agenda. Such a situation would be unlikely to create an atmosphere conducive to fruitful discussions. The entire agenda should be considered and adopted on the first day, so that delegates could participate fully in the subsequent debates.

Mr SÁNCHEZ OLIVA (Cuba)¹ said that, although some of the proposals before the Board would indeed improve the methods of work of the Health Assembly, experience had shown that the agenda was crucial in guiding its work. The two-stage proposals for consideration and adoption of the agenda were not appropriate. It would not be acceptable to take up certain items of the agenda before that agenda had been adopted, particularly as the Director-General and invited speakers were expected to address substantive issues of relevance to the adopted agenda in their statements.

The CHAIRMAN noted that, although speakers had agreed that the ministerial round tables should be discontinued, there had been differing views regarding the other proposals. He therefore suggested that the Board should recommend that the round tables should be discontinued and that it should request the Director-General to continue his consideration of the other issues.

It was so agreed.

- **Provisional agenda of the Fifty-eighth World Health Assembly and date and place of the 116th session of the Executive Board** (Document EB115/21)

Dr KEAN (Director, Governance) said that the proposed provisional agenda set out in Annex 1 to document EB115/21 had been prepared before the Board's current session. On the basis of the Board's discussions so far, the following items should be added under item 18, Technical and health matters: Achievement of health-related Millennium Development Goals (which would be the subject of an electronic consultation before the Health Assembly); Antimicrobial resistance: a threat to global health security; Health action in relation to crises and disasters; Strengthening pandemic influenza preparedness and response; and Public health problems caused by harmful use of alcohol. In response to the earlier observation by the member for Thailand, he said that the proposal for the establishment of World Blood Donor Day was included as provisional agenda item 26. Item 23, Guiding principles for strategic resource allocations, should be deleted; it was in fact an item for consideration by the Board at its 116th session.

Mr AITKEN (Director, Office of the Director-General) explained that, as a consequence of the outcome of the Board's discussion on the working methods of the Health Assembly, the opening agenda items of the Fifty-eighth World Health Assembly would follow the pattern of those for the Fifty-seventh World Health Assembly, and would therefore read:

1. Opening of the Assembly
 - 1.1 Appointment of the Committee on Credentials
 - 1.2 Election of the Committee on Nominations

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

- 1.3 Reports of the Committee on Nominations
 1. Election of the President
 2. 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 114th and 115th sessions
3. Address by the Director-General
4. Invited speakers.

Dr STEIGER (United States of America) said that as WHO's work on alcohol was already included in the proposed provisional agenda under item 18.10, it might therefore be better to include consideration of the public health problems of harmful use of alcohol under that item rather than as a separate item.

It was unfortunate that the Secretariat had chosen to present a provisional agenda for consideration that presupposed that the Board would agree to its proposals concerning the changes in working methods of the Health Assembly, which in fact had not been the case. In future it might be better to consult or await the decision of the Board in such matters.

In reply to Ms DENG Hongmei (alternate to Dr Yin Li, China), Mr AITKEN (Director, Office of the Director-General) confirmed that the timetable would be adjusted to conform with the amendments to the opening items of the provisional agenda he had just indicated, and would therefore revert to the schedule for those items at the previous Health Assembly.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to approve the draft decision contained in document EB115/21, with the amendments proposed and taking account of the comments of the Secretariat.

The decision, as amended, was adopted.¹

The CHAIRMAN drew attention to resolution EB112.R1 which had decided that the Board's session following the Health Assembly should in principle be extended by two days to permit a more even and effective distribution of substantive work between its two annual sessions. In order not to extend members' stay in Geneva for too long, he proposed that the 116th session should therefore be held over three days.

Decision: The Executive Board decided that its 116th session should be convened on Thursday, 26 May 2005, at WHO headquarters, Geneva, and should close no later than Saturday, 28 May 2005.²

Relations with nongovernmental organizations: Item 7.4 of the Agenda

- **Report of the Standing Committee on Nongovernmental Organizations** (Document EB115/22)

Dr HUERTA MONTALVO (Ecuador), speaking in his capacity as Chairman of the Standing Committee on Nongovernmental Organizations, described the outcome of the Committee's consideration of applications for admission into official relations with WHO and review of nongovernmental organizations in official relations. The draft resolution recommended to the Board,

¹ Decision EB115(1).

² Decision EB115(2).

set out in the Committee's report (document EB115/22), proposed the admission into, suspension of and discontinuation of official relations for several nongovernmental organizations.

Following the review of one third of the nongovernmental organizations in official relations with WHO, the Committee had made the recommendations contained in the draft decision set out in its report (document EB115/22). In particular, it had noted that a plan of work had yet to be agreed with Corporate Accountability International (formerly Infact) and had proposed to defer a decision on relations with that nongovernmental organization until the Committee's meeting during the 117th session of the Board in January 2006 when the Committee would receive reports on relations between WHO and the nongovernmental organization and on its conduct at intergovernmental meetings. In the case of four nongovernmental organizations, reports of collaboration had remained outstanding and the Committee had recommended that review of relations should be deferred until its meeting at the 117th session of the Board. The nongovernmental organizations should be reminded that, if no report were provided in time, official relations would be discontinued.

The Committee had expressed its appreciation of the work of the applicant organizations and of those whose activities had been reviewed.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) expressed concern about the reference to allegations of inappropriate behaviour by representatives of Corporate Accountability International at sessions of the Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control (paragraph 8). She asked whether a formal complaint had been received, and whether there was a mechanism for dealing with such complaints which allowed nongovernmental organizations to defend their position. She would welcome an explanation of the proposal to defer the review of that organization to the 117th session of the Executive Board. Jamaica had had a good working relationship with the former Infact, which had helped to move the tobacco control agenda forward.

Dr AHMED (Ghana) expressed concern about paragraphs 2 and 8. Paragraph 2 of the report stated that the Framework Convention Alliance on Tobacco Control met the criteria for admission into official relations, whereas paragraph 8 stated that the Secretariat would be reviewing its future work on the WHO Framework Convention once it had come into force and that a plan for collaboration had not been agreed; accordingly, the Secretariat wished to defer the review until the Board's 117th session. He asked whether that review applied only to Infact or to all nongovernmental organizations concerned.

Dr ACHARYA (Nepal), referring to paragraph 3 of the proposed draft resolution, asked why it had been decided to discontinue relations with the organizations mentioned therein.

Ms MAFUBELU (South Africa),¹ also referring to paragraph 8 of the report, said that in South Africa's experience the participation of Infact had been constructive and had advanced rather than hindered the work of the Intergovernmental Negotiating Body on the WHO Framework Convention on Tobacco Control. It nevertheless supported the deferral of the review of the organization's status until 2006.

Dr HUERTA MONTALVO (Ecuador), again speaking in his capacity as Chairman of the Standing Committee, said that the proposed draft resolution and draft decision were based on the reports received. The review of Infact's status had been deferred for one year because its activities had declined with the ratification of the WHO Framework Convention; if no plan of collaboration had been agreed, relations with the organization could not be maintained. Replying to the member for Nepal, he said that, although the International Council for Science had informed the Committee about

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

the work of its members with WHO, it transpired that most of those members already had formal relations with WHO in their own right. The Standing Committee did not consider that WHO's relations with the remaining members warranted maintaining official relations with the International Council for Science.

The CHAIRMAN invited the Board to consider the draft resolution contained in document EB115/22.

The resolution was adopted.¹

The CHAIRMAN invited the Board to consider the draft decision contained in document EB115/22.

The decision was adopted.²

- **Reconsideration of two applications for admission into official relations with WHO**
(Document EB115/34)

The CHAIRMAN informed the Board that the Director-General had received letters from the two candidates for admission requesting that consideration of the applications should be postponed to a future session of the Board. There was therefore no need to discuss the matter at the present session.

The meeting rose at 12:40.

¹ Resolution EB115.R10.

² Decision EB115(3).

TWELFTH MEETING

Monday, 24 January 2005, at 14:15

Chairman: Mr D.Á. GUNNARSSON (Iceland)

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

Responding to health aspects of crises: Item 4.3 of the Agenda (Document EB115/6) (continued from the second meeting)

The CHAIRMAN invited the Board to consider the revised draft resolution on health action in relation to crises and disasters, with particular emphasis on the south Asian earthquakes and tsunamis of 26 December 2004, which read:

The Executive Board,
Having considered the report on responding to health aspects of crisis;¹

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

The Fifty-eighth World Health Assembly,

~~Noting~~ Regretting the profound human consequences of the earthquakes and tsunamis that on 26 December 2004 struck ~~42~~ many countries, from ~~South-East Asia~~ to east Africa, causing more than ~~150 210 000~~ deaths, ~~including many health professionals, with thousands more still missing,~~ injuring as many as half a million people, and making at least five million people homeless and/or deprived of adequate access to safe drinking-water, sanitation, food or health services;

Noting that citizens of more than 30 countries were affected by the disaster, and that those who died included many health professionals;

Acknowledging that most relief assistance has initially been provided (and will continue to be) provided from within affected communities, and through local authorities, supported through intense international cooperation and expecting that these communities will continue to experience serious difficulties as a result of the loss of their means of livelihood, overloading of health and social services, and both immediate and long-term psychological trauma;

Recognizing that action to address the public health aspects of crises should at all times strengthen the ingenuity and resilience of communities, the capacities of ~~civil society~~ and local authorities, the preparedness of health systems, and the ability of national authorities and civil society to provide prompt and coordinated back-up geared to the survival of those immediately affected;

Appreciating the generous assistance provided to the affected nations by governments, nongovernmental groups, individuals, and national public-health institutions (including through the Global Outbreak Alert and Response Network); ~~and recognizing the major challenges faced by local authorities as they attempt to coordinate both personnel and goods made available in this way;~~

¹ Document EB115/6.

Acknowledging the difficulties faced by under-resourced local health systems in locating missing persons, identifying those who have died, and managing the bodies of the deceased;

Recognizing the challenges faced by overwhelmed local authorities as they coordinate the relief effort, including personnel and goods generously made available as a result of both national and international solidarity;

Noting that the effectiveness with which affected nations respond to sudden events of this scale reflects their preparedness and readiness for focused and concerted action, particularly in relation to saving life and sustaining survival;

Recalling that more than 30 countries worldwide are currently facing major, often long-standing crises, with as many as 500 million persons at risk because they face a variety of avoidable threats to their survival and well-being, and that around 20 other countries are at high risk for serious natural or man-made events, increasing the number of persons at risk to between 2000 million and 3000 million;

Appreciating that analyses of health needs and performance of health systems, within the context of national policies and internationally agreed development goals, including those contained in the United Nations Millennium Development Goals Declaration, are essential for the proper rehabilitation and recovery of equitable individual and public health services, and that this task is best undertaken if there are clear synergies between preparedness and response;

Reaffirming the need to build local capacity to assess risks, prepare for, and respond to, any future catastrophe, including by providing continuous public education, dispelling myths about health consequences of disasters, and reducing the risk of disaster damage in critical health facilities;

Taking into account the outcomes of the World Conference on Disaster Reduction (Kobe, Japan, 18-22 January 2005).

1. CALLS UPON the international community to continue its strong and long-term support to humanitarian action that lays emphasis on saving lives and sustaining survival in areas affected by the tsunami of 26 December 2004, and to give similar attention to the needs of people affected by other humanitarian crises;

2. URGES Member States:

(1) to provide adequate backing to tsunami-affected countries for the sustainable recovery of their health and social systems;

(2) to make their best efforts to engage actively in the collective efforts to establish global and regional preparedness plans and build up capacity to respond to health-related crises;

(3) to formulate national emergency-preparedness plans that give due attention to public health and to the roles of the health sector in crises, in order to improve the effectiveness of responses to crises and of contributions to the recovery of health systems;

(4) to ensure that women and men have equal access to both formal and informal education on emergency preparedness and disaster reduction through gender-sensitive early warning systems that empower women, as well as men, to react in timely and appropriate ways (and that appropriate education and response options are also made available to all children);

~~(4)~~(5) to ensure that – in times of crisis – all vulnerable affected populations have equitable access to essential health care, focusing on saving those whose lives are endangered, and sustaining the lives of those who have survived, and paying particular attention to the specific needs of women and children, older people, and

persons with acute physical and psychological trauma, communicable diseases, chronic illnesses, or disability;

~~(5) to increase as a priority their contribution to existing financing for WHO's support for health actions in crisis so that they are adequate for immediate and significant interventions;~~

(6) to support a review, within the Proposed programme budget for 2006-2007, of WHO's actions in relation to crises and disasters, in order to allow for immediate (and timely), adequate, sufficient and sustained interventions, and to consider increasing contributions in order to ensure adequate financing of significant WHO actions and interventions before, during and after crises;

~~(6)(7) to safeguard protect national and international personnel involved in improving health of crisis-affected communities, and to ensure that they receive the necessary physical protection and professional guidance, emotional support and logistical back-up so that they can to undertake whatever urgent and necessary humanitarian action is needed and relief of suffering (to the greatest possible extent) when lives are endangered, relieve suffering and save lives to the maximum extent possible;~~

3. REQUESTS the Director-General:

~~(1) to build up intensify WHO's support for tsunami-affected to those Member States affected by the tsunami of 26 December 2004 as they establish focus on effective disease-surveillance systems, assess and improved access to clean water, sanitation and good-quality health care (particularly for on mental health), by strengthening the management of medical supply chains and providing necessary technical guidance to all those involved in humanitarian action, health professionals and the general public on matters of public health importance, (including the that on management of dead bodies, and avoidance of communicable diseases), and ensuring prompt and accurate communication of information in a way that reduces misinformation;~~

~~(2) to coordinate the effort of donors to assist governments affected by the said tsunami in the effective planning and implementation of encourage cooperation of WHO's field activities with those of other international organizations, with the support of donor agencies, so as to help governments of countries affected by the tsunami to coordinate responses to public health challenges (under the aegis of the United Nations Office for the Coordination of Humanitarian Affairs) and to plan and implement the rapid and sustainable rehabilitation of health systems and services, and to report to the Health Assembly on the progress of such cooperation;~~

~~(3) to assist in the design of social safety nets and programmes that provide support for to persons unable to function because of the impact of whose lives and livelihoods have been affected by the said tsunami on their lives and livelihoods, and of the services needed to address their psychological physical and mental trauma;~~

~~(4) to extensively adapt, redesign (where necessary), and secure adequate resources for, effective WHO's work in the area of emergency preparedness and response, and other areas of work involved in the Organization-wide response to crises;~~

~~(5) to enhance WHO's capacity to provide support, within the coordination mechanisms of the United Nations system and of other institutions (particularly the International Red Cross and Red Crescent Movement), for formulating, testing and implementing health-related emergency preparedness plans, responding to the critical health needs of people in crisis conditions, and planning and implementing sustainable recovery after a crisis;~~

(6) to establish clear lines of command within WHO to facilitate rapid and effective responses in the initial stages of an emergency, and to communicate those arrangements clearly to Member States;

~~(6)~~(7) to mobilize WHO's own extensive health expertise, to increase its ability to locate outside expertise, to ensure that such knowledge and skills are updated, and to make this expertise available in order to provide prompt and appropriate technical support to both international and national health disaster-preparedness, response, mitigation and risk-reduction programmes;

(8) to foster WHO's continued and active cooperation with the International Strategies for Disaster Reduction, thereby ensuring adequate emphasis on health-related concerns in the implementation of the outcomes of the World Conference on Disaster Reduction (Kobe, Japan, 18-22 January 2005);

~~(7)~~(9) to ensure that WHO helps all relevant groups concerned bodies as they prepare for, respond to, and recover from with preparation for, response to and recovery after disasters and crises – through timely and reliable assessments the levels of suffering and threats to survival, as revealed by (using morbidity and mortality data); coordination of health-related action in ways that reflect these assessments; identification of, and action to fill gaps critical to that threaten health outcomes; and building of local and national capacities, including transfer of expertise, experience and technologies, among between Member States, with adequate attention to the links between relief and reconstruction;

~~(8)~~(10) to develop further strengthen existing logistics services within WHO's mandate, in close coordination with other humanitarian agencies, so that the necessary operational capacity may be available for Member States to receive prompt and timely assistance when faced by public health crises.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that, in his country's experience, one of the most difficult issues to deal with following a disaster was the spread of rumours. In order to prevent public panic caused by such rumours and even more devastating socioeconomic consequences, accurate information should be provided to the media. He therefore suggested the addition of a new paragraph 3(1)*bis*, which would read: "to actively and in a timely manner provide accurate information against rumours to the international and local media so as to prevent public panic, conflicts and other social and economic impacts".

Dr BRUNET (alternate to Professor Dab, France) expressed general support for the draft resolution but recalled that the member for the United Kingdom of Great Britain and Northern Ireland, supported by the member for France, had proposed that in paragraph 3(3) the words between "design of" and "the services needed" should be deleted. The text as it stood was too vague, and he did not think that the design of programmes to support persons whose livelihoods had been affected came within the scope of WHO's activities.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) said that the health aspects of crises should be identified in more detail. For instance, the report stated (paragraph 1) that a threat such as the increasing prevalence of HIV infection could trigger a crisis; the HIV/AIDS epidemic should be identified as a global crisis with no less an impact in medical and social terms than any other crisis or disaster. A combination of an HIV/AIDS epidemic and other types of crisis not only would worsen the situation with regard to HIV infection, but also could lead to a significant deterioration in the epidemiological situation of tuberculosis. In future, more information should be provided on the epidemiology of conditions associated with crises and disasters.

Dr STEIGER (United States of America) suggested that the draft resolution, which he supported, needed minor editorial improvements. The meaning of "gender-sensitive early warning systems" in paragraph 2(4) was not clear, since as he saw it all vulnerable persons should be warned of

disasters and trained in how to deal with them. He proposed adding the words “including displaced persons” after “affected populations” in paragraph 2(5).

Mr YAMAGUCHI (Japan),¹ referring to the final preambular paragraph and to paragraph 3(8), said that the reference to the World Conference on Disaster Reduction should read “World Conference on Disaster Reduction (Kobe, Hyogo, Japan, 18-22 January 2005)”. In order to emphasize the importance of the role of governments of affected countries, he proposed that the words “as primary responsibility lies with these governments” should be added after “Humanitarian Affairs” in paragraph 3(2).

The CHAIRMAN, speaking as the member for Iceland, supported that proposal.

Dr NABARRO (Representative of the Director-General for Health Action in Crises) said that the term “gender-sensitive” in paragraph 2(4) had been suggested by members to reflect the fact that the early warning systems referred to should meet the needs of all groups, in particular women with children.

With regard to the comments of the member for France on paragraph 3(3), he recalled that in many disasters in recent years WHO had been asked to provide input into the design of humanitarian programmes, not only with regard to health services but also access to water, sanitation, food, shelter and security – areas with a direct potential impact on health. The wording of the paragraph was intended to capture the broad notion of public health within the spirit of the primary health care being developed by WHO, and he wondered whether it would be appropriate to delete reference to WHO’s assistance in the design of humanitarian programmes, particularly as bodies such as UNHCR were requesting assistance in that regard.

He agreed that the text did not provide much information on the epidemiology of conditions associated with crises and disasters; the comments of the member for the Russian Federation would be taken into account.

Mr AITKEN (Director, Office of the Director-General) read out the suggested amendments. The representative of Japan, supported by the member for Iceland, had suggested that “Hyogo” be added after “Kobe” in the final preambular paragraph and in paragraph 3(8). In the light of the comments by the member for the United States of America, it might be appropriate to delete the words “gender-sensitive” from paragraph 2(4). That member had also proposed inserting “including displaced persons” after “affected populations” in paragraph 2(5). The member for Thailand had proposed the addition of a paragraph 3(1)*bis*, to read: “to actively and in a timely manner provide accurate information against rumours to the international and local media so as to prevent public panic, conflicts and other social and economic impacts”. In paragraph 3(3), it might be preferable to insert “health aspects of” after “design of”, and to retain the remainder of the text as it stood.

Dr BRUNET (alternate to Professor Dab, France) supported the amendment to paragraph 3(3) suggested by Mr Aitken.

The resolution, as amended, was adopted.²

Infant and young child nutrition: Item 4.4 of the Agenda (Document EB115/7) (continued from the fourth meeting)

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Resolution EB115.R11.

The CHAIRMAN drew attention to the draft resolution on infant and young child nutrition, as amended by a drafting group, which read:

The Executive Board,
Having considered the report on infant and young child nutrition;¹

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

The Fifty-eighth World Health Assembly,
Recalling the adoption by the Health Assembly of the International Code of Marketing of Breast-milk Substitutes (resolution WHA34.22), resolutions WHA39.28, WHA41.11, WHA46.7, WHA47.5, WHA49.15, and particularly resolution WHA54.2 on infant and young child nutrition, appropriate feeding practices and related questions;

Aware that the joint FAO/WHO expert workshop on *Enterobacter sakazakii* and other microorganisms in powdered infant formula held in 2004 concluded that intrinsic contamination of powdered infant formula with *E. sakazakii* and *Salmonella* has been a cause of infection and illness, including severe disease in infants, particularly preterm, low birth-weight or immunocompromised infants and can lead to serious developmental sequelae and death;²

Noting that such severe outcomes are especially serious in preterm, low-birth weight and immunocompromised infants, and therefore are of concern to all Member States;

Bearing in mind that the Codex Alimentarius Commission is revising its recommendations on hygienic practices for the manufacture of foods for infants and young children;

Concerned that there are reports of nutrition and health claims being used inappropriately to promote the sale of breast-milk substitutes instead of breastfeeding;

Acknowledging that the Codex Alimentarius Commission plays a pivotal role in providing guidance to Member States on the proper regulation of foods, including foods for infants and young children;

Bearing in mind that on several occasions the Health Assembly has called upon the Commission 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 relevant public health strategies, particularly the global strategy for infant and young child feeding (resolution WHA55.25) and the Global Strategy on Diet, Physical Activity and Health (resolution WHA57.17);

Recognizing that such action requires a clear understanding of the respective roles of the Health Assembly and the Codex Alimentarius Commission, and that of food regulation in the broader context of public health policies;

Taking into account resolution WHA56.23 on the joint FAO/WHO evaluation of the work of the Codex Alimentarius Commission, which endorsed WHO's increased direct involvement in the Commission and requested the Director-General to strengthen WHO's role in complementing the work of the Commission with other relevant WHO activities in the areas of food safety and nutrition, with special attention to issues mandated in Health Assembly resolutions,

¹ Document EB115/7.

² FAO/WHO Expert Meeting on *E. sakazakii* and other Microorganisms in Powdered Infant Formula: Meeting Report. Microbiological Risk Assessment Series No. 6, 2004, page 37.

1. URGES Member States:

- (1) to continue to protect, promote and support exclusive breastfeeding for six months as a global public health recommendation, taking into account the findings of the WHO Expert Consultation on optimal duration of exclusive breastfeeding,¹ and to provide for continued breastfeeding up to two years of age or beyond, by implementing fully the WHO global strategy on infant and young child feeding encouraging the formulation of a comprehensive national policy, including where appropriate a legal framework to promote maternity leave and a supportive environment for six months' exclusive breastfeeding, a detailed plan of action to implement, monitor and evaluate the policy, and allocation of adequate resources for this process;
- (2) to ensure that nutrition and health claims are not permitted on foods for infants and young children except where specifically provided for in relevant Codex Alimentarius standards or national legislation;
- (3) to ensure, in situations where infants are not breastfed, that clinicians and other health-care providers, community workers and families, parents and other caregivers, particularly of infants at high risk, are provided with information and training in a timely manner on the preparation, use and handling of powdered infant formula in order to minimize health hazards; are informed that powdered infant formula may contain pathogenic microorganisms and must be prepared and used appropriately; and, where applicable, that this information is conveyed through an explicit warning on packaging;
- (4) to ensure that financial support for professionals working in infant and young child health does not create conflicts of interests;
- (5) to ensure that research on infant and young child feeding, which forms the basis for public policies, is always independently reviewed in order to ensure that such policies are not unduly influenced by commercial interests;
- (6) to work closely with relevant entities, including manufacturers, to continue to reduce the concentration and prevalence of pathogens, including *Enterobacter sakazakii*, in powdered infant formula;
- (7) to continue to ensure that manufacturers adhere to Codex Alimentarius or national food standards and regulations;
- (8) to ensure policy coherence at national level by stimulating collaboration between health authorities, food regulators and food standard-setting bodies;
- (9) to participate actively in the work of the Codex Alimentarius Commission;
- (10) to ensure that all national agencies involved in defining national positions on public health issues for use in all relevant international fora, including the Codex Alimentarius Commission, have a common and consistent understanding of health policies adopted by the Health Assembly and to promote these policies;

2. REQUESTS the Codex Alimentarius Commission:

- (1) to continue to give full consideration, when elaborating standards, guidelines and recommendations, to those resolutions of the Health Assembly that are relevant in the framework of its operational mandate;
- (2) to establish standards, guidelines and recommendations on foods for infants and young children formulated in a manner that ensures the development of safe

¹ As formulated in the conclusions and recommendations of the Expert Consultation (Geneva, 28-30 March 2001) that completed the systematic review of the optimal duration of exclusive breastfeeding (see document A54/INF.DOC./4).

and appropriately labelled products that meet their known nutritional and safety needs, thus reflecting WHO policy, in particular the global strategy for infant and young child feeding and the International Code of Marketing of Breast-milk Substitutes;

(3) to urgently complete work currently under way on addressing the risk of microbiological contamination of powdered infant formula and establish appropriate microbiological criteria or standards related to *E. sakazakii* and other relevant microorganisms in powdered infant formula; and to provide guidance on safe handling and explore the necessity of adding warning messages on product packaging;

3. REQUESTS the Director-General:

(1) in collaboration with FAO, to develop guidelines for clinicians and other health-care providers, community workers and family, parents and other caregivers on the preparation, use and handling of infant formula to minimize risk, and to address the particular needs of Member States to establish effective measures to minimize risk in situations where infants cannot be, or are not, fed breast milk;

(2) to encourage and promote independently reviewed research, including by collecting evidence from different parts of the world, in order to get a better understanding of the ecology, taxonomy, virulence and other characteristics of *E. sakazakii* in line with the recommendations of the FAO/WHO expert meeting [see footnote 2] on *E. sakazakii*, and to explore means of reducing its level in reconstituted powdered infant formula;

(3) to provide information in order to promote and facilitate the contribution of the Codex Alimentarius Commission, within the framework of its operational mandate, to full implementation of international public health policies;

(4) to report regularly to the Health Assembly on progress in the consideration of matters referred to the Codex Alimentarius Commission for its action.

Mr AITKEN (Director, Office of the Director-General) pointed out that the words “[see footnote 2]” should be deleted from paragraph 3(2), which in fact had no footnote.

Dr HUERTA MONTALVO (Ecuador) congratulated the drafting group on producing a text that was apparently acceptable to all. He particularly welcomed paragraph 1(6), which clarified the situation and defined the approach to be taken for the future. He agreed that WHO should not be too restrictive in defining its area of competence, bearing in mind that health constituted a state of physical, mental and social well-being and not merely an absence of disease.

Dr HANSEN-KOENIG (Luxembourg), speaking on behalf of the Member States of the European Union and the candidate countries Bulgaria, Croatia, Romania and Turkey, supported the amended draft resolution, and indicated that those countries on whose behalf she spoke wished to be sponsors.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) observed that there appeared to be a contradiction in the text. Paragraph 1(3) stated that, where applicable, packaging should contain a warning to the effect that powdered infant formula might contain pathogenic microorganisms. However, in paragraph 2(3), the Codex Alimentarius Commission was requested to explore the necessity of adding warning messages on product packaging. He acknowledged that the potential existed for powdered infant formula to become contaminated with *Enterobacter sakazakii*, and agreed that further research should be undertaken to obtain a better understanding of the ecology, taxonomy, virulence and other characteristics of *E. sakazakii*. The Codex Alimentarius Commission

should develop guidelines for the quality control of infant formula, which would be the most effective way of reducing the risks of contamination of food products. It was not appropriate, however, to put an explicit warning on packaging, as it might cause unjustified concern among clinicians and carers and have a detrimental effect on the health of children during the first year of life, particularly when infant formula was replaced with other, less suitable alternatives, such as cow's milk. Although all Member States recognized the importance of six months' exclusive breastfeeding and had endorsed that as part of a global strategy on infant and young child feeding, breastfeeding for that length of time was not always possible, and in such cases supplementary feeding would be introduced. Care should be taken over the labelling of food products for infants, and the information on nutritional value and the health benefits of those products should be confirmed by rigorous scientific data.

Dr STEIGER (United States of America) said that, although he shared some of the concerns expressed by the previous speaker, he supported the text as it stood.

Dr ACHARYA (Nepal) proposed that the words "where applicable" in paragraph 1(3) should be deleted.

Dr TANGI (Tonga) said that the issue of infant and young child nutrition was of concern to his country. He too supported the draft resolution as it stood and wished to become a sponsor.

Dr AHMED (Ghana) also supported the draft resolution as it stood.

Dr STEIGER (United States of America) urged members not to reopen discussion of the text, which was a carefully balanced compromise.

The CHAIRMAN, acknowledging the differences of view, urged participants to accept the text as it stood in the interests of consensus.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that, in principle, he had no objection to the text, but reiterated that it contained certain contradictions.

Ms HALTON (Australia), speaking as Chairman of the drafting group, thanked participants for the spirit of compromise that they had shown. The comments made by the members for Nepal and the Russian Federation had typified the essence of the debate and highlighted the different positions. Paragraph 1(3) addressed the public health component of the issue. The phrase "where applicable" was a compromise intended to acknowledge that each country should decide for itself what action to take with regard to warnings on packaging. One factor that was clear, however, was the responsibility of the public health authorities in each country to inform citizens about issues surrounding the use of the products. The point made by the member for the Russian Federation that people might stop using the products and replace them with other less suitable alternatives had been discussed by the group.

Referring to paragraph 2(3), she said that it was the group's expectation that the work to be undertaken by the Codex Alimentarius Commission would be consistent with the latter's mandate.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) thanked the Chairman of the drafting group for her explanation and expressed willingness to join the consensus.

The resolution, as amended, was adopted.¹

¹ Resolution EB115.R12.

Social health insurance: Item 4.5 of the agenda (document EB115/8) (continued from the fifth meeting)

The CHAIRMAN invited the Board to consider the amended draft resolution on sustainable health financing, universal coverage and social health insurance, which read:

The Executive Board,
Having considered the report on social health insurance,¹

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

The Fifty-eighth World Health Assembly,

Noting that health-financing systems in many countries need to be further developed in order to guarantee access to necessary services while providing protection against financial risk;

Accepting that, irrespective of the source of financing for the health system selected, prepayment and pooling of resources and risks are basic principles in financial-risk protection;

Considering that the choice of a health-financing system should be made within the particular context of each country;

Acknowledging that a number of Member States are pursuing health-financing reforms that may involve a mix of public and private approaches, including the introduction of social health insurance, some of which involve the introduction of social health insurance [USA];

Noting that some countries have recently been recipients of large inflows of external funding for health;

Recognizing the important role of State legislative and executive bodies ~~government stewardship~~ [Russia] in further reform of health-financing systems with a view to achieving universal coverage;

1. URGES Member States:

(1) to ensure that health-financing systems include a method for introduce or develop ~~introduce or develop~~ [USA] prepayment of financial contributions for health care ~~the health sector~~ [USA], with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;

(1bis) to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package; [Thailand]

(2) to ensure that external funds for specific health programmes or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms ~~and institutions~~ [USA] for the health system as a whole;

(2bis) to create sustainable and continuing mechanisms, including regular international conferences, in order to facilitate the continuous sharing of experiences and lesson learnt on social health insurance; [Thailand]

¹ Document EB115/8.

- (3) to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, [Russia] to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration-Development Goals [USA], and to achieving health for all;
- (4) to recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, sociocultural and political context of each country;
- (5) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;
- (6) to share experiences on different methods of [USA] health financing, reform including the development of social health insurance schemes, and private, public, and mixed schemes, [USA] with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system;

2. REQUESTS the Director-General:

- (1) to provide, in response to requests from Member States, technical support for strengthening capacities and expertise in the development of health-financing systems, particularly prepayment schemes, including social health insurance, with a view to achieving the goal of universal coverage, and taking account of the special needs of small island countries and other countries with small population [Maldives]; and to collaborate with Member States in the process of social dialogue on health-financing options;
- (2) to provide Member States, in coordination with the World Bank [Czech Republic] and other relevant partners [USA], with technical information on the potential impact of inflows of external funds for health on macroeconomic stability;
- (3) to provide technical support in identifying data and methodologies better to measure and analyse the benefits and cost of different ~~create an evidence base in order to identify best~~ [USA] practices in health financing, covering collection of revenues, pooling, and provision or purchasing of services, taking account of economic and sociocultural differences;
- (4) to provide support to Member States, as appropriate, for [USA] developing and applying tools and methods to evaluate the impact on health services of changes in health-financing systems as they move towards universal coverage.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) pointed out that Thailand's amendment had been mistakenly inserted as paragraph 1(2bis), whereas the intention had been that it should become paragraph 2(2bis).

Dr STEIGER (United States of America), noting that that paragraph referred to "regular international conferences", asked about the possible financial implications of such conferences.

Dr EVANS (Assistant Director-General) suggested insertion of the words "if possible" to indicate that, as usual, the Organization would carry out the recommendation contained in the draft resolution subject to the availability of resources.

The CHAIRMAN took it that those amendments were acceptable.

The resolution, as amended, was adopted.¹

Blood safety: proposal to establish World Blood Donor Day: Item 4.6 of the Agenda (Document EB115/9) (continued from the fifth meeting)

The CHAIRMAN invited the Board to consider the draft resolution on blood safety, as amended at the fifth meeting, which read:

The Executive Board,

Having considered the report on blood safety,² and the Consensus Statement of the WHO Forum on Good Policy Process for Blood Safety and Availability³ [USA]

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

The Fifty-eighth World Health Assembly,
Recalling resolution WHA28.72 which urged the development of national blood services based on the voluntary, nonremunerated donation of blood;

Having considered the report on blood safety;

Alarmed by the chronic shortage of safe blood and blood products, particularly in low- and medium-income countries;

Mindful that preventing the transmission of HIV and other bloodborne pathogens through unsafe blood and blood-product[USA] transfusions requires the collection of blood only from donors at the lowest risk of carrying such infectious agents;

Recognizing that voluntary, nonremunerated blood donation is the cornerstone of a safe and adequate national blood supply that meets the transfusion requirements of all patients;

Noting the positive responses to World Blood Donor Day, 14 June 2004, for the promotion of voluntary, nonremunerated blood donation,

1. AGREES to the establishment of an annual World Blood Donor Day, to be celebrated on 14 June each year;

2. RECOMMENDS that this blood donor day should be an integral part of the national blood-donor recruitment programme; [Gambia]

3.2. URGES Member States:

- (1) to promote and support the annual celebration of World Blood Donor Day;
- (2) to establish or strengthen systems for the recruitment and retention of voluntary, nonremunerated blood donors and the implementation of stringent criteria for donor selection;
- (3) to introduce legislation, where needed ~~none exists~~, [USA] to eliminate paid ~~and family or family replacement~~ blood donation except in limited circumstances

¹ Resolution EB115.R13.

² Document EB115/9.

³ 9 November 2004, Geneva.

of medical necessity and, in such cases, to require informed assent of the transfusion recipient; [USA]

(4) to provide adequate financing for high-quality blood donation services and for extension of such services to meet the needs of the patients; [Thailand]

(5) to promote multisectoral collaboration between government ministries, blood transfusion services, professional bodies, nongovernmental organizations, civil society and the media in the promotion of voluntary, nonremunerated blood donation;

(6) to ensure the proper use of blood transfusion in clinical practice so as to avoid abuse of blood transfusion, which may result in a shortage of blood and hence stimulate the need for paid blood donation; [China]

(7) to support the full implementation of well-organized, nationally coordinated and sustainable blood programmes with appropriate regulatory systems through, in particular: [USA]

(a) government commitment and support for a national blood programme with quality-control systems, by means of a legal framework, a national blood-safety policy and plan, and adequate resources,

(b) organization, management and infrastructure to permit a sustainable blood transfusion service,

(c) equitable access to blood and blood products,

(d) voluntary, nonremunerated blood donors from low-risk populations,

(e) appropriate testing and processing of all donated blood and blood products, and

(f) appropriate clinical use of blood and blood products; [USA]

(8) to establish a quality process for policy- and decision-making for blood safety and availability based on ethical considerations, transparency, assessment of national needs, scientific evidence, and risk/benefit analysis; [USA]

(9) to share information nationally and internationally in order to make clear the scientific, economic and social basis of national policy decisions related to blood safety and availability; [USA]

(10) to strengthen partnerships at all levels in order to accomplish these recommended actions; [USA]

43. CALLS UPON international organizations and bodies concerned with global blood safety to collaborate in promoting and supporting World Blood Donor Day;

54. INVITES donor agencies to provide adequate funding for initiatives to promote voluntary, nonremunerated blood donation;

65. REQUESTS the Director-General:

(1) to work with other organizations of the United Nations system, multilateral and bilateral agencies, and nongovernmental organizations to promote World Blood Donor Day;

(2) to work with concerned organizations to provide support to Member States in strengthening their capacity to screen all donated blood against major infectious diseases in order to ensure that all blood collected and transfused is safe. [Thailand]

Dr SAM (Gambia) noted that many delegations opposed the inclusion of the wording proposed by the United States of America for paragraph 2(3), namely to introduce legislation “where needed” to eliminate paid blood donation “except in limited circumstances of medical necessity”. It was hard to imagine how any situation, even in circumstances of medical necessity, could require paid blood donation, a practice that should be actively discouraged.

Dr STEIGER (United States of America) said that all countries shared the goal of eliminating paid blood donation and promoting voluntary, nonremunerated donation. Payment for blood donations was condoned under domestic legislation in his country, however, and he could not endorse a text that would require a change in that legislation.

After informal consultations, the CHAIRMAN took it that the Board wished to adopt the draft resolution as amended.

The resolution, as amended, was adopted.¹

Malaria: Item 4.11 of the Agenda (Document EB115/10) (continued from the seventh meeting)

The CHAIRMAN invited the Board to consider the draft resolution on malaria, as amended at the seventh meeting, which read:

The Executive Board,

Having considered the report on malaria;²

Noting that few countries endemic for malaria are likely to reach the targets set in the Abuja Declaration on Roll Back Malaria in Africa (25 April 2000) of ensuring that at least 60% of those at risk of or suffering from malaria benefited from suitable and affordable preventive and curative interventions by 2005, but that there is rapidly increasing momentum for expanding malaria-control interventions in African countries,

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

The Fifty-eighth World Health Assembly,

Having considered the report on malaria;

Concerned that malaria continues to cause more than one million preventable deaths a year, especially in Africa among young children and other vulnerable groups, and that the disease continues to threaten the lives of millions of people in the Americas, Asia [USA and Thailand] and the Pacific [Australia];

Recalling that the period 2001-2010 has been proclaimed the Decade to Roll Back Malaria in Developing Countries, Particularly in Africa, by the United Nations General Assembly,³ and that combating HIV/AIDS, malaria and other diseases is included in the internationally agreed development goals, including those contained in the United Nations Millennium Declaration;

Recalling further United Nations General Assembly resolution 59/256 entitled “2001-2010: Decade to Roll Back Malaria in Developing Countries, Particularly in Africa”;

Mindful that the global burden of malaria needs to be decreased in order to reduce child mortality by two thirds by 2015 and to help achieve the other internationally agreed development goals, including those contained in the United Nations Millennium Declaration, of improving maternal health and eradicating extreme poverty;

¹ Resolution EB115.R15.

² Document EB115/10.

³ Resolution 55/284.

Recognizing that the Global Fund to Fight AIDS, Tuberculosis and Malaria has committed 31% of its grants or US\$ 921 million over two years, to projects to control malaria in 80 countries, [USA]

1. URGES Member States:

(1) to establish national policies and operational plans to ensure that at least 80% of those at risk of or suffering from malaria benefit from major preventive and curative interventions by 2010 in accordance with WHO technical recommendations so as to ensure a reduction in the burden of malaria of at least 50% by 2010 and 75% by 2015;

(2) to assess and respond to the need for integrated [Thailand] human resources at all levels of the health system in order to achieve the targets on the Abuja Declaration on Roll Back Malaria in Africa and the internationally agreed development goals of the United Nations Millennium Declaration, and to take the necessary steps to ensure the recruitment, training and retention of health personnel;

(3) to further enhance financial support and development assistance to malaria activities in order to achieve the above targets and goals;

(4) to increase, in countries endemic for malaria, domestic resource allocation to malaria control and to create favourable conditions for working with the private sector in order to improve access to good-quality malaria services;

(5) to pursue a rapid scale-up of prevention, by applying expeditious approaches, including targeted free, or highly subsidized, distribution of materials and medicines to vulnerable groups, with the aim of at least 60% of pregnant women receiving intermittent preventive treatment and at least 60% of those at risk using insecticide-treated nets wherever that is the vector-control method of choice, ~~by applying expeditious approaches, including targeted free, or highly subsidized, distribution of materials and medicines to vulnerable groups; [USA and Thailand]~~

(5bis) to support indoor residual insecticide spraying, where this intervention is indicated by local conditions; [USA]

(5ter) to develop or strengthen intercountry cooperation to control the spread of malaria across shared borders; [Russia and Thailand]

(5quarto) to encourage collaboration between national programmes and other services, including those of the private sector and universities; [Gabon]

(6) to support expanded access to artemisinin-based combination therapy, including the commitment of new funds, innovative mechanisms for the financing and national procurement of artemisinin-based combination therapy, and the scaling up of artemisinin production to meet the increased need;

(7) to support the development of new medicines to prevent and treat malaria, especially for children and pregnant women; of sensitive and specific diagnostic tests; of effective vaccine(s); and of new insecticides and delivery modes in order to enhance effectiveness and delay the onset of resistance, including through existing global partnerships;

(8) to support coordinated efforts to improve surveillance, monitoring and evaluation systems so as to better track and report changes in the coverage of recommended "Roll Back Malaria" interventions and subsequent reductions in the burden of malaria;

2. REQUESTS the Director-General:

- (1) to reinforce and expand the Secretariat's work to improve existing national capabilities, and to cooperate with Member States, in collaboration with Roll Back Malaria partners, in order to ensure the full and cost-effective use of increased financial resources for achieving international goals and targets, including the internationally agreed development goals related to malaria contained in the United Nations Millennium Declaration;
- (2) to collaborate with malaria-affected countries and Roll Back Malaria partners to ensure that countries receive full support for necessary monitoring and evaluation, including the development and implementation of appropriate pharmacovigilance systems;
- (3) to collaborate with Roll Back Malaria partners, industry, and development agencies in order to ensure that sufficient quantities of insecticide-treated mosquito nets and effective antimalarial medicines are made available, especially those required for combination therapies, for example by studying the possibility of WHO undertaking bulk purchases on behalf of Member States [Sudan], noting the need for strictly controlled distribution systems for antimalarial medicines [Thailand];
- (3bis) to provide evidence-based advice to Member States on the appropriate use of indoor residual insecticide spraying, taking into account recent experiences around the world; [USA]
- (4) to strengthen collaboration with partners in industry and academia for development of affordable high-quality products for malaria control, including rapid, easy-to-use, sensitive and specific diagnostic tests; an effective malaria vaccine; novel, effective and safe antimalarial medicines; and new insecticides and delivery modes to enhance effectiveness and delay the onset of resistance;-
- (5) to provide support for intercountry collaboration to control malaria, in particular, where there is a risk of spread across shared borders; [Russia and Thailand]
- (6) to further promote cooperation and partnership between countries supporting malaria control programmes in order to ensure that funds available to combat the disease are used efficiently and effectively. [Sudan]

Dr SAM (Gambia) expressed gratitude, on behalf of the countries of west Africa, for the contributions, which had strengthened the draft resolution. Malaria was indeed a global problem, but in west Africa it was the largest cause of both morbidity and mortality. In 2003 the West African Health Organization had adopted a declaration aimed at accelerating efforts to achieve the Abuja targets. The Health for Peace Initiative brought together several countries in west Africa to use cross-border approaches to combat malaria, approaches that were being coordinated by Gambia.

Mr SHUGART (Canada) proposed, in order to foster collaboration with development partners generally, insertion of the words "and to encourage and facilitate the development of new tools to increase the effectiveness of malaria control, especially by providing support to the UNICEF/UNDP/World Bank/WHO Programme for Research and Training in Tropical Diseases" at the end of paragraph 1(3). In paragraph 1(5), the words "and cost-effective" should be inserted after the word "expeditious".

The resolution, as amended, was adopted.¹

¹ Resolution EB115.R14.

2. MANAGEMENT MATTERS: Item 7 of the Agenda (continued)

Reports of the foundation committees: Item 7.5 of the Agenda (Document EB115/RESTR.DOC./1)

Léon Bernard Foundation Prize

Decision: The Executive Board, having considered the report of the Léon Bernard Foundation Committee, awarded the Léon Bernard Foundation Prize for 2005 to Professor T. Sharmanov (Kazakhstan) for his outstanding service in the field of social medicine. The laureate will receive a bronze medal and an amount of CHF 2500.¹

Dr A.T. Shousha Foundation Prize

Decision: The Executive Board, having considered the report of the Dr A.T. Shousha Foundation Committee, awarded the Dr A.T. Shousha Foundation Prize for 2005 to Dr Kamel Shadpour (Islamic Republic of Iran) for his most significant contribution to the objectives of primary health care in the geographical area in which Dr Shousha served the World Health Organization. The laureate will receive the equivalent of CHF 2500 in United States dollars.²

Jacques Parisot Foundation Fellowship

Decision: The Executive Board, having considered the report of the Jacques Parisot Foundation Committee, awarded the Fifteenth Jacques Parisot Foundation Fellowship for 2005 to Dr Alok Kumar (Barbados). The laureate will receive a medal and an amount of US\$ 5000 in order to complete his proposed research project within a period of 12 months.³

Ihsan Dogramaci Family Health Foundation Fellowship

The Executive Board, having considered the report of the Ihsan Dogramaci Family Health Foundation Selection Committee, approved the revision of Article 4 of the Statutes of the Ihsan Dogramaci Family Health Foundation Prize.

Sasakawa Health Prize

Decision: The Executive Board, having considered the report of the Sasakawa Health Prize Selection Panel, awarded the Sasakawa Health Prize for 2005 to the Centre for Training and Education in Ecology and Health for Peasants (Mexico). The laureate will receive an amount of US\$ 40 000 for its outstanding work in health development.⁴

¹ Decision EB115(4).

² Decision EB115(5).

³ Decision EB115(6).

⁴ Decision EB115(7).

Francesco Pocchiari Fellowship

Decision: The Executive Board, having considered the report of the Francesco Pocchiari Fellowship Committee, awarded the Francesco Pocchiari Fellowship for 2005 to Professor Dr Gönül Dinç (Turkey). The laureate will receive US\$ 10 000 in order to enable her to carry out the research she proposed.¹

United Arab Emirates Health Foundation Prize

Decision: The Executive Board, having considered the report of the United Arab Emirates Health Foundation Selection Panel, awarded the United Arab Emirates Health Foundation Prize for 2005 to Her Majesty Queen Rania Al-Abdullah (Jordan). The laureate will receive US\$ 40 000 for her outstanding contribution to health development.²

State of Kuwait Health Promotion Foundation

The Executive Board took note of the approval by the State of Kuwait Health Promotion Foundation Selection Panel of the guidelines determining the criteria for the assessment of candidatures, the candidate form and the certificate of award.

Reports of the Joint Inspection Unit and related matters: Item 7.6 of the Agenda

- **Previous JIU reports: implementation of recommendations** (Document EB115/23)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had reviewed the implementation of two previous JIU reports that were of relevance to WHO: Managing information in the United Nations system organizations: management information systems and Evaluation of the United Nations system response in East Timor: coordination and effectiveness. Its conclusions were set out in paragraph 80 of its report (document EB115/45).

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) said that the reports, particularly the one on information technology, were timely, since many international organizations, including WHO, were working to create a global information management system. Member States were not being kept sufficiently well informed about those efforts, however, despite JIU's recommendations. Formal annual reports should therefore be submitted to the Health Assembly on the major information technology projects, focusing on such matters as current expenditure, number of consultants and implementation times.

In the context of the plan to reform JIU within the United Nations system, the Unit was making efforts to establish a system to track the status of implementation of its recommendations. It would be interesting to know the views of the inspectors themselves on implementation by WHO.

Mr OUEDRAOGO (Joint Inspection Unit) said that the agenda of the JIU's current winter session included discussion of how to implement the resolution on reform of the Unit adopted by the United Nations General Assembly in December 2004. One aspect stressed in the resolution was that JIU should closely monitor the implementation of recommendations accepted by heads of specialized agencies or their governing bodies. Those recommendations would be covered in the annual reports sent to Member States.

¹ Decision EB115(8).

² Decision EB115(9).

Dr NORDSTRÖM (Assistant Director-General) said that efforts would be made to provide the Programme, Budget and Administration Committee and the Board with an annual progress report on programme budget implementation. Discussions were also under way on how best to engage in dialogue with the Committee on information technology and knowledge management issues; such a dialogue would be useful and the Secretariat would report back to the Board on its progress.

The Board noted the report.

- **Recent JIU reports** (Document EB115/24)
- **Follow-up to Executive Board deliberations on multilingualism** (Document EB115/3)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee had considered the two subitems together, and its conclusions were set out in paragraphs 81 to 84 of its report (document EB115/45). Attention had been drawn to the need to continue to consult widely in order to improve further the current situation regarding the equitable use of official languages and quality control of translation at all levels of the Organization. It had been noted that a committee was being established to deal with all matters related to multilingualism and that a plan of action, together with its cost implications, would be submitted to the Board.

Dr KARAM (Special Coordinator, Multilingualism) said that, since the Board's previous session, progress had been made in the presentation and content of the WHO web site.

Ms WOOD (Acting Coordinator, WHO Web Team) gave a presentation on the web site, which had recently been re-launched in all six official WHO languages, with some 500 new pages in each language. That marked the beginning of the work on multilingualism for public information; ultimately the Organization would be able to publish its technical and other information easily in all six languages. It was to be hoped that with the new framework in place, the volume of content in each language would grow substantially.

English was no longer the primary publishing channel for the web site: documents in each of the six languages were treated as if they were the definitive document. Modifications had been made to the visual design and, more importantly, to the underlying organization of information. A customized search function had been added to facilitate searches in all six languages, and it was possible to move easily from one language version of a document to another without returning to the original page to resume the search.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) acknowledged the progress made to promote multilingualism, but said that more needed to be done. Many documents, for example *The world health report 2004*, had not yet been translated into all languages.

One of the main obstacles to multilingualism was the financial implication. ITU had recently implemented a resolution on the financing of all languages on an equal basis. WHO should bear that in mind when developing a future plan of action. He advised caution, however, in relation to the setting of priorities for translations, despite the JIU recommendation.

Dr QI Qingdong (alternate to Dr Yin Li, China) said that he too appreciated the progress made in improving the web site. Promoting multilingualism was a long-term task, and China welcomed the short-term and medium-term measures proposed. It was to be hoped that evaluations of the use of languages at all levels would be made regularly.

Mr RECINOS TREJO (El Salvador),¹ speaking on behalf of the countries of the Americas, a multilingual region, said that the countries had noted the progress made in multilingualism in WHO, particularly the improvements to the web site and the provision of simultaneous interpretation in meetings other than those of the governing bodies. Efforts should be continued to provide interpretation services for all official meetings, despite the financial implications described in the report, and to pursue the question of increasing costs in the context of the proposed programme budget and plan of action. Simultaneous interpretation should also be provided for meetings of regional groups, as necessary, including those held during the Board sessions, at the request of the group concerned.

Dr BRUNET (alternate to Professor Dab, France) noted that, despite improvements to the web site, much remained to be done. Not all the documents for the current session of the Board had been available on the web site in French, for example, and some of them had had to be sent in hard copy, which was a waste of paper, money and time. It was necessary, therefore, to set priorities for the documents to be translated, and, in some cases, to improve the quality of the translations. A plan of action with quantifiable targets should be drawn up which could be regularly reviewed to ensure that the situation was really improving.

The Board took note of the recent JIU reports and the report on multilingualism.

3. TECHNICAL AND HEALTH MATTERS: Item 4 of the Agenda (resumed)

Influenza pandemic preparedness and response: Item 4.17 of the Agenda (Documents EB115/44 and EB115/44 Corr.1) (continued from the eleventh meeting, section 1)

The CHAIRMAN invited the Board to resume discussion of the draft resolution that had been introduced at its previous meeting. The matter to be resolved was the incorporation of a new paragraph 1(10) as proposed by the member for Thailand.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) proposed, after consultation with the member for the United States of America, that the new paragraph 1(10) should read: “to take all necessary measures, during a global pandemic, to provide a timely and adequate supply of vaccines and antiviral drugs, using to the full the flexibilities contained in the Agreement on Trade-Related Aspects of Intellectual Property Rights.”

Mr HOHMAN (alternate to Dr Steiger, United States of America), expressing appreciation of the cooperation in reaching agreement on the wording of the provision, supported the two other proposals made by the member for Thailand. The titles of the Health Assembly resolutions referred to in the text could usefully be included. With regard to the proposed amendment to paragraph 2(3), following consultations with the Secretariat, he would prefer to retain the text as it stood, if the member for Romania raised no objection.

The CHAIRMAN said that, in the absence of any objections, he took it that the Board wished to adopt the resolution, as amended.

The resolution, as amended, was adopted.²

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

² Resolution EB115.R16.

4. MATTERS FOR INFORMATION: Item 9 of the Agenda

Reports of advisory bodies: Item 9.1 of the Agenda

- **Report on the forty-second session of the Advisory Committee on Health Research (ACHR)** (Document EB115/26)

Professor FATHALLA (Chairman, ACHR), introducing the report welcomed the decision to reinstate the practice of placing the ACHR report on the Board's agenda and highlighted some of its activities. As part of its function of performing an intelligence role in identifying the latest scientific developments relating to public health, particularly in developing countries, ACHR had maintained its interest in genomics and world health. It was particularly concerned that the fruits of that new and rapidly advancing field of science might not become available to developing country populations, thereby creating a "genomics divide". It therefore proposed that WHO should consider establishing an expert committee to monitor that field. As part of its advocacy role for a global health research agenda, ACHR had reviewed WHO's report on knowledge for better health,¹ launched at the Ministerial Summit on Health Research (Mexico City, 16-20 November 2004), which had emphasized the importance of turning scientific knowledge into effective action for people's health; the need for increased investment for an innovative approach to research on health systems, particularly important for countries with limited resources; and the need for effective management of national health research systems in order to derive maximum benefits from them. As part of its function to provide guidance on WHO's research activities and their broad trends, ACHR welcomed WHO's emphasis on support, access to and use of research evidence by national policy makers and managers. In issuing its guidelines, ACHR intended to shift the base of its reliance from expert opinions to sound, unbiased and carefully analysed evidence. ACHR's report for the following year was expected to be more substantive. Having come to the end of his term of office as Chairman of the Committee, he was pleased to be succeeded by the first woman to chair the ACHR – Dr J. Whitworth of Australia.

The CHAIRMAN thanked Professor Fathalla for his valuable contribution to ACHR and looked forward to working with the new Chairman.

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that he appreciated ACHR's efforts to provide advice and advocacy for improving health research activities, but was concerned about the way in which knowledge was viewed. In the scientific world, evidence, and therefore knowledge, came from experiments; unfortunately the current tendency was to focus on evidence-based knowledge and to disregard experience, which deserved equal recognition. The establishment of WHO's new department of Knowledge management and sharing was both timely and far-sighted and should ensure better use of research-based knowledge by WHO and by Member States. It might be useful to review the concept and work of ACHR to ensure that it remained relevant to changing needs.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) expressed support for the health research systems analyses and the pilot project at headquarters, an initiative that should lead to more effective use of new scientific knowledge. He also supported the proposal to establish schemes for WHO research activities on a regular basis, and the establishment, in collaboration with national and international bodies, of a new integrated database. It was important that any such network of factual data on health issues was based on Internet technologies to ensure that the most up-to-date scientific data were used in the development of health policies.

¹ *World report on knowledge for better health: strengthening health systems*. Geneva, World Health Organization, 2004.

The Board took note of the report.

- **Expert committees and study groups** (Documents EB115/27 and EB115/27 Add.1)

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) drew attention to the need to ensure that communication between the expert bodies and other partners in the health sector was effective and timely, and that the issues selected for consideration by the expert committees were fully relevant to the rapidly changing health environment.

Dr EVANS (Assistant Director-General) said that, despite certain processing problems, every effort would be made to issue the reports in a more timely manner.

The CHAIRMAN said that, in the absence of further comments, he took it that the Board wished to thank the experts who had taken part in the meetings, to request the Secretariat to follow up their recommendations, as appropriate, in the implementation of programmes, and to take note of the report contained in document EB115/27 Add.1.

It was so agreed.**Poliomyelitis:** Item 9.2 of the Agenda (Document EB115/28)

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) welcomed the progress of eradication activities, particularly in areas endemic for poliomyelitis. Nevertheless, the unexpected resurgence of the disease in the past year, in the form of imported cases and re-established transmission, showed the need for more leadership, communication and advocacy by WHO, which must secure sufficient financing to maintain the necessary activities.

Mr HOHMAN (alternate to Dr Steiger, United States of America) said that poliomyelitis eradication was one of WHO's top priorities. He reiterated his country's firm commitment to meeting the continuing resource needs for that programme and urged other bodies, particularly the G8, OECD and the Organization of the Islamic Conference countries, to increase their funding.

Dr AHMED (Ghana) stressed the need to improve surveillance of poliomyelitis, especially in Africa, and to enhance health education, involving health and community workers, as weaknesses in both areas had contributed to the resurgence of the disease.

Dr CAMARA (Guinea) said that, although major steps had been taken to eradicate poliomyelitis, the interruption of vaccination in some countries over the past two years had led to the virus being exported to other countries, thereby compromising the considerable efforts that had been made. He called for continuing support by those donors that had already provided resources, as the target of eradication had almost been reached.

Dr ABDULLA (Sudan) said that Sudan was among the countries that were deeply concerned at the reappearance of poliomyelitis in Africa; the disease had recently re-emerged three years after eradication. It was essential, therefore, to continue to control the disease through sustained vaccination campaigns. As that required immense financial resources, countries should increase funding so that appropriate infrastructures could be established.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) said that, in order to achieve the target of global eradication, partnerships must be strengthened and adequate financial resources provided. One priority for eradication concerned the immunization strategy in the post-certification period; the most acceptable for Russian experts was use of inactive vaccine followed by oral, live vaccine. Inclusion of inactivated vaccine in national schedules would eliminate vaccine-associated

poliomyelitis, which was of particular importance in the post-certification period. He requested the Secretariat's view.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho) said that health ministers in African countries were committed to strengthening surveillance and vaccination programmes in order to meet poliomyelitis eradication targets in 2005. He expressed appreciation for the support from Africa's global partners in achieving that task, which would be given further impetus by the forthcoming African Union summit in Abuja, as the Heads of State and Government strengthened their political commitment to poliomyelitis eradication.

Mr HÖRNDLER (Rotary International), speaking at the invitation of the CHAIRMAN, said that he was encouraged by the Board's dedication to the goal of a poliomyelitis-free world. Rotary International was committed to that aim: its global network of community-based volunteers would ensure that nothing stood in the way of success. By the time global certification was achieved, his organization's contribution would have exceeded US\$ 600 million and more than 2000 million children in 122 countries would have been immunized by volunteers. The poliomyelitis eradication campaign, the largest health initiative in history, was close to achieving its goal and it was his heartfelt wish that 2005, the centenary of the Rotarian movement, would also witness the end of the disease.

Dr HEYMANN (Representative of the Director-General for Polio Eradication) said that poliomyelitis was still being transmitted in a number of countries. The strategies for eradication were effective but intensified surveillance and enhanced vaccination campaigns were required. The only strategy that might evolve over the next year was the use of a monovalent poliomyelitis vaccine for use along with the trivalent oral vaccine. The partners in the campaign had recently met with the health ministers of African countries where the disease was endemic or where there was re-established transmission. Those countries had reaffirmed their commitment to strengthening surveillance and increasing the quality of their vaccination campaigns in order to reach every child with trivalent oral poliomyelitis vaccine. A similar meeting was planned in the near future for the Asian countries in which the disease was endemic. Biologically, it was feasible to interrupt transmission of poliomyelitis during 2005.

The Board noted the report.

5. STAFFING MATTERS (Item 8 of the Agenda)

Human resources (Item 8.1 of the Agenda)

- **Annual report** (Documents EB115/25, EB115/25 Corr.1 and EB115/25 Add.1)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were set out in paragraph 77 of its report (document EB115/45). It had welcomed the new approach taken and, in particular, efforts to raise awareness of employment opportunities with a wide range of bodies, although those efforts had not yet shown results in all areas. It had noted the positive efforts to further enhance staff motivation in the area of management and leadership development, and the decision to implement the special operations approach for WHO staff in non-family duty stations.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) acknowledged the efforts made by the Secretariat. It was no easy task to recruit competent staff and, equally important, to ensure equitable geographical representation. Providing training for existing staff was also crucial, particularly in view of the extra burden that would be placed on programme managers by the introduction of decentralization and results-based management.

Was WHO prepared for its next challenge, namely, the impending retirement of large numbers of staff? The staffing structure showed a certain imbalance: there were, for instance, a large number of posts at grades P4 and P5 and relatively few at grade P3 compared with other United Nations agencies. As current staff retired, WHO could perhaps recruit more staff at grades P2 and P3; elsewhere staff on those grades did much of the more routine work. That would free funds that could then be spent on antiretroviral agents or vaccines.

Dr NORDSTRÖM (Assistant Director-General) said that WHO was committed to strengthening the human resource part of the results-based managerial framework and to ensuring that managers became more efficient and staff with the proper competencies were employed. Attention was being given to making planning systems more efficient and to empowering managers, to introducing staff rotation and to planning reforms regarding contract length. It was very important to staff the Organization in the most effective way.

The Board noted the report.

• **Report by the International Civil Service Commission** (Document EB115/33)

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were set out in paragraph 78 of its report (document EB115/45). The Committee had noted the main points in the report of the International Civil Service Commission and the Secretariat had confirmed that the financial implications would be absorbed from the regular budget and from extrabudgetary sources.

The Board noted the report.

• **Confirmation of amendments to the Staff Rules** (Documents EB115/38, EB115/38 Corr.1, EB115/38 Corr.2 and EB115/38 Add.1)

The CHAIRMAN invited the Board to confirm the amendments to the Staff Rules submitted by the Director-General in accordance with Staff Regulation 12.2. The Board was invited to consider the two draft resolutions contained in document EB115/38. The figure in the last line of paragraph 2 of resolution 2 should read "US\$ 137 453". The Board was also invited to consider a third draft resolution, contained in document EB115/38 Add.1.

Dr YOOSUF (Maldives), speaking in his capacity as Chairman of the Programme, Budget and Administration Committee, said that the Committee's conclusions were contained in paragraph 79 of its report (document EB115/45). The Committee had recommended that the Board should adopt the three draft resolutions.

Ms BLACKWOOD (alternate to Dr Steiger, United States of America) requested confirmation that the Secretariat would in due course report back to the Board regarding a proposal for amendments to the Staff Rules.

Mr KOCHETKOV (adviser to Mr Skotnikov, Russian Federation) asked for precise figures concerning the financial implications of the amendments.

Dr NORDSTRÖM (Assistant Director-General) said that, although there would be financial implications, they would not be significant and could be absorbed within existing resources. Some

small extra constraints would be placed on the Secretariat. He was unable to be more precise at present. The reply to the question from the member for the United States of America was affirmative.

The three resolutions were adopted.¹

Statement by the representative of the WHO staff associations: Item 8.2 of the Agenda (Document EB115/INF.DOC./1)

Dr AL-SHORBAJI, (representative of the WHO staff associations) said that some matters brought to the attention of the Board the previous year required highlighting again. On the matter of salaries and pensions, the impact on staff of currency devaluations or cost-of-living increases should be minimized. The rapid decline in value of the United States dollar had adversely affected purchasing power and pension entitlements. General Services staff were locked into the existing seven-grade scale. A joint staff management committee should be formed to look into those issues.

Although staff members welcomed the decentralization process, they recognized its potential impact and proposed that, to the fullest extent possible, use should be made of voluntary rotation and natural fluctuations in staff numbers. The staff associations wished to be fully informed about the process and its implications for staff.

The staff associations wished to pay tribute to those who had given their lives to promote public health, including, most recently, Lisa Véron. They had noted the recent actions to increase staff security in the field. However, much remained to be done and WHO should set an example in that area. Special efforts were needed to establish mechanisms for ensuring the highest level of health and safety for staff at all duty stations. Another matter of concern was official travel: long flights in cramped conditions could lead to deep vein thrombosis.

Following the conversion of a considerable number of “long-term, short-term” positions into fixed-term contracts, it was important to address the issue of prevention. Unless there was a change in the system whereby staff working on consecutive short-term contracts had to leave for at least one year after four years’ service, WHO would face a severe brain drain. Increasing the number of posts might be the solution.

The staff associations welcomed the initiatives taken to improve management practices and train leaders across the Organization. Managers should use contracts appropriately and plan their staffing needs in advance. In that context, he endorsed the discussions at the recent Global Staff/Management Council, during which staff and management representatives had looked together into ways of improving human resource planning and controlling the use of temporary contracts. Staff development efforts should be expanded to cover field offices. He looked forward to the establishment of a staff management working group to initiate a review of good practices and prepare a report for consideration by the Council in 2005.

He recognized that during the past year some significant issues of concern to staff had been tackled and was pleased with the progress made globally, for example, regarding contractual reform. He welcomed the constructive spirit at the recent Global Staff/Management Council, and looked forward to the timely implementation of its outcomes.

The Board noted the statement by the representative of the WHO staff associations.

¹ Resolutions EB115.R17, EB115.R18 and EB115.R19.

6. MATTERS FOR INFORMATION: Item 9 of the Agenda (resumed)

Reports requested by earlier resolutions: Item 9.3 of the Agenda (Documents EB115/31 and EB115/31 Corr.1)

A. Promotion of healthy lifestyles

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that many activities were being arranged for the forthcoming Sixth Global Conference on Health Promotion. Under the theme of "Policy and partnership for action: addressing the determinants of health" the proposed Bangkok charter would complement the Ottawa Charter for Health Promotion in promoting appropriate life styles in a dynamic globalized world. Success required strong support from all partners within and beyond the health sector and he requested the Director-General to ensure extensive participation by all partners at the Global Conference, and a clear, transparent, participatory process in preparing the charter.

Ms VALDEZ (alternate to Dr Steiger, United States of America) said that charters negotiated at past global conferences on health promotion had taken the form of informal guidance to Member States rather than a negotiated consensus document. She wondered whether the same would apply to the outcome of the Sixth Global Conference.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) supported the activities described in the report for health promotion at global, regional and country levels. In particular, he welcomed WHO's initiative to strengthen national capacity in health promotion, including the project to develop evidence about the effectiveness of health promotion and efforts to strengthen the capacity of research and academic institutes and promote joint initiatives with WHO collaborating centres.

The Russian Federation was developing an evaluation system to measure the effectiveness of prevention programmes by analysing demographic and health-status indicators, socioeconomic trends and preventive measures. Monitoring of prevention activities covered the areas of reproductive health, health promotion for children and adolescents, health promotion among people of working age, health protection for elderly people, promotion of healthy lifestyles and reduction of adverse health effects due to alcohol, narcotic drugs and tobacco.

Dr LE GALÈS-CAMUS (Assistant Director-General), thanking Thailand for its assistance and cooperation throughout the preparations for the Sixth Global Conference on Health Promotion, said that the Conference would be a success only if all relevant partners were involved in the preparations as well as in the event itself. The preparatory work for the Conference would be finalized at a meeting to be held in Kobe, Hyogo, Japan, in February 2005. Some resolutions currently being discussed or already adopted would give further impetus to the promotion of healthy lifestyles, with special emphasis on children's health. The question of healthy ageing, which had been discussed by the Board during the current session, was also of relevance to the work.

B. Violence and health

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that violence was becoming a major cause for concern in developing countries. He was disappointed to note that only 40 countries worldwide had nominated their focal points and that only four had prepared a national report on violence, while 13 others were working on their reports. Stronger advocacy was needed for violence prevention. He therefore requested the Director-General to continue support in that field and urged donors to contribute more to WHO and the developing countries for the work. In addition, he requested a report on progress for the Board and the Health Assembly in 2007.

Mrs IORDACHE (alternate to Professor Cinteza, Romania) said that the *World report on violence and health*¹ was a landmark publication in that it had, for the first time, clearly demonstrated the impact of various forms of violence on health, and had alerted many people to the magnitude of the problem and to the role that public health decision-makers could play in reducing its impact. Furthermore, the report still provided authoritative guidance on the topic. She commended the remarkable effort made to devise practical measures to implement the report's recommendations, and the active collaboration between headquarters and the Regional Office for Europe in many areas. Romania had appointed a focal point for violence prevention in its Ministry of Health and had organized a policy debate on the report. As a follow-up to the latter, it had also set up a national family protection agency which was responsible for facilitating and coordinating violence prevention activities in line with WHO recommendations. In 2002, Romania had adopted a law on domestic violence, which had led to the creation of appropriate national and local bodies. Although the number of activities outlined in the Secretariat document was impressive, that was just the beginning of a long process aimed at curbing violence in families and communities. Romania would therefore like to remain actively involved in those activities in coming years. It would welcome regular opportunities to monitor and discuss progress and suggested that the item should be included at two-yearly intervals on the agenda of both the Executive Board and the Health Assembly.

Dr CAMPBELL FORRESTER (alternate to Mr Junor, Jamaica) said that crime and violence were major public health problems in her country and responsible for rising morbidity and mortality levels in the under-30 age group. Her Government had put many of the WHO recommendations into practice; the Jamaica Chapter of the Violence Prevention Alliance had been launched in November 2004 and a violence-free day would be celebrated in February 2005. Her country was committed to combating violence and encouraged Member States to appoint focal points to prepare their national reports and continue investing in multisectoral violence response services.

Dr LE GALÈS-CAMUS (Assistant Director-General) agreed that the report had made it possible to identify the scope of the issue, but such awareness-raising could not be an end in itself and further guidelines needed to be formulated and incorporated into national policy. Such work, which would be given priority in the next few years, would be carried out in cooperation with the regional offices and a number of countries that had requested assistance in that respect.

C. Smallpox eradication: destruction of variola virus stocks

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) supported the conclusions and recommendations of the sixth meeting of the WHO Advisory Committee on Variola Virus Research. In response to resolutions WHA52.10 and WHA55.15, his country was conducting a national research programme in the Russian State Centre for Research on Virology and Biotechnology to establish new methods of diagnosing, preventing and treating smallpox, in line with the Secretariat's recommendations. He urged more action to facilitate exchanges of information about the outcome of experimental and theoretical research. He thanked all the Centre's partners, and in particular its United States colleagues, for participating in the joint research being conducted under the auspices of WHO.

Dr TANGI (Tonga) requested assurances about the control mechanism for safeguarding variola virus DNA.

Mr SHUGART (Canada) noted that the full report had not been made universally available. His country would like to study it further before expressing a final opinion. Given that the aim was the

¹ *World report on violence and health*. Geneva, World Health Organization, 2002.

destruction of the virus, he wished to be completely sure that the remaining research was truly essential for public health purposes; he therefore looked forward to further discussion of the Committee's recommendations.

The CHAIRMAN pointed out that the subjects under discussion were likely to remain on the Board's agenda for many years to come.

Dr ASAMOA-BAAH (Assistant Director-General) said that he had taken note of the points made with regard to the biosafety implications of the research in question. It was precisely because of those concerns that the Director-General was reviewing the Advisory Committee's recommendations. Although the scope of and need for the research were not being called into question, biosafety was a concern, especially in cases where the recommendations related to work that could be done outside the two repositories.

D. Traditional medicine

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand), commenting on the need for a balanced approach to traditional medicine, said that finding ways of performing quality controls, proving the efficacy of medicines, and ensuring their safety had initially been overemphasized in his country, whereas other important issues, such as encouraging wide, equitable and appropriate use, had been neglected. A major change had occurred in 2001 when treatment with traditional medicines first came under the national health insurance system. In 2002 the Government had established a department of Thai traditional medicine development and alternative medicine in systematic support of traditional medicine. All stakeholders should strike a balance between scientific and practical knowledge in the field of such medicines, where much essential knowledge was hard to prove scientifically. The fact that knowledge could not be proved, however, did not rule out any basis for it.

Dr LEPAKHIN (Assistant Director-General) said that the use of traditional medicine was spreading in all countries, being one of the fastest-expanding areas of the work of WHO and on which many training guidelines had been issued in 2004. He expressed gratitude to the countries supporting that work.

E. Scaling up treatment and care within a coordinated and comprehensive response to HIV/AIDS

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) said that his country had acted to improve care before resolution WHA57.14 had been adopted, but unfortunately only half the patients complied with the prescribed treatment regimen. That situation was caused by weaknesses in the health-care system and inadequate voluntary counselling and testing, compounded by stigmatization. Other countries with scarcer resources should therefore be cautious about expanding access to antiretroviral medicines, since ensuring the availability and affordability of good-quality products was not enough. The experiences of developing countries that had extensive antiretroviral coverage should therefore be documented in a systematic, unbiased and transparent way. Global expansion of access to antiretroviral medicines should be handled prudently with sustainable resources.

Professor FURGAL (adviser to Mr Skotnikov, Russian Federation) expressed his strong support of WHO's approach, forming as it did an integral part of activities to combat the pandemic. A balanced mix of prevention and treatment, with emphasis on broad access to antiretroviral therapy, would be a major contribution to the fight against HIV/AIDS.

He commended the efforts to implement resolution WHA57.14. Strengthening national health systems was essential to implementation of the "3 by 5" initiative, since without it there could be no

guaranteed access to treatment. He welcomed the initiative to create an HIV/AIDS and health systems platform in order to identify and remove obstacles to the expansion of care for people with HIV. However, improvements to health infrastructure must cover all programme and technical areas, from HIV testing to palliative care.

As more funds were made available for the fight against the HIV/AIDS pandemic, it was important to strengthen countries' technical capacity, which should include the provision of professional training for finance managers. Training for national experts should cover not only health professionals proper but also social workers, staff working in AIDS services and volunteers.

It was important to improve epidemiological surveillance systems and, in particular, to conduct behavioural research among specific population groups. The collection and analysis of such information would provide a basis for forecasting, planning, and evaluation of the effectiveness of action taken.

Ensuring equity of access to care for all population groups was an important ethical principle for WHO. As well as monitoring access to antiretroviral treatment, it was important to gather information about the treatment provided for hard-to-reach groups such as injecting drug users, sex workers and migrants.

He welcomed the WHO initiative to create a rapid response group on HIV and tuberculosis and the publication of guidelines on antiretroviral treatment for women living with HIV and on prevention of vertical transmission of HIV. Guidance was indeed urgently needed on the treatment of HIV infection in people using and dependent on narcotics, and individuals with coinfections, especially viral hepatitis, as were methods to improve patients' compliance with antiretroviral therapy.

Dr BRUNET (alternate to Professor Dab, France), expressing unease at the haste with which the Board was considering the final items on the agenda, observed that, while the figures "3 by 5" were in everyone's mind, of greater significance was the gulf between intention and achievement. He referred to that disparity, not critically, but to call attention to the difficulties ahead and the need for a different approach. Regrettably, the report did not give enough figures to provide a picture of the exact situation. The statement from the member for Thailand was most interesting when seen in conjunction with paragraph 46 of the report. It was a matter of urgency that the Board should learn of the platform's conclusions, so that the Organization's activities could be adjusted accordingly. The coordinating role played by WHO in care systems ought to enable it to find out why some programmes succeeded while others did not. There was no point in awaiting the end of the period to discover why the initial goal had not been reached. More detailed and accurate information was therefore required.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho), speaking on behalf of the African group, welcomed the highly informative report. At its fifty-fourth session the WHO Regional Committee for Africa had urged Member States to develop and implement comprehensive plans for improving access to treatment and care, ensuring equity and including nutritional support for people living with HIV/AIDS, with defined targets for greater prevention efforts.¹ It had also welcomed the "3 by 5" initiative. The African group therefore requested the Director-General to strengthen WHO's role in providing technical leadership and direction to the health system response to HIV/AIDS within the United Nations system, to supply technical support and guidance for the development, implementation, monitoring and evaluation of treatment and care, and to mobilize more international resources to improve access to care and treatment. It also urged him to ask the Global Fund to Fight AIDS, Tuberculosis and Malaria to continue fund-raising, to speed up the implementation procedure and access to the funds, and to advocate continuous research into new drugs and vaccines.

¹ Resolution AFR/RC54/R5.

Ms THOMPSON (European Commission), speaking at the invitation of the CHAIRMAN, said that the Commission fully shared the aim of strengthening national health systems. In late 2004 it had set out its response to the re-emerging epidemic in Europe in its working paper "Coordinated and integrated approach to combat HIV/AIDS within the European Union and in its neighbourhood" and its global response in its Communication "A coherent European policy framework for external action to confront HIV/AIDS, malaria and tuberculosis". The Commission was committed to expanding with all its partners the surveillance of HIV/AIDS in Europe. WHO and the Commission should step up collaboration on building national capacity through training. The Commission was facilitating discussions between Member States and the pharmaceutical industry with a view to securing access to affordable antiretroviral therapy and was willing to improve cooperation by exchanging experience and information with WHO and UNAIDS. The action set out in its working paper had been completed by the end of the year and achievements would be assessed. A further Communication from the Commission to be issued later in the year would outline a more focused and longer-term strategy to combat HIV/AIDS within the European Union and neighbouring countries.

Dr CHOW (Assistant Director-General), acknowledging the support for the implementation of the "3 by 5" initiative, concurred that building health systems was an essential part of a robust response in the prevention, treatment and care of HIV/AIDS. In addition to the vertical work of making treatment accessible at low cost, the critical horizontal linkages between finance, expertise and implementation were being examined; of those, the health workforce was all important. He agreed with the member for France on the utility of a proper analysis with figures to show whether certain milestones had been reached, using the data in a way that would permit a more strategic, comprehensive response. The Director-General would soon be offering such an analysis at the World Economic Forum in Davos. The current target was 700 000 people under treatment. Success stories were being identified of countries that had resolutely committed political will and financial resources to improving treatment and prevention. Obstacles and bottlenecks were being pinpointed in an effort to find ways of improving the supply of care, removing resource constraints and making a compelling case for political and social advocacy to create an environment conducive to public health action for persons in need of antiretroviral and prophylactic treatment. He assured the member for Lesotho that the Secretariat was working closely with UNAIDS and the Global Fund to implement the "Three Ones" principle and drawing up a blueprint that would be sent to countries receiving funds. It was vital that WHO should join the call for more financial and human resources. The Global Fund's 2nd Replenishment Conference (Stockholm, 11-12 June 2005) provided a major opportunity to commit to concerted action linking finance and expertise. The Secretariat, with external partners, was exploring ways of promoting research into and development of a new generation of antiretroviral agents. He welcomed the European Commission's moves to develop a policy framework and its emphasis on the requisite infrastructure.

F. Strategic approach to international chemicals management

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) recommended that the Secretariat should provide more technical and financial support to enable developing countries to take part in the meetings of the Preparatory Committee for the Development of a Strategic Approach to International Chemicals Management, and that the Director-General should report on progress with the Strategic Approach to the Board in 2006 before the final conference.

Dr LEITNER (Assistant Director-General) said that she shared concerns about the apparent scant awareness that the health sector ought to take part in international discussions concerning chemical safety. Ways were being sought of obtaining funds, to be made available through the regional offices, to enable more developing countries to attend the third session of the Preparatory Committee. It was definitely an exercise calling for more attention from the health sector, because chemical safety was vital to the protection of human health; it was often impossible to restore the health of people who had been poisoned or intoxicated in a chemical accident. The Secretariat,

therefore, had to be more active in framing strategies and creating management systems. She took note of the Board's interest in receiving a full report in 2006.

The Board noted the report.

Commission on Social Determinants of Health: Item 9.4 of the Agenda (Document EB115/35)

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand), expressing his appreciation of the Director-General's leading role in addressing the importance of social determinants, observed that health was a multifactorial state and by no means confined to health systems. Given a well-defined role and mandate, the Commission on Social Determinants of Health could be expected to make a substantial contribution to well-being. He agreed with the chosen social determinants but proposed others, including civil society; globalization and international trade; and political freedom. The Commission's studies should reflect both the positive and the negative health impacts of such determinants.

Dr ANTEZANA ARANÍBAR (Bolivia) said that the identification and study of the social factors affecting the health status of the population in general, and health services in particular was an important task for WHO. The plan set out in the report was wide-ranging and comprehensive, providing for a study of fundamental changes in the approach to health and the factors influencing it. It was the right time to set up such a Commission, and the proposed knowledge networks and their operation at regional and subregional levels would encompass all the factors pertaining to the social determinants of health, which would doubtless include those mentioned by the member for Thailand. There were many economic or political aspects to be covered, in addition to those singled out in the report. In view of the importance of the study for health policy, the Board should be given regular updates on the Commission's work before its completion in 2008.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that the role of WHO in developing international cooperation in health, improving public health and reducing inequities was timely and relevant. Moreover, the work of the Commission would contribute to achieving the Millennium Development Goals, in terms of sustainable development and the elimination of poverty and hunger, which were key social determinants of health. His country's policy for the coming decade was focused on reducing poverty, increasing welfare, arresting the fall in population and improving public health. For those aims to be achieved, people must have access to affordable and high-quality housing, education and health care, and the most vulnerable sections of the population must receive social support. Medico-social problems in his country were tackled by drawing on both domestic and international experience in development and health. The Russian Federation supported the formation of the Commission and the plan for its activities, and was ready to participate in them.

Ms VALDEZ (alternate to Dr Steiger, United States of America) said that, even though much more work was needed, a growing body of scientific evidence existed about the social mechanisms that helped to shape health and affected social inequities. She noted that focal points for the Commission were being identified within other organizations of the United Nations system, which would undoubtedly participate in its work. As to the funding plan for the Commission, it would be useful to have more information about the resource implications for WHO. Given the competing global priorities for the Secretariat's expertise, the Commission's mandate should benefit its core competencies, so that quantifiable benefit accrued to Member States. She applauded the suggestion that countries could play a leading role in the work of the Commission, and expressed the interest of the United States in doing so. She also expected that the interim report from the Commission to the Director-General at the mid-point of the Commission's work would be made available to Member States.

Dr NSIAH-ASARE (alternate to Dr Ahmed, Ghana) said that the Commission would help to find solutions to the numerous health issues in developing countries, especially in Africa. Its work would consolidate progress already made in identifying social and environmental determinants of health, such as poverty, food insecurity, social exclusion and discrimination, poor housing, childhood diseases, and low occupational status. That knowledge had yet to be translated into action, whether globally or nationally. His delegation therefore supported the detailed plan for the Commission's activities and encouraged the Secretariat to continue work on it.

Mr RAMOTSOARI (alternate to Dr Phooko, Lesotho), speaking on behalf of the African group, welcomed the initiative and expressed appreciation of the Director-General's commitment to ensuring that the composition of the Commission reflected a balance in geographical representation and between men and women. Much work had already been done on the social determinants of health, but the findings had yet to be turned into effective action. He looked forward to further action and reports on the Commission's future work, especially under the Eleventh General Programme of Work 2006-2015.

Mrs IORDACHE (alternate to Professor Cinteza, Romania) congratulated the Director-General on his initiative and commended the report. Romania hoped to be actively involved in the future consultations and activities of the Commission, at both the political and technical levels.

Ms LACROUX (United Nations Human Settlements Programme) welcomed the timely initiative. Of special concern to her Programme were the dynamics of urban conglomerations in both developing nations and countries in transition, which factors were rapidly changing as a result of inequitable forms of globalization. In those new urban settings, change was largely unregulated, and poverty was increasing along with the pressures on health, natural resources and social cohesion. Rapid urbanization was a major trend not always receiving the attention it deserved, in spite of the fact that Millennium Development Goal 7 "to ensure environmental sustainability" included, as Target 11, the goal of achieving by 2020 a significant improvement in the lives of at least 100 million slum dwellers. By 2006-2007, half the world's population would be living in urban areas. About 1000 million people were already living in slums, deprived of adequate housing and basic services, and that population was expected to reach 2000 million by 2030. The greatest impact would then be felt in the developing world, and would predominantly affect women, children, the elderly and indigenous groups. Her Programme was ready to assist the new Commission and the technical programmes of WHO to enhance health for those populations.

Mr SHUGART (Canada), while welcoming the proposed Commission, said that it should not approach social determinants of health solely from the angle of inequalities. The determinants of health were relevant to everyone, regardless of circumstances. Research findings showed that the effective use of public funds in every sector could increase the resources allocated to health. Accordingly, the path to understanding what shaped health did not always lie in the health sector.

The CHAIRMAN, speaking as the member for Iceland and referring to the Report of the WHO Commission on Macroeconomics and Health,¹ said that that Commission had estimated that expenditure of about US\$ 25 000 million a year would be needed for some time to bring countries out of poverty. Improvements in health were invariably linked to poverty reduction. The purpose of the new Commission was to turn existing knowledge into public policy and action nationally and globally, drawing on the successes and failures of past efforts in the field.

¹ Document A55/5.

Dr EVANS (Assistant Director-General) said that the composition of the Commission had been decided so as to bring in a wide range of expertise, and the criteria for its work had been selected with an eye to both impartiality and clarity of focus. As independent members, the experts might select further topics of their own. He could promise the Board regular updates on the Commission's work, each with a focus on special determinants of health. The Commission would also examine the situation in countries, to determine which policies were proving successful and how. WHO would seek to integrate the Commission's findings into the work of all its technical programmes, and would cooperate fully with Member States and with other organizations in the United Nations family, including the United Nations Human Settlements Programme. On the question of resources, the Commission's funding would be provided within the Policy-making for health in development area of work, and was part of the resource mobilization plans. The Commission's aim would be to translate knowledge into action, and its work would be reflected in the Eleventh General Programme of Work 2006-2015. He assured the member for Canada that its approach would not be confined to inequalities in health.

The Board took note of the report.

Reproductive cloning of human beings: status of the debate in the United Nations General Assembly: Item 9.5 of the Agenda (Document EB115/INF.DOC./2)

Professor PAKDEE POTHISIRI (alternate to Mrs Sudarat Keyuraphan, Thailand) observed that reproductive cloning involved both ethics and human rights. Thailand had no legislation on the question, only a regulation by the Medical Council prohibiting it; nor was it punishable under criminal law. The report indicated that only 35 countries had adopted laws forbidding human cloning. The issue should be given more attention, and laws to govern it should be developed and enforced.

Dr RYAZANTSEV (alternate to Mr Skotnikov, Russian Federation) said that reproductive cloning was dangerous and unethical, in addition to having been badly developed. His country fully supported prohibition of the practice, which it had banned for the past five years. Nevertheless, advances in molecular and cellular biology had made for new and effective biomedical technologies, in the form of so-called "therapeutic cloning", with the prospect of curing numerous diseases; stem cells could be used to restore worn-out cells. Therapeutic cloning must, nevertheless, be strictly regulated, kept free of commercial exploitation and developed by the world's scientists and doctors through productive international cooperation.

Ms VALDEZ (alternate to Dr Steiger, United States of America) expressed her appreciation of the continuing efforts of Member States, in the Sixth Committee of the General Assembly of the United Nations, to resolve the implications of reproductive cloning. Her country called for further efforts to ban it in all its forms.

Ms MAFUBELU (South Africa)¹ welcomed the report and requested that attention continue to be paid to the debate on the subject in the General Assembly of the United Nations. The Secretariat should keep Member States informed through its governing bodies.

The Board took note of the report.

¹ Participating by virtue of Rule 3 of the Rules of Procedure of the Executive Board.

7. TECHNICAL AND HEALTH MATTERS (resumed)

eHealth: Item 4.13 of the Agenda (Document EB115/39) (continued from the tenth meeting, section 2)

Mr AITKEN (Director, Office of the Director-General) read out the amendments to the draft resolution, which had been agreed in informal consultations between members. The second preambular paragraph should be amended to read: "... health-care delivery, public health, research and health-related activities ...". In the third preambular paragraph, the phrase "on the part of Member States of WHO, partners and other international organizations" should be deleted. The fifth preambular paragraph should be amended to read: "... serve as a basis for WHO's activities on eHealth". The seventh preambular paragraph should be deleted.

Paragraph 1(1) should be amended to read: "to consider drawing up a long-term strategic plan for developing and implementing eHealth services that includes an appropriate legal framework and infrastructure as well as encouraging public and private partnerships". Paragraph 1(2) should be amended to read: "to develop the infrastructure for information and communication technologies for health as deemed appropriate to promote equitable, affordable and universal access to their benefits, and to continue to work with information telecommunication agencies and other partners to strive to reduce costs to make eHealth successful". Paragraphs 1(3), 1(6) and 1(8) should be deleted. A new subparagraph should be inserted in paragraph 1: "to consider establishing and implementing national public-health information systems and to improve, by means of information, the capacity for the surveillance of, and rapid response to, disease and public health emergencies".

Paragraph 2(3) should be amended to read: "... experiences and best practices, in particular on telemedicine technology; ...". Two new subparagraphs should be inserted in paragraph 2, the first reading: "to provide support to Member States to promote the development, application and management of national standards of health information, and to collect and collate available information on standards with a view to establishing national standardized health information systems in order to facilitate easy and effective exchange of information among Member States". The second would be worded: "... to support regional and interregional initiatives in the area of eHealth among groups of countries that speak a common language".

The resolution, as amended, was adopted.¹

8. CLOSURE OF THE SESSION: Item 10 of the Agenda

After the customary exchange of courtesies, the CHAIRMAN declared the 115th session closed.

The meeting rose at 19:10.

¹ Resolution EB115.R20.

